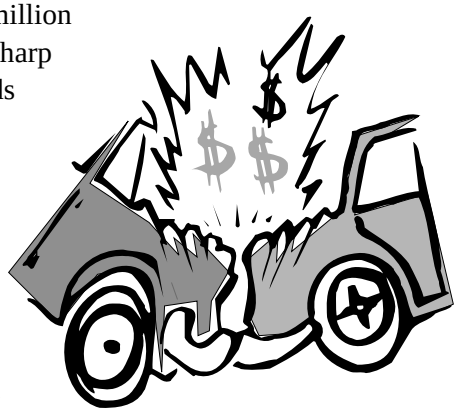
THE REGULATOR™
INSURANCE REGULATORY EXAMINERS SOCIETY

Auto insurance in crisis? Maybe . . . and maybe not

by Scott Hoober
Special to *The Regulator*

The nation's pool of assigned-risk motorists, which has dropped in recent years from records highs, has begun to rise again. The New York Auto Plan, for instance — which often accounts for half of the nation's total — reached 1.4 million a few years ago out of some 8 million vehicles statewide, and after sharp declines, it's climbing upwards again at the rate of some 9,000 a week.



The recent increases have been raising fears that the system is out of control, not only in New York but nationwide.

"You could call it either a problem or a crisis," said John Reiersen, president and CEO of Commercial Mutual, a Long Island-based subsidiary of the Robert Plan, which handles assigned risks for many insurers. "I think it's a crisis."

18% of market

For a while there in the '90s, things were going great guns in the auto market.

Besides external market forces, Reiersen recalled, the New York Legislature and the Department of Insurance enacted flex-rating, which allowed companies operating in New York to raise or lower rates up to 7% without prior approval. They also inaugurated multi-tier rating, which freed up insurers from having to set up separate companies to sell standard, nonstandard and preferred policies, for instance.

"Generally, companies were making money in New York," Reiersen said, "there wasn't a big fraud problem, and as a result there

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Proactive v. Reactive

Market Conduct 'Baseline' Exams

by Donald P. Koch, CIE

At the June 2002 NAIC meeting, market conduct examinations and their continuing role in the regulation of insurance evoked considerable discussion.

One obvious concern was the extent to which these examinations constitute a duplication of effort and overly burden some insurers. Most states conduct only target market conduct examinations and unfortunately the definition these states use for target examinations in effect equates to a limited-scope examination.

Many states feel they cannot afford to conduct comprehensive market conduct examinations. Subsequently, the role and nature of baseline examinations have become the subject of increased attention.

However, regulators are having

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NOVEMBER 2002

The Regulator™

Wayne Cotter, Editor
quepasa1@optonline.net

Kathleen McQueen, Associate Editor

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THE REGULATOR is published every other month by the

™ INSURANCE REGULATORY EXAMINERS SOCIETY

www.go-ires.org

130 N. Cherry, Suite 202 Olathe, KS 66061
913-768-4700 FAX 913-768-4900
IRES Continuing Education Line: 913-768-NICE

David V. Chartrand, executive secretary
Susan Morrison, office manager
Joy Moore, continuing ed coordinator

e-mail us at
ireshq@swbell.net

From the President

The Face of the Consumer

Often — in the blur of deadlines, meetings, and shifting priorities — it's easy to lose track of why we regulate insurers and agents. We think about the financial reports, the reinsurance treaties, the license status of agents and adjusters, the minutiae of advertising, the interpretation and meaning of regulations. And we forget that it's all about the consumer.

We don't regulate insurance companies financially simply so they'll stay in business; we regulate them financially so they'll stay in business to pay consumer claims. We don't license agents just to create more paperwork; we license them to ensure they provide professional service and accurate information to consumers. We don't write claim settlement regulations simply to create more laws; we write them to ensure consumer claims are settled fairly. Everything we do is about protecting the consumer.

We often forget that consumers are real people with real problems. I've been fortunate to work closely with thousands of consumers, both in a small rural state, Vermont, and in a large urban environment, New York City. The settings may change, but the consumers and their problems remain constant.

Take the case of Alma C (not her real name) whose vehicle was struck as she backed out of her Vermont driveway. The other driver had crossed the double yellow line from the opposite lane. The other driver's insurer determined Alma was 50% at fault for the accident. Until we intervened.

Or John W, who paid his agent $140 in cash for a new auto policy. The agent claimed she had no receipts and instead photocopied John's ten and

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President's Column ...

twenty dollar bills. Predictably, John's real cash and his application were never forwarded to the insurer. After John's accident, the insurer denied coverage. Until we intervened.

How about Sarah B whose foot was severely injured in an auto accident? She called her HMO for authorization to go to the emergency room. After 15 minutes, her HMO had failed to get back to her. Finally a state trooper at the scene took her to the ER, judging her injury too severe to wait any longer. Her claim was denied for lack of prior approval. Until we intervened.

Or Ramon and Juanita D, a couple in their 80s and in poor health. An agent convinced the elderly couple to cash in a bank CD from which they were drawing income to purchase a variable annuity that was not a qualified retirement account and lacked an income stream. The agent backdated the policy delivery date to a time when Juanita had been hospitalized. The company refused to reverse the sale and reimburse them for the early withdrawal penalty for the CD and the tax liability. Until we intervened.

You get the picture. As insurance professionals, we would all know how to handle these problems. But to lay consumers, insurance is an inescapable maze. Remembering that it is consumers such as these that we serve can focus us and enable all of us to do our jobs a little better. It's all about the consumer.

Paul J. Bicica, CIE
IRES President

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difficulty coming to grips with how to define a baseline examination and identify the elements it should contain.

Baseline

When I worked for the Alaska Insurance Department, I used the phrase "baseline examination" to mean a comprehensive examination conducted of an insurer being examined or reviewed by our Department for the first time. The idea was that a department needed a comfort level that a company was operating properly from the beginning. The baseline provided a starting point for more focused exercises at later dates. Obviously this is not the kind of baseline that the NAIC is currently discussing.

Over the past four years I have been conducting a series of these comprehensive exams, with a strong focus on the company operations/management component. Essentially, the kind of analysis I do during the company operations/management component of the exam focuses on how proactive or reactive a company is in each of the business areas subject to an examination.

In view of recent NAIC discussions, my experience in proactive/reactive analysis, and the need for states to accomplish these examinations with minimal resources, states might well consider a baseline examination that departs substantially from past definitions. Examinations that focus on the company operations/management, proactive/reactive analysis of each business area, and a detailed review of patterns that arise from complaint systems should provide an insurance commissioner with the necessary data to determine when and where a more limited-scope, targeted examination is appropriate.

Experience

I have been conducting examinations for the past 20 years, but only recently started using this form of analysis. What I have found is that proactive/reactive analysis tends to be very predictive. Since the examina-

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Market conduct 'baseline' exams

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tions conducted during this testing phase have been comprehensive examinations with reasonable levels of sampling, the samples tend to support the notion that the proactive/reactive analysis is a valid tool.

The sampling of business areas for companies with proactive tendencies generally yielded fairly clean results. Occasionally I found limited systemic problems and human errors, but rarely deliberate errors.

On the other hand, companies with management at the other end of the spectrum – reactive – tended to have considerable human error, systemic errors, and certainly more deliberate errors than are seen with proactive management. This suggests that if the analysis of proactivity vs. reactivity can be refined, it may function as the exact tool the NAIC is seeking to help states focus their field examination resources.

"Regulators are having difficulty coming to grips with how to define a baseline examination."

Management

In H.B. Maynard's "Handbook of Business Administration," the author focuses on the management cycle in a typical company. The discussions are fairly generic, suggesting that any type of company could apply Maynard's theories.

The management of well-run companies, insurance or otherwise, adopt processes that are similar in structure. An absence or ineffective application of such processes in an insurance company often presages an adverse result in sample testing conducted during the course of a market conduct examination. The processes typically include the following components:

Donald Koch, CIE, is a supervising market conduct examiner with INS Regulatory Insurance Services, Inc. (InsRis), located in Philadelphia. Mr. Koch worked for 27 years at the Alaska Division of Insurance, where he served as Chief of Market Surveillance. He chaired the NAIC Working Group that drafted the initial version of the current Market Conduct Examiner's Handbook and is a former IRES President (1993-94).

√ a planning function where direction, policy, objectives and goals are formulated;

√ an execution or implementation of the planning function elements;

√ a measurement function that considers the results of the planning and execution; and

√ a reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of its operations.

Planning

The planning function, where direction, policy, objectives and goals are formulated, is found in the written policies and procedures of the company. These are sometimes called processes, strategies or directives, and are tested for clarity, currency, functionality and conflict with existing statutes.

A proactive process that results in a reduced amount of negative feedback as the examiner conducts the examination is one that is clearly stated, up to date, fits the intended purpose and complies with state law.

A reduced amount of negative feedback means fewer errors and fewer violations uncovered by the examiner.

Findings from this review tend to be fairly predictive of areas where criticisms and errors will be found in the review of a sample. It also provides the examiner with data that helps to identify whether problems found are systemic, intended, unintended, or true error. Finally, it aids the planners of the examination in determining which business areas may need examiner attention.

Implementation

The implementation of the planning function elements occurs when management-directed policies and procedures are disseminated throughout the company to appropriate and affected persons. Review

Market conduct 'baseline' exams

of this process is useful in determining if the company is effectively distributing its directives.

Measurement

The measurement function, which evaluates the results of planning and implementation, is usually found in internal audits, management reports, supervisory reports, minutes of the Board, minutes of the Compliance Committee, minutes of the Quality Review Committee, market conduct examination reports, etc. This measurement is concerned with the quality of information developed to inform the Board of the results and the effectiveness of its directives.

> **"A regulator truly appreciates a company that takes proactive steps to avoid error."**

Without measurement, management cannot know whether its directions are being implemented effectively. The measurement process must be written, formal, and documented.

About eight years ago, I led an examination of the policies issued by one insurer for all Alaskan policyholders. We uncovered only one error in the company's entire book of Alaska writings. We later found that the company had already detected the potential for that kind of error and had established an internal task force to devise a way to prevent such errors.

We also found that the company, on a semi-annual basis, reviewed 25 files for each of its underwriters and claims persons. The tests in the company review were more stringent than those applied in our own examination process. In fact, test results were used by the company to evaluate its employees and to target areas for additional training.

Moreover, the results were applied in a manner that was both accepted and welcomed by company employees. Thus the company had designed a highly effective method for providing concrete evaluation of its directives.

Reaction

The process requires some reasonable way to utilize the information arising out of internal audits, management reports, and complaint systems. This would typically be reflected in the responses to internal audits, management reports, supervisory reports, minutes of the Board, minutes of the Compliance Committee, minutes of the Quality Review Committee, market conduct examinations, and errors detected through company complaint systems analysis.

This information needs to flow directly back to management so that it can use these findings to modify policies and procedures. The company should also resolve, through documented remediation, any errors that resulted in harm to policyholders and the public.

The Cycle

This cycle of preparing instructions (policies and procedures), disseminating those instructions, testing the results of those instructions, and modifying the instructions should be a continuous and ongoing cycle. A continuous and ongoing cycle is indicative of proactive management.

Of course, not every company is fully proactive or fully reactive. It has been my experience that the same company can be at both ends of the proactive/reactive spectrum depending on which business area is being reviewed. For example, a company with a proactive claims environment may have a reactive underwriting environment.

Ethical Management

A critical element in any scheme to develop allocation of examiner resources is ethical management. Ethical management is not a direct standard in the NAIC Market Conduct Examiners Handbook. It is usually not a direct requirement of the statutes regulating the business of insurance; however, it is strongly inferred through the structure of those statutes.

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Market conduct exams

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For example, a pattern of misrepresentations will raise strong doubts about an insurer's ethical base. The standards and tests found in the Handbook are generally objective indicators that can measure this behavior. Factors such as company attitude and negative, confrontational or resistive reaction by company management may be more subjective, but no less apparent to the regulator.

Attitude

Examiners experience a wide range of attitudes on the part of insurer management. My instruction to my examiners has always been to be cordial, but firm. Listen to explanations; evaluate on the basis of your knowledge and powers of observation; and act accordingly. The fact that a company may not want to be examined is no excuse for negative, belligerent, or discourteous treatment of examiners. A negative attitude on management's part is a strong hint that the company is not likely to receive a clean bill of health on its market conduct examination.

Conclusion

Regulatory agencies tend to be reactive due to broad directives and limited resources. I can therefore understand why a company may take offense at being labeled reactive by a state insurance department. Nevertheless, there is a different incentive at work for the company. Reactivity suggests that a company is accepting a level of error that may not be immediately discernible to the company. This means the company is accepting that errors will occur but will only be concerned with those errors if uncovered. That approach, however, often results in fines, penalties and negative publicity. A regulator truly appreciates a company that takes proactive steps to avoid error. It means that regulator can shift its attention to the companies that truly need it.

Having said this, it makes sense to me that a reasonable baseline examination for states to consider would be a proactive/reactive analysis of company management along with a thorough review of complaint patterns and other factors including, but not limited to, management ethics and attitude. ■

C.E. News

DID YOU MISS THE CE COMPLIANCE DEADLINE?

Designee holders who missed the Oct. 1 deadline for reporting required continuing education credits during the annual compliance period (Sept. 1, 2001 to Sept. 1, 2002) will soon be receiving notices that IRES will no longer recognize their designation.

To be automatically reinstated, designee holders must certify all past CE hours and pay a $60 reinstatement fee. Those who filed extensions prior to the deadline have one year to complete the required CE hours.

If insufficient CE hours were earned during the compliance period, a written appeal for reinstatement must be made in writing to the Accreditation & Ethics Committee in care of the IRES CE Office.

NEXT REPORTING DEADLINE IS OCT. 1, 2003

If in doubt about what qualifies for CE credit go to www.go-ires.org and review the NICE Manual online or better yet, print the manual and replace the outdated text in your NICE binder with the current edition.

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NAIC: Producer reciprocity standard in place for 35 states

The Gramm-Leach-Bliley Act of 1999 (GLBA), Section 321(a)(2), requires that by November 12, 2002, at least 29 states enact reciprocity laws and regulations governing the licensure of their nonresident agents and brokers.

To monitor the progress of reciprocity among the states, the NAIC established the National Association of Registered Agents and Brokers (NARAB) Working Group. The Group recommended the NAIC certify 35 states as having met the standards established by GLBA.

The 35 states are: Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Oklahoma, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

The Working Group based its recommendations on the following:

- Did the state adopt the Producer Licensing Model Actor or similar legislation?*
- Did the state insurance department submit a Certified Reciprocity Checklist and Addenda to the NAIC?
- What representations did knowledgeable state insurance department personnel make regarding the application of state law?
- Were consultations conducted with state insurance department personnel (as well as with the NAIC Legal Division and other NAIC staff) with expertise in producer licensing issues?
- What were the recommendations of the NARAB Working Group?
- What, if any, comments were submitted by interested parties?

* In order to provide states with a model for meeting these reciprocity requirements, the NAIC adopted the Producer Licensing Model Act (PLMA) in 2000. The PLMA serves as the primary vehicle for states to achieve reciprocity with respect to producer licensing. It also takes major steps toward reaching uniformity among states. With respect to reciprocity, the PLMA provides for streamlined administrative licensing requirements, reciprocal recognition of continuing education, and reciprocity for surplus lines and limited lines producers.

Quote of the Month

"I suggest that one regulator is going to have to wear 51 hats because the forms used and the rates charged would presumably still reflect state law and other local conditions present in the several states"

"The fact is we are all trying to eat each other's lunch, and some are asking Congress to set the table."

— Remarks by John R. Lowther, Senior Vice President of State Automobile Mutual Insurance Company, Columbus, Ohio, before a U.S. House Financial Services Subcommittee Roundtable discussion exploring federal regulation of the insurance industry. The discussion was conducted on September 17.

Are high-risk customers driving the auto market crazy?

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was intense competition, starting around ’91. The plan had gotten down by December of ’99 to about 200,000 cars. It had been about 18% of the market, and then it dropped all the way to about 2-2.5%.”

But by the end of the decade, things turned in the other direction.

“Around December ’99 companies began to look at their ’99 results, and they realized they were losing a lot of money. We have an enormous no-fault fraud problem in New York,” he said.

Reiersen speculated that perhaps one reason for the sudden increase in no-fault fraud in downstate New York, in particular, is that New Jersey did a lot to solve its no-fault problems, sending scammers across the bridge to set up their staged accidents (including the so-called swoop and squat, in which the scammer swoops in front of an unsuspecting driver — often a woman driving alone — then stops, causing a rear-end collision).

> **My company is getting over 500 no-fault lawsuits *a week.* These doctors are flooding us with bills, chiropractors, orthotic and supply houses, you name it. These medical clinics are making easy money.**
>
> **— John Reiersen**

Whatever the cause, he said, the cost of such mock accidents sent up claims costs. That in turn made the market less competitive, and thus the increase in the population of the assigned-risk pool.

Brian Sullivan, editor of *Auto Insurance Report*, a publication covering the nation’s auto insurance market, see things a little differently.

“This is not a crisis,” he said.

“This is a totally natural cycle. All of the assigned-risk plans are growing because times are tough.”

The auto cycle

The problem is not just that the factors affecting the cost of insuring autos (or homes, or businesses, or lives) go through cycles. The real problem is that (a) the effect of those externals isn’t always immediately visible, and (b) insurers inadvertently extend the lag between when something significant happens and the point where data come in that forces them to realize it’s happening and give up the ruinous competition.

For instance, when times are good, prices drop nationwide. All well and good. But then, insurers will often drop prices still further, in essence buying business. Unfortunately, they’ll sometimes do that just as another corner is about to be turned — the stock market, the general economy, oil prices, 9/11 — increasing the shock when they realize what’s happening to their price structure, loss costs and profitability.

In the cattle business, it’s called the beef cycle. Whenever beef prices go up, everyone grows their herd — depressing beef prices and starting another turn of the wheel.

Here’s how Sullivan sees the . . . let’s call it the auto cycle . . . over the past decade: “In the late ’80s, very early ’90s, insurers had not been making any money in personal auto, and therefore were not particularly interested in high-risk drivers,” he said. “They didn’t have their rates together, they didn’t have their underwriting together, they just weren’t making money with that group of drivers.

“Then, in ’92-93, claims costs collapsed for a bunch of reasons. Some of them are pretty simple. Demographics — the baby boom was moving from its most dangerous driving years to its safest. Drunk driving fell. The introduction of car safety features, side-impact panels being just as important as airbags. And then you had a major shift in the way juries looked at plaintiffs, that is to say, the juries became much more conservative.

“Then the stock market takes off. So insurers are making money hand over fist — making record profits in ’94, ’95, ’96, ’97.”

Around that same time credit scoring and other more sophisticated underwriting techniques also began to come to the fore.

New York, the nation and the high-risk auto market

"Companies started to realize that drivers who had points also had data points on which you could rate them," as Sullivan put it. "So you could begin to separate good drivers with DWIs from bad drivers with DWIs."

In a market like that, some motorists will move from assigned risk on their own. With lower prices and greater competitiveness, many people who formerly couldn't get coverage in the voluntary market find that now they can. On top of that, the new underwriting tools allowed some companies to go after the cream of the pool.

Subsidies

In '99 and '00, when claim costs started back up, some insurers were, sure enough, still engaged in aggressive rate-cutting. That led to a complete reversal of profitability. And that — surprise! — led to sharp growth in assigned-risk plans, in New York and in other states.

"It's just a cycle," said Sullivan. "It's sort of the nature of competition in the insurance industry. Auto's certainly not unique."

Best of all, he said, the market's already turned, at least in auto. But of course, since the data making it clear that the market has turned always take a while to become available, companies are still acting as if conditions are still awful (as indeed they are in some other lines).

Reiersen

"The market will improve," Sullivan said. "In fact, the market has improved — you don't see the data yet, but the second half of 2002 and the first half of '03 are likely to be very nice for personal-lines auto insurers. But you won't see assigned-risk plans start to shrink until probably late 2003, '04."

But lag or no lag, the New York Auto Plan is by leaps and bounds the largest in the nation (among states that have a residual market). Clearly, something is going on there that isn't going on elsewhere.

"It's on purpose," Sullivan said. "New York, politically and legislatively, has always desired to have a subsidized assigned-risk plan, because they want to provide as low a price for auto insurance for urban drivers as they possibly can. The New York assigned-risk plan has always been intentionally big, because it's priced at a loss.

"It's really a New York City deal, and it was always meant to be subsidized," he added.

Reiersen estimates the subsidy at about $150 per motorist in the voluntary market on a statewide averge. "But it varies," he said, from about $300 per motorist in New York City to $100 upstate.

> **"The second half of 2002 and the first half of '03 are likely to be very nice for personal-lines auto insurers."**
>
> — Brian Sullivan

Sullivan added: "Michigan is another state with an intentional subsidy, and if you look at the Michigan plan, it's pretty big. New Jersey too. But New York is big on purpose — not because the market has some egregious problem but because the Legislature has decided that it wanted it that way."

Now, there's nothing wrong with governments making decisions like that. The marketplace is about economic good. Period. Government's job is social good, and subsidies — from the progressive income tax to highway construction to the defense budget — don't have to make dollars-and-cents sense.

Trouble is that, in this case, part of the deal is that no one talks about it. The Legislature has to go on pretending the size of the pool is a problem and enact carrots and sticks to depopulate it. But all without doing away with the basic goal: to subsidize the cost of high-risk drivers owning a car in the big city.

"It's an ironic thing," said Sullivan.

"They set up the plan so that it is a superior competitor — I mean, if the rates in the New York Plan went up to an actuarially sound level, all those customers would wind up in companies — but the politicians don't want the rates to go up to actuarially sound levels. Then the subsidy would be gone, and

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The high-risk auto market: Crisis? What crisis?

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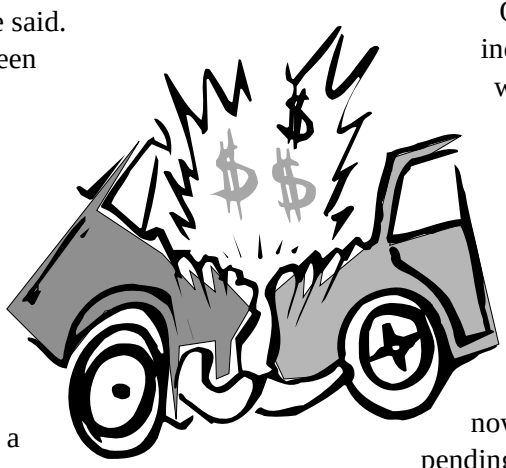
those people would have to pay too much money, in their perception.

"It's trying to burn the candle at both ends. They say, 'OK, now we've got to get people out of this plan that we forced them into with an attractive rate.' And so they give insurers credits and things to take customers out, which again is part of the social policy: trying to get insurers to write business in markets where they normally wouldn't go.

"They're managing the market," he said. "It's not an uncommon behavior, it's been going on for years, and it hasn't really hurt anybody."



Fraud

Why the subsidy? Because the actual, unsubsidized cost of insuring a car in Manhattan, Queens or, especially, Brooklyn is indeed unconscionably high.

Reiersen said that even in the pool, a clean Brooklyn driver — experienced, no violations, no accidents — will pay $3,900 a year for 25/50 coverage, with no physical damage, no comprehensive and no collision. That's *in* the pool.

"If you happen to have a surcharge for an accident or a ticket, if you want limits higher than 25/50, well, it's going to be significantly higher than $3,900," Reiersen said.

"And that's really unaffordable. The same is true in other areas: Queens is around $2,900, Manhattan around $2,900. If you want physical damage and 100/300 coverage like the average motorist, you're going to pay close to $8,000-$9,000."

And it's not solely a big city problem. Reiersen said 60% of policies in the pool now belong to motorists on Long Island or in upstate New York.

Even if, as Sullivan says, the New York market is subsidized, there are cost problems that need to be addressed. Proposals that went nowhere in this year's Legislature (and which might pass next year) may not slow growth in the Auto Plan — which is, as noted earlier, currently seeing some 9,000 new applications a week. Yet anything that keeps down costs can't hurt.

Even in this election year, some progress has been made on one cost: driver fraud. The New York Police Department now has a 15-member squad focused on no-fault auto fraud, every district attorney in the city has its own special unit, and pretty much every insurance company has increased the size of its Special Investigation Unit (SIU).

"There's a lot of prosecution going on, and a lot of the staged-accident rings have been broken up," Reiersen said.

Other legislative proposals include going after runners, those who steer victims of staged accidents to cooperative clinics, chiropractors and lawyers, making their trade a class C felony.

There's also hope for reform of the no-fault arbitration system, designed to be a prompt, efficient system but now facing a backlog of 100,000 pending cases and a delay of 14 months. No-fault claimants can also go to court, and they do.

"My company is getting over 500 no-fault lawsuits *a week,"* Reiersen said. "These doctors are flooding us with bills, chiropractors, orthotic and supply houses, you name it — these medical clinics are making easy money."

Another bill that went nowhere this year would certify all medical providers to treat no-fault auto victims. If they're found to be abusing the system and decertified, they still wouldn't lose their license, which might make the bill palatable once the election is past.

In the 30 years since no fault has been in effect in New York, only one provider has lost his license for abusing the system, Reiersen said, and that was only after he was found to have submitted 3,500 bills for medical procedures that he hadn't performed.

"It took a lot of pressure to get that guy to lose his license," he said.

There's clearly plenty that can be done to reduce claim costs — whether auto insurance is experiencing a problem, a crisis or simply a cycle. ■

Garamendi Wins?

Some may wonder why anyone would want to actually *run* for the job of Insurance Commissioner. After all, it's a position where the headaches never stop and one that hardly ever leads to higher office, especially in California.

Well, John Garamendi, a Democrat, not only wants to be California's next insurance commissioner, he wants it *for the second time*. He was California's first elected commissioner serving a full four-year term in the early '90s. Those years, marked by Executive Life's insolvency (including the controversial buyout by AXA) and the protracted implementation of Proposition 103, apparently did not dampen Mr. Garamendi's enthusiasm for the job.

After stints in the Clinton Administration and the private sector, Mr. Garamendi appears primed to once again mix it up with California insurers and producers. But can he win?

His Republican opponent, Gary Mendoza, former commissioner for California's Department of Corporations, lacks an extensive insurance background and has little name recognition. Four other minority party candidates are also vying for the post. Despite escalating auto premiums and increasing concern about the availability of homeowners coverage, the election has generated little interest.

The current California Commissioner, Harry Low, is a retired judge who was appointed when Chuck Quakenbush stepped down in 2000.

At press time, Garamendi's chances look good due to his high name recognition, his consumer-oriented campaign (although both major candidate eschew insurance industry contributions), and an apparent desire by California voters to cleanse themselves of the scandal-ridden Quakenbush years. It doesn't hurt that Democratic incumbent Gov. Gray Davis now leads Republican opponent Bill Simon Jr. in one of the more rancorous California gubernatorial contests in memory.

We understand John Garamendi, unlike his successor Chuck Quakenbush, is a legitimate "people person" who, during his tenure as California Commissioner, actively sought input from the Department's rank and file. It's been a long eight years since Mr. Garamendi last served. Should California voters return him to office, our bet is most Department of Insurance staffers will be pleased to see a familiar face.

Stay tuned. ■

Oldest Working Life Actuary to Leave State Service

Actuary *extraordinaire* and New York Department of Insurance staffer, James Gardiner, has announced his intention to retire in November 2002. Mr. Gardiner, 95, began his career with the Metropolitan Life Insurance Company the same year Wyatt Earp died, 1929. After working nearly 43 years for MetLife, he joined the New York Insurance Department in April 1972 for an additional 30+ years, working primarily on public pension issues.

Mr. Gardiner

Mr. Gardiner, who was featured in a recent *Regulator* article ("*The Country's Oldest Working Life Actuary,"* Jan. '01), plans to complete work on his family's genealogy and enjoy life in Manhattan, where he makes his home. IRES salutes James Gardiner for over seven decades of service to the insurance community. ■

Welcome, new members!

Charlotte A. Carter, AIE,
New Mexico

Robert C. DeBerge, Arizona

Regulation helps insurers stay healthy in unhealthy climate

by Joseph L. Petrelli
President
Demotech, Inc.

The more I read about other industries, the more I like the insurance business. As a matter of fact, I think it is time for publicly traded property and casualty insurance companies to stop focusing on their potential September 11 property losses or their K-Mart surety exposure and, instead, promote the quality and quantity of the financial scrutiny they undergo.

If the Enron situation has caused investors concern about revenue estimates and the quality of earnings, insurance stocks may provide the value they seek. It seems to me that the four fundamental financial issues at Enron were:

1) How does one calculate top-line revenue?

2) How does one calculate bottom-line revenue?

3) How do you value assets?

4) What is disclosed on the balance sheet and what is not?

Enron and its auditors focused on these issues because, in part, Enron was on the cutting edge of its industry. Accordingly, there was limited guidance or precedent for regulators to follow. Compare such cutting-edge oversight with the established scrutiny that a publicly-traded insurance company endures:

(1) independent audits;
(2) internal audits;
(3) financial examinations by the insurance department of its state of domicile;
(4) market conduct examinations by insurance departments;
(5) review of loss and loss adjustment expense (LAE) reserves by its corporate actuary;
(6) review of loss and LAE reserves by its auditor's actuary;
(7) review of strategy and operating results by at least two major insurance rating agencies;
(8) review of 10-Qs, 8-Ks, and 10-Ks by the Securities and Exchange Commission;
(9) scrutiny of Wall Street analysts; and
(10) scrutiny of reinsurers.

The knock on insurance companies used to be (yes, I used the past tense) they were risky because they charge a premium today to protect against unknown future losses. In other words, they may not know the ultimate cost of their product until many years after they sell it.

Guess what? Within reasonable boundaries, insurance companies know the cost of their product. Whether they charge the appropriate premium is influenced by other factors – investment income opportunities, marketing strategy, insurance department negotiations and their market leadership position or lack of position.

The interesting thing about insurance companies is that their claims personnel, regulators, actuaries, and auditors focus on the ultimate cost of the product (loss and LAE ratio and related reserves) with an extensive array of standard financial disclosures. These disclosures have been derived and/or executed by trained professionals, disinterested third parties, regulators, and rating agencies.When material differences in the estimates of liabilities appear, the news travels fast.

With the issue of liabilities fairly well addressed, let's turn our attention to revenue and income.

For an insurer, top line revenue is net premium earned — not what a company wrote without regard to reinsurance costs or the cash it took in. Top line revenue is that portion of premium that under no circumstances can be refunded to insureds. For the remaining unearned premium, insurers are required to establish reserves. Not only do they establish a reserve for that unearned premium, that reserve includes a

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Joe Petrelli is the founder and President of Demotech, Inc., a financial analysis and actuarial services firm. He has been employed in the P&C insurance business since 1969. He is a member of the Casualty Actuarial Society, American Academy of Actuaries, Conference of Consulting Actuaries and the Society of Financial Examiners.

Regulation and insurers

provision for operating expenses, operating expenses that have already been paid!

Bottom line income is impacted by the conservation of the top line revenue. However, income is fairly conservative in its own right because the insurer's losses and loss adjustment expenses — have not been adjusted to reflect the time value of money.

As for asset valuation, the National Association of Insurance Commissioners Securities Valuation Office assigns the value for virtually all publicly-traded bonds or stocks owned by insurers. Other asset safeguards imposed by insurance accounting:

- Buildings are carried at cost less depreciation, not market value.
- Office furniture and fixtures can be expensed but are carried at no value.
- Automobiles, from the Presidents' brand new Lexus to the mailrooms' Chevy van, are carried at no value.

Are insurance companies indestructible? No, some fail. Even publicly-traded insurers do, and will, fail. However, the underlying accounting and financial issues that rang the death knell for Enron and undermined the retirement plans of its employees have long been silenced in the insurance industry.

Most publicly traded insurance companies, in my view, are currently undervalued in the marketplace — they should be priced at higher multiples than most insurer stocks currently trade.

As an insurance company's coverage reduces the risk of its policyholders, the insurance industry's "cost of regulation" has become a badge of honor and should provide investors with a good measure of comfort that insurance stocks will not follow the Enron cycle. ■

Come to the 2003 CDS and bring your swimsuits!

The 2003 IRES Career Development Seminar will be July 27-29 at the Hyatt Gainey Ranch hotel and resort. It is the perfect educational and training atmosphere — and the perfect vacation for members of your family. Swimming, biking, golfing, tennis, spa, and just about everything else you can imagine is available in this resort, just outside Phoenix in Scottsdale, Arizona.

The many pools of the Scottsdale Hyatt

IRES has a very low group room rate of $135 per night single or double. Our block of rooms is limited so do not wait until next summer or you may not get a room.

Call the Hyatt now at 480-991-3388, or 800-55-HYATT at tell them you are with the IRES group. You find lots of info and pictures about the hotel at http://scottsdale.hyatt.com

Persons Without Health Insurance*
United States, 1992-2001
(numbers in thousands)

		Uninsured	
	All People	Number	Percent
2001	282,082	41,207	14.6%
2000	279,517	39,803	14.2
1999	274,087	39,280	14.3
1998	271,743	44,281	16.3
1997	269,094	43,448	16.1
1996	266,792	41,715	15.6
1995	264,314	40,581	15.4
1994	262,105	39,718	15.2
1993	259,753	39,713	15.3
1992	256,830	38,641	15.0

Source: Estimates are derived from Current Population Survey (CPS) 1992-2001, U.S. Bureau of the Census.
* The CPS counts as insured those individuals with (1) employment-based health insurance coverage; (2) individual health insurance; (3) government health insurance such as Medicaid or Medicare; (4) military health coverage such as CHAMPUS; and (5) health insurance purchased through associations or organizations. An uninsured person would be one without any of these coverages.

Seeking a Common Vision: Part 2

Editor's Note: *The following interview was conducted by* ***Scott Hoober*** *and* ***Wayne Cotter*** *following the Commissioners Roundtable at the San Antonio CDS. The Regulator would like to thank Iowa Commissioner and NAIC President* ***Terri Vaughan,*** *Texas Commissioner* ***Jose Montemayor****, Oregon Commissioner* ***Joel Ario*** *and Ohio Commissioner* ***Lee Covington*** *for participating. Due to a prior engagement, Texas Commissioner Montemayor was not able to participate in this portion of the interview. Part I of the interview appeared in the September issue.*

Regulator: *We've been talking about more cooperation among states, yet I see states that are essentially turning their backs on professional organizations, the very organizations that can help foster such cooperation. Attendance is down at this year's CDS — of course 9/11, cutbacks in state budgets and other factors impacted that. I wonder if there is enough emphasis on the state level on professional organizations such as IRES?*

Vaughan: My strong suspicion is that the reason your attendance is down has to do with state budget cuts. I was just at a National Conference of State Legislators meeting last week and they normally have 7,500 people at their meetings. They were down to 5,500. That was because of state budget issues, primarily . . . I think that when you have these state budget cuts, one of the first things you cut is training and education. That, unfortunately, is the wrong thing to do. It's absolutely the wrong thing to do . . . training and education are critical. Now, today, with these national issues we're dealing with, with the change we're trying to motivate, I think it's critical that people from different states come together because we have to start thinking alike about things, we have to start developing a common vision and working toward that common vision at the staff level. We've done it on the commissioner level; we've got to get a common vision. But we've got to get that common vision on the staff level and it happens in organizations like this.

Commissioner Vaughan of Iowa

Ario: Sometimes, I think, people overly focus on these differences in law and say "All this is based on state law." It's not, it's based on administrative regulations, customs and all of that and if you don't have people properly trained, no matter how much uniformity you get in the laws, we're still going to have operational problems. People have to work together and have the same kind of expertise to make these changes work.

Covington: Training is critical. I couldn't say it any more eloquently than Terri did. The *last* thing you need to do in these times is cut training budgets. We've been faced with that [in Ohio] and people have come to me and asked me about training and I've said "We need to go; we need to go." Because the things we're working on will make us more efficient. So we have an investment here and we've got to do that in the here and now.

Ario: The last time Oregon went through a real serious budget problem back in the early 1980s, that caused the insurance industry, the regulator and all the stakeholders to come together and say: "Let's go to a dedicated fund model for insurance regulation because we can't have these gyrations" . . . now we have an all-dedicated fund so in the current budget trough, we're not directly affected. We're not losing anybody. The rules about travel . . . that apply to a general-fund agency, do not apply to us. I think the states that have any significant reliance on general funds will probably look at a model with dedicated funding.

Vaughan: In Iowa, we had an early retirement program. In January, our property/casualty form analyst took early retirement and we were not allowed, because of the state budget situation, to fill the position until now when the new fiscal year started. It's not good, but I don't think politically we could ever get to that type of dedicated funding.

Ario: Really? The industry may help you there.

Ario of Oregon

Vaughan: Yes, they have said they would, but there is just this [opposition] in Iowa to that kind of dedicated funding.

Covington: Legislators tend to have trouble because they lose control to some degree.

Vaughan: Right

Regulator: *Yes, money is power. Lastly, what questions haven't we asked or were not addressed in this morning's Roundtable?*

Covington: One issue that wasn't raised, and these guys may kill me, was this issue of suitability in life insurance products.

Vaughan: Actually, I'm not going to kill you, I look forward to hearing if you have an answer.

Covington: The one thing I will say is I do think we need a suitability standard. Whether the model we have drafted right now is the right one is a question we need to evaluate . . . I think we need to give it a lot of thought and proceed forward.


Lee Covington

Ario: I have said in Oregon that if we don't get a suitability model out of the NAIC, we are going to move forward on our own and we will look to the states, like Iowa, that already have suitability models. One thing that distinguishes those from the current NAIC model (and I think a lot of time and effort and good faith went into putting together that model, but in the end, like a lot of NAIC models, it gets more complicated probably than it needs to), is that they are simple and straightforward . . . it's just a basic duty to inquire about financial circumstance and make a recommendation that's not unsuitable and not a lot more than that.

> **"Training is critical. . . . the last thing you need to do in these times is cut training budgets."**
>
> — Commissioner Lee Covington

Regulator: *Could someone define suitability?*

Vaughan: On the securities side there is a requirement that recommended securities be suitable for the individual that is purchasing them. Suitability means suitable in terms of [the customer's] risk profile, financial condition, family circumstances and so forth. So we've been working for several years now on a suitability model at the NAIC that would require that when life insurance agents make recommendations, that the products . . . are appropriate for the individual in light of their personal circumstances. Part of what the industry is concerned about is having a suitability model adopted in all the states with market conduct examiners taking different interpretations on suitability because it's so subjective. And then you get fined by two states for something that all the other states think is OK. And then those fines are used as evidence of wrongdoing in some kind of litigation and that is — bottom line — what the industry's complaint is on suitability.

Covington: I think it's a legitimate concern and we need to address that.

continued on next page

Seeking a Common Vision: Part 2

continued from previous page

Regulator: *Is it a big agent issue?*

Ario: Part of this issue does become who is responsible, the agent or the company . . . that's one of the complicating dynamics to get in a model. You can look at securities where it has worked as a standard. You can look at the states that have it where it works as a standard and I think we need to find a way to go off of those models because what we have now is essentially process-oriented regulation and that gets most of the problems. Most of the time when we find a really awful deal in the marketplace, there's going to be misrepresentation or there is going to be failure to disclose — most of the time. But sometimes you've got a real smart *and* sleazy agent at the same time. He'll figure out how to dot all the "i's" and cross all the "t's"; do all the disclosure properly; not make any misrepresentations, but *still* sell a grossly unsuitable product, particularly to an elderly person, and we think we need a regulatory tool to deal with those situations.

Covington: Let me tell you what we know today. We know today that a significant [portion] of the life insurance industry uses six to eight forms to assess suitability. They do it today. Not all the industry does it. So, my position is that everybody should do that, everybody should use some tool to assess suitability . . . . Number two, we know that the Life Insurance Marketing & Research Association is continuing to develop a program that can be used by an agent . . . that uses a number of tests to assess suitability. And it even has green light, red light, yellow light and that information automatically goes to the company for a peer review if there's a yellow or red light. And that product is very new . . . so, there are tools out there to help us address this issue.

NASD put out a Notice to Members in 1999 and in 2000 that dealt with variable life and variable annuities . . . [that] actually require the companies to have a system in place where the registered principal has to monitor [suitability]. I'm not sure that's going on by 100% of the companies in the life insurance industry today. And there ought to be a system in every life company where they are looking at this and monitoring the activities of their agents using some objective criteria.

Ario: Well I'll be a little bit provocative this morning and say that if you look at any state's insurance code, they give a lot of discretion to the Insurance Commissioner. Not every issue can be standardized and objective and measurable . . . I'm all for that wherever we can do it. And I think we will be much better in market conduct when we're closer to financial in the way we do things. But the idea that every standard has to have a clear objective or meaning, we couldn't do the kind of regulation we do. Almost every state in the ratemaking process has the words: "rates cannot be inadequate, excessive or unfairly discriminatory." Now those are not words that are very precise, but it's important to have that kind of discretion. I'm for getting as far toward consistency as we can, but I think the concept of suitability will not lend itself to as much precision as some other concepts.

Covington: I do think insurers need to know the rules of the game and that's a difficult challenge . . . to do that, but I think that we should explore whether we can provide more certainty than what the current model contains. Whether we can or not, I don't know.

Ario: I totally agree with that. Right now, this *is* the debate we have to [resolve] in order to move forward on this issue.

Regulator: *Thank you, commissioners.* ■

IRES State Chapter News

NEBRASKA — The Nebraska IRES Chapter held a continuing education meeting on August 21. Our speaker was **Bruce Ramge**, Chief of Market Regulation with the Nebraska Department of Insurance. Bruce gave an overview of the IRES 2002 Career Development Seminar. In addition, he spoke on effective presentation skills, including preparing for speeches. It was an overview of what he learned from the NAIC "Train the Trainer" program. Our next meeting was scheduled for Oct. 23.

— Submitted by Karen Dyke, kdyke@doi.state.ne.us

LOUISIANA — The Louisiana State Chapter of IRES now has a membership in excess of 65. The Chapter held a meeting on Aug. 23 with **Acting Commissioner Wooley** as our speaker. Commissioner Wooley addressed the meeting of approximately 50 attendees. The meeting was a lively discussion of the pros and cons of speed to market. Membership cards and packets were distributed to state chapter members. The next meeting is scheduled for Oct. 25.

— Submitted by Larry Hawkins, lhawkins@ldi.state.la.us

VIRGINIA — Twenty-five Virginia IRES chapter members recently attended a presentation on the emerging issues and industry trends affecting market regulation. Our speakers were **Mary Bannister**, Deputy Commissioner for property and casualty insurance, and **Jackie Cunningham**, Assistant Deputy Commissioner for life and health insurance. Mary and Jackie discussed how the focus and goals of state regulators have changed due to the Gramm-Leach-Bliley Financial Services Modernization Act, the events of September 11, issues at the national level, and initiatives at the federal, NAIC, and state levels. They also discussed the various NAIC and national groups and legislative proposals that have been created as well as technology changes both at the NAIC and in Virginia to deal with these issues. Members were treated to a box lunch and received continuing education credit for attending the meeting. Our next meeting is scheduled for November with the San Antonio CDS as our topic for discussion.

— Submitted by Catherine West, CWest@scc.state.va.us

Charlie Elgin: 1929 - 2002

Charles C. Elgin, one of the original IRES "founding fathers" and a former officer and board member of the Society, passed away Sept. 24. He was 73.

Charlie went to work for the Missouri Division of Insurance in 1972 as a rate examiner. Prior to that he had been a loan officer, bail bondsman and insurance agent. Although fluent in most types of insurance, his specialties were those insurance products that were out of the mainstream and posed harm to consumers. Those included credit-related coverages, mobile home policies, bail bonds and non-standard auto coverage. Charlie served in various positions while with the Missouri department, including market conduct examiner, examiner in charge and supervisor. He also worked for the Oklahoma Insurance Department and later the Kentucky Insurance Department.

"Charlie was always friendly and willing to offer the benefit of his experience when asked," says Don Koch, longtime market conduct examiner and former IRES president.

Charlie was involved in IRES from its initial organizational meetings and served on its first board of directors, including a term as secretary. In 1999, he received the Society's Al Greer Achievement Award.

"As a young former college professor, I was lost as an examiner," said Brad Connor, a veteran Missouri regulator and former IRES president. "When Charlie became my EIC, he taught me how to be an examiner and a great deal about the lending and credit industry. I was always impressed with the knowledge and gentleness of the man."

REGULATORY ROUNDUP

by
Stroock & Stroock
& Lavan LLP

COLORADO – Division of Insurance issues bulletin regarding producer involvement in the placement of unauthorized and illegal health coverage

The Colorado Division of Insurance issued Bulletin No. 1-2002 on June 3, 2002 concerning producer obligations and potential liability in connection with unauthorized and illegal health coverage. The Division recently learned that certain unauthorized insurers have been representing themselves as self-funded or partially self-funded multiple employer welfare arrangements, multiple employer trusts or some other plan that is exempt from state insurance regulation. The Bulletin reports that some of these unauthorized plans are being fraudulently operated or are under-funded and, as a result, some Colorado residents have been unable to collect on their insurance claims. The Bulletin notes that such unpaid claims are not covered by the state guaranty fund and that producers marketing and issuing these unauthorized plans may be held liable for payment of unpaid claims and subject to administrative action. The Colorado Division of Insurance emphasizes that a producer is responsible to perform adequate due diligence to verify the legitimacy of any insurance program being marketed and to determine whether the program is subject to state or federal jurisdiction, or both. *To view Bulletin No. 1-2002, visit www.dora.state.co.us/insurance/regs/b01-02.pdf. See also Massachusetts Division of Insurance Bulletin B-2002-11 on this same topic (visit* ***www.state.ma.us/doi/bulletins).***

MINNESOTA – Division provides guidance on use of new file-and-use privilege for health insurance rates

The Minnesota Insurance Division recently issued Bulletin 2002-5 to provide guidance to all licensed health insurers regarding the recently enacted health insurance rates file-and-use provisions set forth in House File 2988 and codified in the Minnesota statutes, Section 62A.02, Subdivision 2(b). The Bulletin reminds health insurers that Section 62A.02, Subdivision 2(b), as subsequently amended by Senate File 3024, excludes Medicare-related coverage from the file-and-use privilege. Consequently, only an insurer filing rates applicable to an accident and sickness policy other than a Medicare supplement policy may use the file-and-use option, which permits the use of rates that have not been disapproved by the Minnesota Insurance Division within 60 days of such rate filing. The Bulletin also notes some of the risks associated with the new file-and-use privilege, including the expense that may arise from implementation of a rate pursuant to the file-and-use privilege that is later disapproved or modified by the Minnesota Insurance Division. The Bulletin also notes that the 60-day period used in connection with a file-and-use rate filing does not begin until the corresponding policy forms have been approved. New policy forms and accompanying rates should be filed simultaneously and cross-referenced. Moreover, the Bulletin advises that insurers should exercise careful judgment when deciding whether to utilize the file-and-use privilege. While the privilege may be appropriate for minor rate changes, it may not be prudent for filings involving major rate increases. The file-and-use privilege applies to rate filings submitted on or after July 1, 2002. *To view Bulletin 2002-5, visit* ***www.commerce.state.mn.us/pages/Insurance/InsBulletin.htm.***

NEW YORK – Law enacted to let proprietors purchase small group health insurance coverage

Senate Bill S.7360 was signed into law by the Governor and is now Chapter 557 of the Laws of 2002. Chapter 557 provides that, if an insurer issues coverage to an association group, including a chamber of commerce, the insurer must issue the same coverage to individual proprietors (who are association members) as the insurer issues to small groups that purchase coverage through the association. Chapter 557 also provides that, for all coverage purchased by individual proprietors who are association members or who otherwise have their own coverage as of the effective date of the legislation, such proprietors must be classified in their own community rating category, provided however, that prior to Jan. 1, 2006, the premium rate established for such individual proprietors shall not be greater than 120% of the rate established for the same coverage issued to association

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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.

groups. Chapter 557 became effective on September 20, 2002.
For more information, visit ***www.assembly.state.ny.us.***

NEW YORK – Law to require health insurers to provide coverage for infertility tests and treatments
Assembly Bill A.9759-B was signed into law by the Governor and is now Chapter 82 of the Laws of 2002. Chapter 82 requires health insurers to provide coverage for: (i) surgical and medical procedures to treat malformation, disease or dysfunction resulting in infertility; (ii) diagnostic tests and procedures used to determine fertility; and (iii) prescription drugs used in the treatment of infertility, if coverage for prescription drugs is already provided under the policy. Persons aged 21 through 44 years of age may be provided with such coverage. Coverage is not required to be provided for the diagnosis and treatment of infertility in connection with: (i) in vitro fertilization; (ii) gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (iii) reversal of elective sterilizations; (iv) sex-change procedures; (v) cloning; or (vi) experimental procedures. The Superintendent of Insurance, in consultation with the Commissioner of Health, is required to promulgate regulations stipulating the medical guidelines and standards to be used to implement the law. The law also appropriates $10 million to establish a grant program intended to improve access to infertility services, treatments and procedures. Chapter 82 became effective on Sept. 1, 2002. *For more information on A.9759-B, visit* ***www.assembly.state.ny.us.***

MISSOURI – Legislation revising the Long-Term Care Insurance Act signed into law
Governor Bob Holden signed into law House Bill 1568 on July 12, 2002, which includes provisions revising the Missouri Long Term Care Insurance Act (codified in the Missouri Revised Statutes, Sections 376.951 to 376.958 and 376.1121 to 376.1133). House Bill 1568 defines "Qualified long term care insurance contract" and provides that such a contract is included within the definition of "Long-term care insurance." The outline of coverage provided to long-term care insurance applicants must now include a statement indicating whether the coverage is intended to be a federally tax-qualified long-term care insurance contract. The legislation sets forth various other consumer protections applicable to the sale of long-term care insurance. For example, the legislation requires an insurer, at the request of a policyholder or certificateholder, to provide such person with a written explanation of the denial of any claim. In addition, House Bill 1568 requires long-term care insurance carriers to give policyholders, and in some cases, certificateholders, the option to purchase a nonforfeiture benefit. If the policyholder or certificateholder declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon a policy lapse that will be available for a specified period following a substantial increase in premium rates. House Bill 1568 directs the Missouri Director of Insurance to promulgate rules regarding the types of nonforfeiture benefits and contingent benefits to be made available upon the lapsing of a policy. House Bill 1568 also contains provisions amending Missouri statutes governing reinsurance and insurance company investments. *For additional information concerning House Bill 1568, visit* ***www.house.state.mo.us.***

VIRGINIA – Bureau of Insurance outlines license application process applicable to foreign and alien insurers seeking to do business in the state
The Virginia Bureau of Insurance issued Administrative Letter 2002-7 on June 17, 2002, detailing requirements applicable to foreign and alien insurers seeking admission to do business in Virginia. Prior to being issued a license and a certificate of authority to do business as a foreign or alien insurer in Virginia, an applicant must satisfy the qualifications set forth in Administrative Letter 2002-7. An applicant must meet applicable statutory minimum capital amounts. An applicant must also have surplus in excess of minimum capital in an amount determined by the Virginia Bureau of Insurance to be sufficient, but in no event less than $500,000. In addition, Administrative Letter 2002-7 requires an applicant to submit financial statements and any other reports or documents deemed necessary by the Commissioner of Insurance to evaluate the applicant's financial condition. Finally, an applicant must provide assurance that it is solvent and capable of meeting its obligations to policyholders. Administrative Letter 2002-7 advises that Virginia is a uniform state for insurer licensing purposes, and therefore, all applicants seeking admission to do business as foreign or alien insurers in Virginia must complete the Expansion Application included in the National Association of Insurance Commissioners' Uniform Certificate of Authority Application. The Virginia Bureau of Insurance intends to process such applications within a reasonable time frame, but advises applicants that they must respond promptly to all inquiries from the Bureau in connection with an application. Any failure to respond to the Bureau's inquiries within 30 days shall be deemed grounds for rejecting the application. Administrative Letter 2002-7 supersedes Administrative Letter 1999-9. *To view Administrative Letter 2002-7, visit* ***www.state.va.us/scc/division/boi/index.htm.*** ■

REGULATOR™

Published by the
Insurance Regulatory Examiners Society
130 N. Cherry, Suite 202, Olathe, Kansas 66061

e-mail: ireshq@swbell.net
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In next month's REGULATOR:

Sizing up Suitability

HIPAA: State Responsibilities

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