

Courts may decide the future of state insurance regulation

by David F. Snyder

The future of state insurance regulation may not be decided in insurance commissioners' offices, in state legislative chambers or in the halls of Congress.



Instead, it is being decided in the nation's courtrooms, in cases filed from Washington State to Washington, D.C., that call into question the value and legal foundation of the state regulatory system. If one or more of these cases goes the wrong way, the public policy support for, and the economic value of, state regulation may disappear.

Perhaps the most appealing justification for state regulation is that the interests of a state's citizens can best be identified and protected by an insurance regulator in that state.

Yet if basic state public policy judgments can be overturned by another state or by federal law without clear preemption, this critical function cannot be performed by the states. The resulting inability to assure this public "benefit" would dramatically alter the cost/benefit balance of state regulation. Under these circumstances, the continuing "cost" of state regulation, with its inherent non-uniformity, would clearly outweigh any residual "benefit" of state regulation.

These cases also raise another fundamental concern — the substance of insurance regulation when created by judges and juries. Without the responsibility to balance consumer protection with solvency and assuring a viable market, along with the tools to do it, this new courtroom regulation could easily lead to market chaos or even meltdown.

Threat from other states

In *State Farm v. Campbell*, the insurer was penalized with punitive damages arising out of its initial failure to pay an excess verdict. [EDITOR'S NOTE: In this case, State Farm had rejected a settlement at the liability limits of its insured in favor of taking the action to court. Ultimately, the courts ruled that the State Farm insured was at fault. The "excess" verdict equaled the amount of court-imposed damages in excess of the insured's liability limit.] The huge award, however, was based not only on that and similar actions in the state of the case, but also on totally different actions that occurred in other states. The U.S. Supreme Court is reviewing the case.

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'Suitability' standards

When life products don't fit consumers' needs, what then?

by Scott Hooper
Special to *The Regulator*

We've all heard the stories of the insurance companies that sent agents into poor African-American communities and sold life insurance policies to people who probably couldn't have afforded the coverage even if the policies hadn't been overpriced.

The discriminatory premiums were of course wrong in any case. But the broader question was whether those people needed those policies in the first place — or whether the companies and their agents were selling them for their own benefit instead of the customers'.

Blatant sales of inappropriate policies are a thing of the past. Yet in some cases, insurance con-

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From the President

Brave new world of regulation

The recent elections have brought 20 new governors to office, some Republicans, some Democrats. And with these changes come, in many cases, changes in insurance commissioners, as newly elected governors make appointments to fulfill voters' mandates. In addition, we have newly elected commissioners who are striving to fulfill their campaign promises.



Bicica

These newly appointed and elected officials will be confronting a crescendo of change in the insurance marketplace. The Speed to Market initiative introduces new challenges to the consumer services and market conduct areas. We must meet the challenge of getting products to market faster, while ensuring consumers are protected with regard to fair pricing, adequate disclosure and an honest marketplace.

The new federal terrorism insurance bill will restructure just about all property and casualty commercial coverages, from surety to workers' compensation. In fact, as I write this, insurers are scurrying to understand their responsibilities under the bill. Reverberations generated by this bill will undoubtedly create additional pressure on consumer service divisions to ensure that markets remain available and affordable.

Mold coverage will necessitate reviews in southern states where heat and humidity are issues, as well as in northern states where tightly sealed houses can exacerbate the problem.

The hardening reinsurance market will impact all lines. Availability of coverage will be a serious issue no longer restricted to health

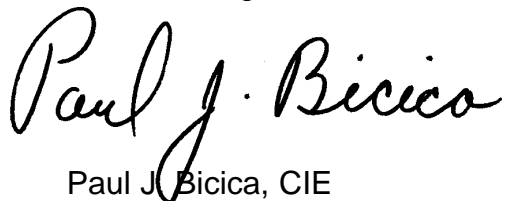
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insurance, as more companies tighten underwriting guidelines. The market is already hardening for D&O coverage, garage liability, apartment building coverages, nursing homes, etc., while escalating premiums are likely to create public frustration and further limit access to meaningful coverage.

With all of these new challenges comes the news that state governments are facing some of their worst deficits in the past 50 years.

While it may seem I've painted a bleak picture, it is also a time of challenge.

Challenge to find innovative solutions. Challenge to write and enforce regulations that protect the consumer, while recognizing the legitimate market concerns of companies. We must focus our energies on those things that best serve the most consumers, while never forgetting that financial solvency is the ultimate consumer protection. Lastly, we must ensure our first priority — the insurance consumer — is well served in this brave new world of insurance regulation.



Paul J. Bicica, CIE
IRES President

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Regulation by judge and jury

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The industry *amicus* brief lays out both the constitutional and public policy challenges to this imposition of insurance regulation by one state on another. Based on the Supreme Court's analysis in an earlier case, *BMW v. Gore*, we argued that such action violates the Due Process clause, so it is unconstitutional.

We also argued that the imposition of punitive damages invalidates the public policy determinations made by the other states, to the detriment of their citizens. Moreover, in connection with the assessment of punitive damages, the jury heard evidence of the company's actions in other states that were either lawful or unlawful but not punishable with private damages. We also objected to consideration of unrelated matters, such as underwriting practices, when it was a claim practice that was involved in the case.

This same issue was clearly decided in December 2002 by the United States Court of Appeals for the Ninth Circuit in *White v. Ford Motor Company*. There, as in *Campbell*, the Court, had under consideration a punitive damages verdict based, in part, on out-of-state actions. In overturning the verdict it wrote that: "The Court in *BMW* imposed a territorial limitation on punitive damages in the interest of federalism. This federalism includes the flexibility to exist, no state can be permitted to impose its policies on other states." (Federalism is the principle that some policy matters fall under state authority and others under the authority of the national government.)

To rule otherwise would be to put a company in a Catch-22 situation. By abiding by the law in one state, it could be violating another state's law. Again quoting *BMW*, the *White* court stated: ". . . to punish a person because he has done what the law plainly allows him to do is a due process violation of the most basic sort" and it interferes with interstate commerce.

According to the *White* majority, important but differing state public policies could include making an action legal in one state when it is not in another and even if illegal, punishing it differently. In either case, it is a policy determination that cannot be upset by another state.

Whether this view prevails with respect to insurers will have a lot to do with the future of state insurance regulation. If it does not, then insurers will routinely be caught by cases where they are punished in one state for actions legal in another or even if illegal, would not have given rise to the same amount of

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Regulation by judge and jury . . .

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punitive damages. *Avery v. State Farm* is exactly that scenario.

In *Avery*, now on review before the Illinois Supreme Court, the insurer was assessed more than \$1 billion in damages for using aftermarket crash parts. Among the plaintiffs were residents of many other states, including some from states where the use of the parts was legal and even mandated. The industry's *amicus* brief asked the Illinois Supreme Court to set aside the judgments and verdicts for the same reasons cited in our brief in *Campbell* and in the court's ruling in *White*.

In the *Avery* brief, we stated: “. . . the trial court's punitive damage award in essence sanctioned the petitioner for acts that occurred in states other than Illinois, despite the fact that those acts were legal in those other states. The effect of the trial court's ruling was that the petitioner was punished for its use of non-OEM parts in other states where use of such non-OEM parts was permitted and sometimes even required. . . . The decisions of the trial and appellate courts presently stand as a direct affront to our nation's fundamental principles of state sovereignty and comity, and at the same time these rulings trample the constitutional rights of one of Illinois' citizens (the insurer).”

Insurance commissioners have recognized these same threats to their regulatory systems. They have participated in Washington State, Illinois, Ohio, Federal and other cases to raise similar concerns. More needs to be done, however. This matter must be raised to the highest priority — the very existence of our state regulatory system is at stake.

Unintended federal preemption

The second current threat to state regulatory systems comes by way of preemptions not intended as exceptions to McCarran-Ferguson. Another case illustrates the issue. A Federal District Court in Texas ruled against Allstate's use of credit scoring and other practices as violative of federal law. It found under a disparate impact theory that Allstate's use of credit scoring violated federal civil rights and fair housing laws. Insurers argued against that ruling.

Insurers certainly are not above the law and are punishable for intentional acts of discrimination. However, disparate impact theory arises from the unintended adverse effects on protected minorities of certain actions. It should not be used to judge insurance practices. Insurers must use distinctions among groups of policyholders for their rating and underwriting practices, approved under state insurance regulatory law. As the industry brief states: “The fact that insurance policyholder classifications, properly based on risk through analysis of actuarial data, may correlate with policyholders' race renders use of the disparate impact test an unreliable means to identify illegal discrimination. . . . Risk discrimination is not race discrimination.”

Even if an adverse result were demonstrated for a protected class of people, the business necessity defense could still allow use of the factor. But, as noted in the industry brief, weighing this would “entangle the court in issues that are by law the province of

individual state insurance regulators.” In any event, another federal law, the Fair Credit Reporting Act, expressly allows insurers to use credit scoring. In combination with McCarran-Ferguson's broad assignment of regulatory responsibility to the states in the absence of clear preemption, these other considerations strongly argue against seizing regulatory jurisdiction under general federal laws, especially in the face of more specific federal laws and McCarran-Ferguson.

If these cases ultimately go against insurers, we will have established a *de facto* national insurance regulatory apparatus headquartered in our courtrooms. This will be one of the greatest arguments supporting a movement toward true national insurance regulation, one with the balance necessary to assure consumer protection and a healthy market.

Insurance regulation by the courts

Effective insurance regulation is a balance of many factors, including consumer protection against abusive market practices, solvency oversight and the need to help assure a viable and competitive market. To accomplish that, insurance regulators are given

“The trial court's punitive damage award in essence sanctioned the petitioner for acts that occurred in states other than Illinois, despite the fact that those acts were legal in those other states.”

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wide-ranging tools, including rate and form review, unfair trade practices enforcement authority and financial supervision. Judges and juries have neither the legal obligation to balance these factors nor the tools to do so.

These are fundamental principles for insurance regulation that have withstood the test of time. In 1869, Pennsylvania Governor John W. Geary called for the creation of an insurance department in his state. Without it, Geary said, "the operations of the number of worthless companies . . . without any solid basis . . . suddenly expired, to the injury of all whose confidence they obtained. . . ." He called on the legislature to create an insurance department that would ensure that "so careful a supervision is had over the transactions of insurance companies that frauds are rendered almost impossible, and spurious companies can have no existence."

The three basic goals of insurance regulation are consumer protection, solvency and fostering competition. Giving preference to one goal at the expense of the other(s) is a formula for disaster. This is why regulation is best left to the balanced decisions of the regulator and the market.

This is also why the optional federal chartering proposals being discussed in Washington, D.C. include the balance of objectives and the tools to accomplish them. There is little doubt that if federal or state courts become or continue as insurance regulators, the optional federal chartering system will be even more desirable.

The quiet revolution

State insurance regulation is facing a quiet revolution in the courtrooms of America. In the end, adverse decisions in these critical cases — and others like them — will seriously compromise state insurance regulation and erode its most appealing justifications. ■

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Snyder

C.E. News

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Congratulations to Beth Stuchel, who takes over as chair of the IRES Foundation from Dave Abel.

Getting hip to HIPAA: New HIPAA privacy rules are coming

by Francis J. Serbaroli and Vimala Varghese
Cadwalader, Wickersham & Taft

The Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191 (HIPAA), contains an increasingly noteworthy provision entitled "Administrative Simplification." This subsection authorizes the United States Department of Health and Human Services (HHS) to promulgate regulations governing the use of health information, specifically health information that identifies a particular individual.

The regulations (collectively known as the "HIPAA Regulations") issued by HHS govern: (a) the privacy of individually identifiable health information ("Privacy Rule"); (b) electronic transactions of health information ("Transactions Rule"); (c) the security of health information and electronic signatures ("Security Rule"); (d) adoption of a standard national provider identifier ("Provider Identifier Rule"); and (e) adoption of a standard national employer identifier ("Employer Identifier Rule").

This article will focus primarily on the Privacy Rule.

Overview of privacy rule

In accordance with HIPAA directives, HHS issued a health privacy regulation in final form on December 28, 2000 after Congress failed to enact such legislation in the time period prescribed by HIPAA. The Privacy Rule generally requires compliance by April 14, 2003. The purpose of the Privacy Rule is to limit the circumstances in which an individual's "protected health information" may be viewed, used, or disclosed by others. Protected health information is defined in the Privacy Rule as personally identifiable health information that is created or received by a "covered entity" (defined below) and relates to the past, present, or future provision of or payment for health care services.

Who must comply?

The simple answer is that almost every organiza-

tion and individual that comes into contact with protected health information, whether during an initial encounter with a patient or in the course of payment for medical care and supplies, must comply with the Privacy Rule. The Privacy Rule applies *specifically* to the following entities, which are collectively defined in the Regulations as "covered entities": (a) health care providers who transmit any health information in electronic form, (b) health plans, and (c) health care clearinghouses.

What the privacy rule requires

Specifically, the Privacy Rule requires covered entities to:

1. Use and disclose only the minimum protected health information necessary to accomplish the intended purpose of the use or disclosure.
2. Grant individuals certain rights with respect to their protected health information, such as the right to access, inspect, copy, amend, limit disclosure, and receive an accounting of past uses and disclosures. Moreover, each covered entity must issue a notice of privacy practices to its covered individuals setting forth these rights.
3. Implement procedures that will safeguard protected health information.
4. Obtain satisfactory assurances from third parties, known as business associates, with which they share protected health information. These assurances take the form of a business associate contract, which requires the business associate to safeguard protected health information and abide by the same restrictions with respect to protected health information that are imposed on covered entities by the Privacy Rule.
5. Document the required privacy policies and procedures, communication, consents, authorizations and other necessary records to demonstrate compliance with the Privacy Rule. These documents must be retained for six years from the date of their creation or the effective date of the Privacy Rule, whichever is later.

Does it preempt state law?

The Privacy Rule apparently preempts any state law contrary to its provisions. A state law is contrary to the Privacy Rule when (a) a party would find it impossible to comply with both the state law and the Privacy Rule or (b) when the state law obstructs the objectives of the Privacy Rule. State law relating to privacy is not preempted under any of the following five conditions:

1. The state law is “more stringent” than the Privacy Rule;
2. The Secretary of HHS has determined that the state law is necessary
 - to prevent fraud or abuse related to the provision of or payment for health care;
 - to ensure appropriate state regulation of insurance and health plans;
 - to report on state health care delivery or costs; or
 - to serve a compelling need related to public health.
3. The state law has as its principal purpose the regulation of controlled substances;
4. The state law requires certain disclosures of health information, such as the reporting of disease, injury, child abuse, birth, death, or is necessary to conduct public health surveillance, investigation, or intervention; or
5. The state law requires a health plan to report or provide access to information for the purposes of auditing or monitoring programs.

Enforcement responsibility

The Secretary of HHS is responsible for ensuring compliance with and enforcement of the Privacy Rule. The Secretary has delegated responsibility for enforcement of this regulation to the HHS Office for

Civil Rights. According to HHS, HIPAA enforcement activities will include: working with covered entities to secure voluntary compliance by providing technical assistance; answering questions about the Privacy Rule and providing interpretations and guidance; responding to state requests for exemptions; investigating complaints and conducting compliance reviews. In instances where voluntary compliance cannot be achieved, HIPAA authorizes HHS to

“Neither the Privacy Rule nor HIPAA-related guidance so far published in the Federal Register indicates what compliance and enforcement responsibilities state agencies have, if any.”

impose civil monetary penalties on covered entities and to refer cases for criminal prosecution. *Neither the Privacy Rule nor HIPAA-related guidance so far published in the Federal Register indicates what compliance and enforcement responsibilities state agencies have, if any.*

Role of states

As set forth in the preamble to the Privacy Rule, a state insurance commission (*i.e.*, department) is generally considered a health oversight agency, even though a health oversight agency is technically defined as an agency that is authorized by law to oversee the health care system. Disclosure to (or use of protected health information by) a health oversight agency does not require an individual’s consent, authorization, or an opportunity for the individual to agree or object.

In addition, covered entities are not required to sign business associate contracts with health oversight agencies when they disclose protected health information to these agencies for oversight purposes. Rather, covered entities are encouraged to work with health oversight agencies to determine the scope of information needed for health oversight inquiries.

Notably, a health oversight agency may also be a covered entity. State insurance commissions should engage in a self-assessment to determine whether they

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Getting hip to HIPAA

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qualify as covered entities. For example, a state insurance commission may also be acting as a health plan, and therefore as a covered entity, if it operates the state's Medicaid managed care program. In this instance, the Privacy Rule provides that when a covered entity is also a health oversight agency, it is allowed to use protected health information in all cases in which it is allowed to disclose such information for health oversight purposes.

Compliance strategies

Taking the following four steps may help state insurance commissions to comply with HIPAA:

1. Appoint key individuals in the organization to spearhead efforts to comply with the Privacy Rule.
2. Conduct a self-assessment to determine whether the commission would be considered a "covered entity."
3. If the insurance commission is a covered entity, it should consider the following:
 - Comparing its current practices and policies against practices and policies required by the Privacy Rule.
 - Conducting a "risk assessment" to identify areas of vulnerability, including tracking the flow of protected health information that is used or maintained by the agency or its agents and contractors, investigating who in the work force has access to protected health information, investigating when and how protected health information is disclosed to, and used by outside contractors, service providers and professionals through various contractual arrangements.
 - Identifying "business associates" and developing or revising contracts with them.
4. Identify opportunities to participate in state-wide efforts to comply with HIPAA. For example, New York State has begun work to address HIPAA compliance among New York State agencies and has established a Central HIPAA Coordination project office at the Office for Technology (OFT).

Transactions rule

The Transactions Rule will set national standards for the electronic transmission of health information by covered entities in 11 specific transactions. The Transactions Rule required compliance by October 16, 2002, unless the covered entity requested a one-year extension. In its extension application, the covered entity must explain how it intends to comply with the Transactions Rule by October 16, 2003.

Other rules

HIPAA's Employer Identifier Rule requires that the Employer Identification Number (EIN) assigned by the Internal Revenue Service (IRS) be used to identify employers. The Employer Identifier Rule was promulgated to establish a single method for identifying employers as a source of information required in the administration of health plans, including eligibility information. The Rule requires compliance by July 30, 2004.

The Provider Identifier Rule was published in proposed form in the Federal Register on May 7, 1998, and the Security Rule was published in proposed form in the Federal Register on August 12, 1998. Neither rule has yet been finalized. When finalized, the rules will become effective two years after the effective date of the final regulations, which will be 60 days after the final rules are published in the Federal Register.

The proposed Provider Identifier Rule seeks to establish a single method for identifying health care providers, specifically a unique eight digit alphanumeric identifier for each health care provider. The proposed Security Rule mandates a framework for protecting the confidentiality, integrity, and availability of health information. The rule would require each covered entity to assess the potential risks and vulnerabilities associated with the protected health information in its possession and develop, implement and maintain appropriate security measures that protect this information. ■

Mr. Serbaroli is a partner and Ms. Varghese is an associate in Cadwalader, Wickersham & Taft's 20-attorney health law department. This article provides general information and should not be taken as legal advice for specific situations, which depend on the evaluation of precise factual circumstances.

Terrorism Risk Insurance Act of 2002: Highlights

After more than a year of debate, Congress passed the Terrorism Risk Insurance Act of 2002 in mid-November. The act took effect Nov. 26, the day it was signed into law by President Bush. The following provides some basic information about the Terrorism Insurance Program, but should not under any circumstances be used as a replacement for the full text of the law.

What is the purpose of the new law? The act establishes a temporary federal program in which specified terrorism losses are shared between commercial property/casualty insurers and the federal government. The program is designed to protect consumers by making coverage available for terrorist acts, while allowing a transitional period for insurers to build capacity and gain the loss experience necessary for pricing this new coverage.

What acts qualify under the program? An act of terrorism under the program must have resulted in damage within the United States or to U.S. aircraft, ships or diplomatic missions. Individuals acting on behalf of foreign interests must have conducted the act of terrorism for the purpose of coercing the U.S. civilian population or influencing U.S. government policy.

Who determines if an act of terrorism qualifies for coverage? The Secretary of the Treasury (with the concurrence of the Secretary of State and the Attorney General) must certify that the act is an "act of terrorism" under the provisions of the program.

Are there any dollar thresholds on losses from an act of terrorism? Yes, the act of terrorism must result in property and casualty losses above \$5 million to qualify as an "act of terrorism" under the program.

What lines of insurance does the program apply to? The program applies to most commercial property/casualty lines.

What lines are excluded? Personal lines, medical malpractice, title insurance, mortgage guaranty insurance, federal crop insurance, health insurance, life insurance, national flood insurance and financial guaranty insurance issued by monoline companies.

When does the federal government begin

paying losses of individual insurers? The federal government begins paying 90% of an insurer's terrorism losses once those losses exceed a specified deductible, i.e., a percentage of an insurer's property/casualty premium in the previous year. In 2003, for example, that percentage is 7%. If an insurer wrote \$100 million in commercial property/casualty premium in 2002, the federal government would begin payments once that insurer's 2003 terrorism losses reached \$7 million. The percentage increases to 10% in 2004, and 15% in 2005.

Are there any industry-wide retention amounts? Yes, the industry must incur insured terrorism-related losses of a certain magnitude (\$10 billion in 2003, \$12.5 billion in 2004 and \$15 billion in 2005) to trigger federal payments. This is called an "Insurance Marketplace Aggregate Retention Amount."

Can the federal government recoup payouts under the program? Yes, recoupments are permitted, and in some cases mandated, under the program. Surcharges to policyholders of up to 3% of premium would be charged to cover the costs of the recoupment.

Are insurers compelled to provide terrorism coverage? Insurers must "make available" coverage to their policyholders and must notify policyholders and applicants of the premium to be charged for coverage under the program.

When does the program terminate? Dec. 31, 2005.

Where can I get more information? The following Web sites should be helpful: *U.S. Treasury*: www.treas.gov/offices/domestic-finance/financial-institution/terrorism-insurance, *Insurance Information Institute*: www.iii.org/media/hot-topics/hot/terrorismact, *Zurich North America*: www.zurichna.com, *NAIC*: www.naic.org ■

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- 5) CPCU 520 — Insurance Operations & Regulation
- 6) CPCU 530 — The Legal Environment of Risk Management & Insurance
- 7) CPCU 552 — Commercial Liability Risk Management & Insurance
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To obtain a CIE, you must take and pass any four of the following additional courses: [American College course equivalents — shown in brackets — can be used as substitute.]

- 1) FLMI 280 — Principles of Life and Health Insurance [HS 323]
- 2) FLMI 290 — Life and Health Insurance Company [HS 323, Operations]
- 3) FLMI 320 — Marketing Life and Health Insurance
- 4) FLMI 340 — Information Management in Insurance Cos.
- 5) AIRC 410 — Regulatory Compliance — Companies, Producers & Operations
- 6) AIRC 420 — Regulatory Compliance — Insurance and Annuity Products

Life and Health Educational Path To obtain the AIE, applicant must complete the required four core courses, PLUS an additional four courses that can be chosen from either the LIFE or HEALTH or INFORMATION SYSTEMS options. (Must be all Life or all Health or all Information Systems — not a mixture)

Required Core Courses

- 1) FLMI 280 — Principles of Life and Health Insurance
- 2) FLMI 290 — Life and Health Insurance Company Operations
- 3) AIRC 410 — Regulatory Compliance: Companies, Producers & Operations
- 4) AIRC 420 — Regulatory Compliance: Insurance and Annuity Products

Optional Courses (Must be four life or four health or four I.S. option; not a mixture)

LIFE OPTION

- FLMI 310 — Legal Aspects of Life and Health Insurance
- FLMI 320 — Marketing Life and Health Insurance
- FLMI 330 — Management of Organizations & Human Resources
- FLMI 340 — Information Management in Insurance Companies
- FLMI 361 — Accounting and Financial Reporting in Life and Health Insurance Companies

HEALTH OPTION

- ICA C1 — Medical and Dental Aspects of Claims, or:
ICA C3 — The Claims Environment
- AHM 250 — Managed Healthcare: An Introduction
- AHM 510 — Managed Care Organizations: Governance and Regulation
- AHM 530 — Network Management in Managed Care Organizations

INFORMATION SYSTEMS OPTION

- IDMA 2 — Insurance Data Quality
- IDMA 3 — Systems Development and Project Management
- IDMA 4 — Data Management, Administration and Warehousing
- ACL Exam — ACL Proficiency Exam administered by NAIC

To obtain a CIE, you must pass any four additional courses:

- 1) INS 21 — Property & Liability Insurance Principles
- 2) CPCU 520 — Insurance Operations & Regulation
- 3) CPCU 530 — The Legal Environment of Risk Management & Insurance
- 4) AIC 34, 35 or 36 — Claims (may only count 1) -see description under P&C path
- 5) IR 201 — Insurance Regulation

Where to call for course information . . .

American Institute for CPCU Insurance Institute of America

720 Providence Road
Malvern, PA 19355-0770
(610) 644-2100
www.aicpcu.org

INS 21	CPCU 530
INS 22	CPCU 560
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CPCU 552	AIAF 111
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ICA C3
ICA C1

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Atlanta, GA 30339 (770) 951-1770
www.loma.org

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FLMI 290	FLMI 330	AIRC 410
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The American College (CLU, ChFC)

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HS 323, 324, 325

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201-469-3069
www.idma.org
IDMA courses

Insurance Regulatory Examiners Society, 130 N. Cherry, Suite 202 Olathe, KS 66061

IRES State Chapter News

VIRGINIA — The Virginia IRES Chapter recently held its quarterly meeting. Thirty-six members gathered at lunch to listen to reports from the IRES CDS. The discussion was led by five of the department's staff who had attended the **San Antonio** meeting. Our next meeting is scheduled for February, during our state legislative session. Our topic of discussion will be proposed legislation and how it will affect insurance laws in Virginia.

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

COLORADO — The Colorado Chapter of IRES has presented classes each month during 2002 at the office of the Division of Insurance. Classes were attended by a total of 95 Colorado Division of Insurance staff in the last six months. Presentations included such diverse presentations as Component Rating and Credit Insurance, a two-hour training class on the use of I-Site, Workers Compensation Loss Costs, the Current and Continually Changing Environment for Senior Health and Market Surveillance and Market Analysis. The Colorado Chapter held a holiday party and is currently planning the classes for December 2002 through November 2003. The tenta-

tive plan for our next class is for a joint presentation by **Ron Arthur** of the CPCU Society in Malvern, Penn., and **Reid Miller**, Colorado CPCU Society Chapter President. Those two are confirmed as speakers and Chapter Vice President **Tom Abel** is working with representatives of two other professional organizations to join in the presentation. The focus will be to explore opportunities for continuing education and enhancing professionalism among Chapter members and other DOI staff.

— Submitted by Violetta R. Pinkerton, Vi.Pinkerton@dora.state.co.us

NEBRASKA — The speaker at the Oct. 23 meeting of the Nebraska Chapter was **Jim O'Connor** from Baird, Holm, McEachen, Pedersen, Hamann & Strasheim, LLP in Omaha. Jim gave a great presentation on HIPAA security, encompassing electronic transmission of private information. The chapter did not have a meeting in December because of the holidays. However, members did get together for a nice social gathering on Dec. 4. The next meeting will be Feb. 19. Details will be posted on the IRES Web site. ■

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



Quote of the Month



"If four times [the ratio of punitive damages to compensatory damages] is O.K. and 145 times is not, how about 80 or 60 or 20? How do we grapple with that? Are we going down the road to saying that at some point we've got to put this in a less protean state and we have to pick a number? Is it our business to do that?"

— U.S. Supreme Court Justice David H. Souter, commenting on the *Campbell v. State Farm* case, in which a State Farm insured was awarded \$1 million in compensatory damages and \$145 million in punitive damages.

'Suitability' model act under fire

continued from page 1

sumers are still being sold the wrong policies — policies that are unsuitable considering their age, income and/or financial needs.

How about a high-premium whole life product for a widow with no heirs? Or a variable annuity for a retiree subsisting on Social Security?

The National Association of Insurance Commissioners is currently wrestling with whether it needs to come up with suitability standards for life and annuity products, in the form of a model code. Even though companies and agents are vehemently opposed to the NAIC's latest draft — often a next-to-certain sign that the regulators are on the right track — there's a legitimate question as to whether standards are in fact necessary.

Exercising discretion

Here's why. In the absence of blatant violations, such as those old black-only policies, many suitability questions fall into a gray area. It takes judgment on the part of agents and companies to sell the right products to the right people. And it takes judgment on the part of insurance regulators to keep insurers and agents from overstepping their bounds.

Fortunately, exercising regulatory discretion is something that regulators have proven to be pretty good at.

Perhaps that's why only eight or so states currently set suitability standards. The others rely on the judgment of examiners when they look at life insurers' market conduct.

"We look at suitability as part of the market conduct routine," said Merwin Stewart, commissioner of insurance in Utah, one of the majority of states without a specific suitability standard.

Nonetheless, Stewart feels that it's possible to set standards that would make the process go more smoothly.

That's appropriate, since he chairs NAIC's Life Insurance and Annuities (A) Committee, under whose auspices the Suitability Working Group came up with its draft model act. The draft — available on the Web at www.naic.org/1papers/models/models.html — was before the Committee during NAIC's quarterly meet-

ing last month in San Diego.

The draft's drawn intense fire from the insurance industry. Much of the ire was over who might assume greater liability if suitability standards were adopted widely: agents or companies.

"We don't want to get into that," Stewart said. "What we ought to do is find ways each can help the other.

"If we can find a system that would help protect the company and also help the agents or the producers to sell the product appropriately — to the right people, giving them the right information and so on — if we can do that, then I think we would have a good program. And we're working on that."

More than 1,000 industry people attended NAIC's quarterly meeting in San Diego, but they didn't get to express their opinions. Instead committee members discussed the draft behind closed doors.

Birny Birnbaum, executive director of the Center for Economic Justice, was in San Diego for the occasion and was disappointed he didn't have a chance to have his say.

"There's very little support for it in the industry, and there are a lot of regulators who take their cues from the industry," said Birnbaum. "If the industry doesn't want to do it, then the regulators don't want to support it. The last model had so many exemptions to placate the ACLI that it was a meaningless model. And it made things really difficult for agents."

Lawrence Mirel, commissioner of insurance and securities regulation for Washington, D.C., is one who feels a model act may never see the light of day. Or if it does, he thinks the odds are that few states will adopt it.

That happens on occasion. While some model acts — noncontroversial ones, or ones required for NAIC accreditation — get adopted by virtually every one of the 54 insurance jurisdictions in the U.S., some get ignored. The suitability model act, in whatever its final form, may end up being one of the latter.

Insurance vs. securities

Yet whether or not a model act makes it out of committee, and whether or not it gets adopted by more than one or two states, the issue is one that's worth raising.



Stewart

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'Suitability' model act under fire . . .

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Birnbaum, for one, feels there's a definite need for more regulation in this area.

"If it were up to me," he said, "I think I would develop a relatively simple model which, instead of saying you have to sell a suitable product, would say you can't sell an unsuitable product. It's easier to define something that's not suitable: basically something that harms a consumer.

"There may well be products that are totally unsuitable — alien-abduction insurance may be unsuitable for anyone," Birnbaum added. "But basically, suitability is related to the circumstances of an individual consumer. You don't want to sell a variable annuity to a 75-year-old."

Commissioner Mirel has spent more time thinking about suitability than most of his peers, since his department is one of the handful nationwide that regulate both insurance and securities. And suitability standards have been commonplace for securities for some time.

Yet just because suitability works in the securities arena doesn't mean it's transferable to insurance products.

"Securities are things that people buy to make money," Mirel said. "Insurance is something that you buy to protect yourself, and they're very different kinds of products.

"You don't want to mislead investors, because you're taking their money — it's kind of like gambling. Insurance, on the other hand, is bought for other reasons: You're trying to protect yourself against some future unknown catastrophe."

The dividing line isn't always easy to find. For instance, how about variable annuities — investment vehicle or insurance?

"The answer is that it's a little bit of each," Mirel said. "Should suitability standards apply then as a security? Maybe the answer to that is yes."

In the District of Columbia, the answer is definitely yes. Mirel's department, in common with only a handful of other jurisdictions, regulates variable annuities as investment instruments. (The D.C. department has separate insurance and securities bureaus, although its fraud unit handles both areas.)

Despite the differences, Mirel feels there's some

sense behind establishing suitability standards for life insurance and annuity products.

"I must tell you, I was very skeptical about suitability when I first started looking into it," he said.

"I'm a little more sanguine about it now, for a couple of reasons. One is that I thought that defining it would be very difficult, but somebody has put together a computerized suitability testing program. I was very impressed with that, because it struck me that it was a lot simpler than I was thinking."

That system, put together by LIMRA International, a life insurance marketing association, asks basic questions — how old is the applicant? what's his or her family status and objectives? what kind of insurance are you selling? — and then gives the agent a red, green or yellow light."

Another association, the Insurance Marketplace Standards Association (IMSA), has guidelines in place that encourage its member companies to do the suitable thing.

"There are more than 200 companies that have qualified to be members of IMSA and that have already made a commitment to needs-based selling and have instituted processes to ensure that the insurance needs or financial obligations of its customers are based upon reliable information obtained from the customers," says Brian K. Atchinson, IMSA's executive director.

"These companies recognize the need for consistent use of fact finding tools to reasonably assure determination of customers' insurable needs or financial objectives," he added.

Birnbaum, the consumer activist, agrees that a useful model code shouldn't be all that hard to come up with.

"There are already a number of states that have suitability laws and regulations, so I don't think we're talking about rocket science here," he said.

On top of standards or programs, Mirel likes an idea he first heard of from Lee Covington, until recently commissioner in Ohio (and a proponent of suitability standards). "It was to tie this together with a safe harbor," he said. "That is, if you do a suitability test, and it comes up that it is suitable, and you go ahead and sell it, then you can't be sued later on the grounds that it was unsuitable.

"We had a [suitability] policy in place, you fol-



Mirel

. . . will it be going anywhere?

lowed it, you did what it said, and now you can't come back and sue me later for what was suitable."

The point of the model act, though, is to be agnostic about LIMRA's program or any other set up to evaluate suitability. Right now, no one outside of LIMRA and the insurers that subsidized creation of the program know what assumptions underlie its red, green and yellow lights. Even if regulators knew the details, though, it probably wouldn't be a great idea to endorse one program.

The model code encourages companies to set up some kind of system to evaluate suitability, then to train agents and monitor compliance. Whether they adopt LIMRA's system or another alternative, or come up with their own program, isn't for regulators to say. "This is a process approach," explained Stewart. "If the process is followed, it should lead to appropriate sales.

"We would not promote LIMRA," he added. "We would probably promote the idea, but not necessarily any individual service or organization. We would say, 'Here's a way that another group has done it. If you can do something like that that has such-and-such elements in it, we'll feel comfortable about that and we can go with that.' The elements of them will all be about the same."

99 to 1

No matter what program, if any, is ultimately established, it shares one flaw with other regulatory standards: human fallibility.

"The problem with everything like this is that 99% of the sales are fine — agents are careful about this," Mirel said. "But you always have the 1%, the wise guys who are trying to sell the 98-year-old man a 10-year annuity. So you want to catch that guy, but you don't want to put a lot of burden on everybody else."

That's pretty much the point of the company and agent associations that have come down firmly

against the model act: We already have enough liability, don't give us any more. With troops of trial lawyers out looking for the next asbestos, they have a point — if hard-edged guidelines would make it easier for suit-happy customers and their counsel to haul companies and agents into court, why not skip it?

Utah's Stewart agrees that it can be easy to come up with a suitability claim.

"When the product was sold, it may have been appropriate, but in our lives we have a lot of circumstances that change," he said.

"And after that happens, if you look at it at that point, you can say, 'Well, obviously, this is not suitable.' So it sets the companies up for potential liability and makes them very nervous.

"We're dealing with human beings," he added, "and we're dealing with their abilities or inability to communicate.

"We're dealing with products that are not precisely designed for each individual's circum-

stances. It puts a lot of burden on the agents — and that's appropriate: They should do due diligence in finding out what the appropriate product would be for an individual, to do their best.

"But we've got to be careful that we don't set them up to fail, with a standard that implies that anything can be a perfectly suitable product."

Jessica Fulginiti Waltman, manager of state health policy for the National Association of Health Underwriters, says her association agrees that all licensed insurance professionals should always act in the best interest of their customers. At the same time, though, "each individual consumer must take ultimate responsibility for his or her own purchasing decisions; complete liability for suitability should not be placed on either a producer or a carrier."

Robert M. Nelson, president of the National Association of Insurance and Financial Advisers, has concerns that loopholes in the enforcement of suitability standards would create "competition in laxity," a race to the bottom as insurers create programs that push liability onto their producers.

The model code encourages companies to set up some kind of system to evaluate suitability, then to train agents and monitor compliance. Whether they adopt LIMRA's system or another alternative, or come up with their own program, isn't for regulators to say.

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'Suitability' model act

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Ironically, one of the concerns of both producers and insurers is inconsistency, with a standard that works in one state and leads to lawsuits across the state line. The irony, of course, is that NAIC's goal is to establish more or less common standards in every state — unless industry opposition derails the effort.

Cost vs. benefit

Considering that the latest draft of the model act is just over two pages long and works hard at not being overly descriptive, it's hard to understand how so much ire has been generated from the industry. Add to their opposition the very real possibility that even proposing a nationwide standard may be overkill, and it begins to look as though maybe, just maybe, nothing much will change.

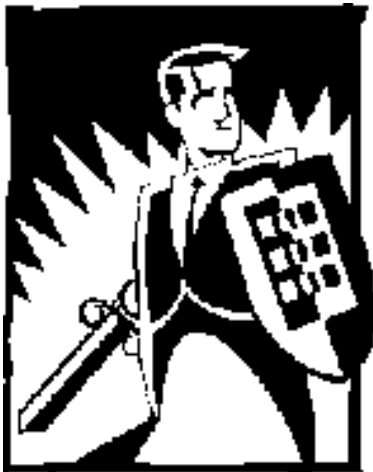
Now, insurance commissioners are an independent lot who are probably unlikely to let a bunch of

irate insurance company and trade association executives cow them. Yet on the other side of the cost-benefit equation is the fact that aside from some flaps over viaticals and variable annuities, there's been no crisis that demands a political or regulatory solution.

"To me the real question is, is there a problem out there?" said Mirel. "And does [a nationwide NAIC standard for] suitability address the problem? Are there instances of products being sold that are demonstrably not suitable? And how widespread is that? Is it widespread enough to put that extra burden on everybody who's selling life insurance?"

So here's a prediction. Today, perhaps 8-10 states have specific suitability standards. After NAIC promulgates the final version of its model act, that number leaps to 10-12. And the rest of the states go on as before, assessing suitability on a case-by-case basis as part of the market conduct exam process.

"It doesn't seem to me it's a burning issue," Mirel said. "So my thought is it's not going to go anywhere." ■



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CANCELLATIONS AND REFUNDS

Your registration fee, minus a \$25 cancellation fee, can be refunded if we receive written notice before June 30, 2003. 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, 2003.

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Regulatory Roundup

by
**Stroock & Stroock
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CALIFORNIA — Legislation Enacted to Extend Risk-Based Capital Requirements to Workers' Compensation Insurers

Assembly bill 1985 has been signed into law by the Governor and is now Chapter 873 of the Laws of 2002. Chapter 873 revises the definition of "property and casualty insurer" to include workers' compensation insurance. It also provides that: (i) authorized insurers writing only workers' compensation insurance are subject to the risk-based capital requirements applicable to property and casualty insurers; (ii) workers' compensation rates must be adequate to cover an insurer's losses and expenses; and (iii) the Commissioner may disapprove a workers' compensation insurer's rates if premiums resulting from the use of such rates, or those rates as modified, would be inadequate to cover the insurer's losses and expenses or would impair or threaten the solvency of the insurer. Chapter 873 has an effective date of Jan. 1, 2003. *For additional information on Chapter 873, visit www.leginfo.ca.gov*

CALIFORNIA—Legislation Enacted to Modify Reinsurers' Workers' Compensation Deposit Requirements

Senate bill 2093 has been signed into law by the Governor and is now Chapter 899 of the Laws of 2002. Chapter 899 repeals existing California law requiring every insurer reinsuring the injury, disability or death portions of workers' compensation insurance policies under the class of disability insurance to maintain with the Commissioner a bond, or a cash deposit in lieu of a bond, in favor of the Commissioner for awards made to beneficiaries against the insurer, to the extent of the reinsurance. In place of the repealed law, Chapter 899: (i) allows letters of credit that perform in "material respects" as otherwise allowable securities to be used to make deposits by workers' compensation carriers; (ii) requires any reinsurer that accepts liabilities to identify their ceding carriers and the amount ceded, and requires ceding carriers to identify their reinsurers and

the liability ceded; (iii) requires, as of Jan. 1, 2005, reinsurance agreements used by ceding carriers to include a provision allowing the Commissioner, in the event of an insolvency, receivership or delinquency proceeding, to use the reinsurer's deposit if the reinsurer refuses to pay claims under the policy; (iv) requires the Commissioner to give a reinsurer's deposited funds to the California Insurance Guarantee Association ("CIGA") for the purpose of allowing CIGA to pay claims; (v) requires reinsurers to place additional funds on deposit within 15 days of notice of a deficient deposit, and disallows credits otherwise given to the ceding carrier when the reinsurer places its own funds on deposit; and (vi) creates new penalties for reinsurers if deposits are deficient. Chapter 899 has an effective date of Jan. 1, 2003. *For additional information on Chapter 899, visit www.leginfo.ca.gov*

NEW JERSEY — Department of Banking and Insurance Issues Bulletin Regarding "40 States" File and Use Standards and Procedures

The New Jersey Department of Banking and Insurance recently issued Bulletin 2002-26, informing licensed life insurers that they may utilize the file and use standards set forth in New Jersey Statutes Annotated (NJSA) Section 17B:25-18.4 prior to the Department's formal adoption of implementing regulations. NJSA Section 17B:25-18.4 allows an insurer to market certain individual and group life and annuity forms without obtaining the prior approval of the Department. To market such forms on this basis, an insurer must file the forms with a certification memorandum that states that the forms have already been made available for sale or use, pursuant to applicable state regulations, in at least 40 states. A responsible officer of the insurer is required to execute the certification memorandum. The insurer may use the forms upon receipt of an acknowledgment from the Department stating that the forms and certification memorandum have been received and comply with the requirements of NJSA Section 17B:25-18.4. Bulletin 2002-26 also notes that the Department previously proposed, but never adopted, regulations implementing NJSA Section 17B:25-18.4. The Department has since re-proposed new rules, with which insurers will be required to comply pending

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 Laurenzano, an insurance finance consultant. They gratefully acknowledge the assistance of Robert T. Schmidlin and Todd Zornik, associates in the group. This column is intended for informational purposes only and does not constitute legal advice.

their formal adoption. *To view Bulletin 2002-26 and the re-proposed regulations, visit www.njdobi.org*

NORTH CAROLINA — Department of Insurance Issues Bulletin on New Paperless Filing Option for Life and Health Filings

The North Carolina Department of Insurance recently issued Bulletin No. 02-B-9, which announces a new paperless option for submitting rate and form filings, known as “NC NoPaPER,” which allows insurers to e-mail rate and form filings to the Department. NC NoPaPER may be used only with respect to filings submitted to the Department’s Life & Health Division. Rates and forms submitted under this option must be converted to a Portable Document Format (Adobe PDF) and mailed electronically to the Life & Health Division at landhdivision@ncdoi.net. Such e-mails must comply with the Department’s detailed filing instructions (available at www.ncdoi.com). Filings that are too large to send electronically may be delivered on compact disk or diskette. The Department will continue to accept electronic filings submitted via SERFF, and such filings will continue to be reviewed according to SERFF filing and review procedures. The Department will also continue to accept paper filings during the Department’s transition to a paperless filing system. However, insurers filing paper submissions are still required to include an e-mail address with every submission, as all follow-up correspondence from the Department regarding any filing will be communicated via e-mail. This procedure is applicable whether the filing is submitted in paper or electronic form. *To view the Bulletin No. 02-B-9, visit www.ncdoi.com*

OHIO — Department of Insurance Issues Bulletin Establishing Guidelines on the use of Credit History and Credit Scores in the Underwriting and Rating of Certain Personal Lines Policies

The Ohio Department of Insurance recently issued a Bulletin offering property/casualty insurers guidance on the use of credit history and credit scores in connection with underwriting and rating. The Bulletin applies only to personal lines coverage as defined in Ohio Insurance Code Section 3937.03(C)(1)(b), which refers to any policy issued to a natural person for personal or family protection, including, but not limited to, personal automobile, homeowner’s, tenants, and personal umbrella liability coverages. “Credit history” is defined in the bulletin to mean any information “bearing on a consumer’s creditworthiness, credit standing, or credit capacity that is used or

expected to be used, or collected in whole or in part, for the purpose of serving as a factor in determining rates, placement within a tier or with an affiliated company, or eligibility for coverage.” “Credit score” is defined to mean “a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit history.” The Bulletin states the Department’s position that credit history and credit scoring is permissible under various Ohio insurance statutes governing unfair or deceptive acts, the grouping of risks by classification, and unfair discrimination with respect to insurance rates. However, an insurer’s use of credit history and credit scores must comply with the guidelines enumerated in the Bulletin. Among other requirements, an insurer must show that credit history and credit scores used are valid risk characteristics and are consistent with actuarial principles and standards of practice. An insurer must also implement standards regarding how credit history and credit scores impact underwriting and rating decisions and must file with the Department all risk classification criteria and rating manuals relating to such credit information. *To view the Ohio Department of Insurance Bulletin, visit www.ohioinsurance.gov/Legal/Bulletins/2002-2.htm*

OKLAHOMA — Insurance Department Adopts File and Use System for Commercial Property/Casualty Products

The Commissioner of the Oklahoma Insurance Department has issued Order 02-0765-PRJ, exempting certain commercial property/casualty products from the state’s prior approval process. The Order applies to forms of commercial property/casualty insurance, commercial marine and inland marine insurance, and commercial vehicle insurance on risks or operations located in Oklahoma. An insurer submitting a policy form, endorsement or any other contract language is required to certify that the filing complies with all applicable Oklahoma statutory and regulatory requirements and that it be complete. The certification must be signed by an officer of the company. Any filing made pursuant to the Order must be filed at least 30 days prior to the filing’s effective date. The Order also exempts insurers covering large commercial risks (defined as risks with annual premiums in excess of \$10,000) from the policy filing requirement. *To view Order 02-0765-PRJ, visit www.oid.state.ok.us ■*

THE REGULATOR



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Are the Courts Taking Over State Insurance Regulation?

Article, p. 1



BULLETIN BOARD

√ You should already have received your 2003 IRES dues notice. PLEASE don't forget to fill out your membership profile information on both sides of your dues notice before returning it. We are completely updating all member information, so it's very important that you tell us about your regulatory expertise — this helps us plan educational programs geared to the needs of IRES members.

√ There is a mandatory \$15 late fee — no exceptions — on all dues payments that are received late. Failure to include the late fee will result in automatic suspension of membership and the possible suspension of a member's

AIE/CIE status. Payments must be received in the IRES office by March 1.

√ Stephen St. Cyr, CIE, retired in July after a 32-year career in insurance — 16 with the Colorado DOI. He plans to continue a schedule of travel in his retirement and would enjoy hearing from his many friends, both in IRES and the industry: saintcyrco@aol.com

√ Now is the time to nominate someone for the Paul DeAngelo teaching scholarship funded by the IRES Foundation. The award provides a \$1,000 scholarship to persons who have made major contributions to the education and training of state regulators. See the IRES Foundation Web site, www.ires-foundation.org, for more information about the award and to obtain a nomination form. Nominations must be received by Jan. 31, 2003.

In next month's REGULATOR:

Rating the Rating Agencies