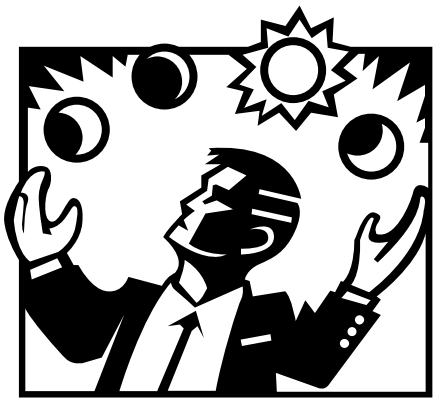
THE REGULATOR™
INSURANCE REGULATORY EXAMINERS SOCIETY

Regulators juggling responsibilities in light of stringent state budgets

by Scott Hoober
Special to *The Regulator*

A few years ago, at least in part to improve the health of their citizens, a group of state attorneys general joined in a lawsuit against the big tobacco companies.



Today, with millions in tobacco money rolling in to state coffers — but other sources of revenue shrinking — some states have put aside health concerns and begun defending the tobacco industry, lest the golden calf be turned into veal.

Yes, budget crunches make strange bedfellows. After all, the states are short $30 billion in revenue this year, says the National Governors Association, and likely to be $82 billion short next year.

Meanwhile, as made clear by ire over CLUE reports, credit scoring, rising med mal premiums and a host of other insurance company practices, insurers and consumers need effective regulation today every bit as much as a few years ago, when the good times were rolling. But statewide budget cuts make it difficult to do the job properly.

How have the hard times affected insurance regulation?

There's tremendous variation from state to state in the percentage of fee revenue, as well as other factors affecting the bottom line. But here's a snapshot of how several states are managing to maintain services to both companies and consumers.

Oregon

This isn't the first time the states have been hard-hit by declining tax revenues. Another recession, in the '80s, was particularly tough on the Oregon Insurance Division.

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Insurance and the risk of terrorism

by Conning Research & Consulting

In a society where free speech, no matter how distasteful or fatuous, is protected and promoted, it is very difficult to understand suicide terrorism. It seems incomprehensible that people are willing to sacrifice their lives to inflict harm on non-combatants. Nevertheless, suicide terrorism is not new.

Until recently, most terrorism *was* suicide terrorism. Given the lack of sophisticated, long-distance weaponry, there were not many other options. Since most weapons, such as daggers, pistols, and explosives, were effective only at short-range, most of the assailants did not even attempt to get away.

Whether we review the near-term or the distant past, history is replete with examples of suicide terrorism. The tyrannicides of ancient Greece, the regicides of the Middle Ages are two noteworthy examples. Throughout history and

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From the President

The Changing of the Guard

Shortly after joining IRES, I was fortunate enough to be asked to Chair the Consumer Services Section for the CDS, which I did for 7 years. That experience led me to run for the IRES Board of Directors, which culminated in my becoming President of this great organization.

I say I was fortunate because there were great people in place to teach me and show me the ropes all along the way. People like Angela Ford who affectionately calls me her "needy friend." I also learned a great deal from Gerald Milsky, Scott Laird, Gary Domer, Christel Szczesniak, Steve Martuscello and a host of others too numerous to mention. They prepared me well for the trials and tribulations of running IRES.

I believe we have now reached another plateau; it's time for a new generation of IRES members to forge their place in the annals of IRES history. A myriad of difficult issues confront the organization at this time. Certainly the economy and the threat of terrorism have created economic challenges for the leadership of IRES.

There is also tremendous change occurring in the marketplace, including the affordability of terrorism coverage for our commercial insureds, speed-to-market initiatives, and the lack of meaningful health insurance for millions of Americans. IRES must grow to meet the needs of an ever-changing regulatory environment. We are attempting to accomplish this goal by creating more innovative CDS seminars and working to develop a market conduct certification program.

However, more needs to be done. Those in leadership positions in this organization, including myself, should be reaching out and cultivating a new generation of IRES leaders. We should be encour-

continued on next page

President's Column ...

aging this new generation to get involved in the organization, to run for seats on the Board of Directors and the Executive Committee.

In recent years, some members may have been dissuaded from seeking leadership positions in the organization because they believed IRES elections were preordained — that we weren't really looking for new people to help run the organization. Nothing could be further from the truth. We need and want new people to step up and be counted. In fact, it is essential if IRES is to maintain its drive and enthusiasm in the years ahead.

I therefore put forth a challenge to IRES members in leadership roles to make an effort to reach out and encourage a member to run for a Board position or to volunteer to be involved in our CDS. I also challenge all other members to contact Board of Directors or Executive Committee members to ask about getting involved in the leadership of IRES. I'm convinced that the same talents you bring to the workplace every day can be brought to our organization. Remember, the whole is only as strong as the sum of its parts.

Paul J. Bicica

Paul J. Bicica, CIE
IRES President

IRES-SOFE panel on MEWAs

"MEWAs: What They Pretend To Be and What They Really Are," will be presented June 22 in New York City, a joint educational workshop sponsored by IRES and the Society of Financial Examiners (SOFE).

The program will be 1-2 p.m. in the Trianon Room, 3rd Floor of the New York Hilton & Towers, during the NAIC's annual summer meeting. The program qualifies for continuing education credits for IRES and SOFE members.

Farewell to Christel

Christel Szczesniak, a former president of IRES and one of the Society's most ardent boosters, retired from the Colorado Division of Insurance on April 30.

Christel has advanced the interests of all insurance regulators through her years of leadership in IRES. She served the organization in various capacities, including President, CDS Chair, Director and a member of the Past Presidents Council.

In 2000, she was named a recipient of the IRES President's Award in recognition of her years of service to the Society.


Christel Szczesniak

Kirk Yeager, Colorado assistant commissioner, noted that Christel "enjoys an excellent reputation among both her fellow regulators and the industry." He added that "those who have worked with Christel are continually impressed by her expertise, professional competence, and technical proficiency, and delighted by her caring nature, great sense of humor and forthright manner."

During her nearly 30 years of service to Colorado, Yeager said, Christel became the Division's acknowledged technical expert on property and casualty insurance and enforcement issues and no-fault auto insurance. "She has, for nearly three decades, provided the solid rock of property and casualty insurance know-how necessary for the success of the Division's mission, blending knowledge gained from her earlier experience in industry with an unswerving commitment to consumer protection through fair regulation."

Christel has served as the chairperson of the state Workers' Compensation Cost Containment Board and manager of the Automobile Personal Injury Protection Independent Medical Examination Program. Her professional designations include Chartered Property and Casualty Underwriter (CPCU), Certified Insurance Examiner (CIE), Associate in Insurance Management (AIM), Associate in Risk Management (ARM), and Certified Professional Insurance Women (CPIW).

Tight budgets force regulators into juggling act

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"We lost a third to a half of our staff," recalls Joel Ario, administrator of the division.

"Coming out of that experience, we all got together and said we need a better funding system — one that's more stable in good and bad times — and that was the genesis of our current system."

That system today provides for all of the division's budgetary needs through fees assessed on insurers operating in the state.

"We have essentially a three-part system," Ario explained.

"The first and most important is fees for specific kinds of services — agent fees, and we also have a fee for doing Form A's and that sort of thing. That's probably 50% of our budget. Then 30% of it is examination-related fees."

> ***I can say with certainty that the regulatory activities that the Department carries out have not suffered.***
>
> **— Indiana's McCarty**

The remaining 20% or so comes out of a pro rata assessment on each line of insurance, based on its claim on division staffers' time.

"Every year there's a staff survey of how much time each staffer spends on property-casualty vs. life vs. health," Ario said. "Say health turns out to be 24% of the time, then the health line has to account for 24% of the remaining part of the budget, and that's pro rata to them based on market share.

"We think it's a quite effective system, because we don't have to calibrate our fees exactly. We can understate them and then pick it up on our assessment."

Similar dedicated funding sources pay for most of the agencies handling business regulation in Oregon, including the entire Department of Commerce, of which insurance is a part. Most of overall department revenue comes from an 8% assessment on workers' comp, which supports the separate Workers' Comp Division and OSHA Division, among other operations.

This system, in place since the late '80s, doesn't mean that the insurance division can totally ignore the realities of the state's budgetary woes, but it does provide some insulation. For instance, one response to the current budget stringency has been a statewide travel ban, and that ban affects members of the division just as it does state employees whose agencies' budgets aren't covered by dedicated funds — making it hard to take advantage of professional-development opportunities and the like.

Plus, says Ario, "There's a difference between a spending limitation and revenue.

"The Legislature always sets our expenditures, and we can only spend what they approve. And then the spending is basically tied to personnel slots. So we have a certain number of slots available to us."

"We're fine on the revenue side," he added. "We never have a problem raising the revenue that we need to accommodate our expenditure limitations. So what limits us is if the Legislature says. 'We're not going to give you any new spending limit, or we're going to cut your spending limit' — then we're restrained."

Indiana

In its successful efforts to bounce back from adversity, the story in Indiana is similar. A few years ago the Department of Insurance was so starved for funds that it made the front page of the Wall Street Journal.

But Sally McCarty, commissioner during those bad old days, and still commissioner today, has managed to beef up the department. And by tightening their belts, staffers are able to continue to serve companies and consumers.

""Our state has a serious situation, just like everyone else does." McCarty says.

"We were in a surplus situation several years ago, and now we're in a deficit. Tax revenues are down,

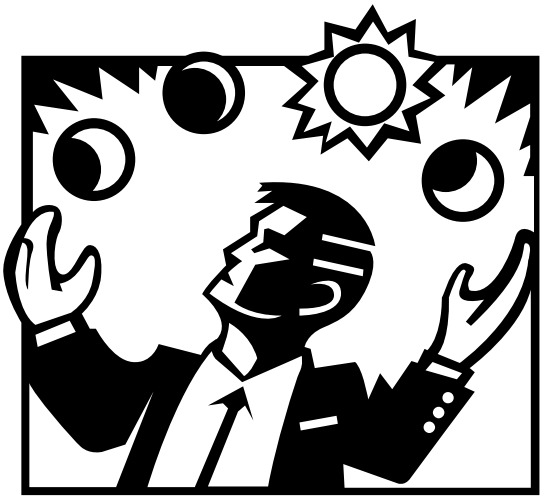
and there doesn't seem to be any light yet at the end of the tunnel.

"As far as our department budget goes, it's pretty much been flat-lined, with cuts in certain areas, like travel.

"But as far as our regulatory activities, our limited resources are going to make sure that those don't suffer, that there are no sacrifices made in that area.

"Where we're cutting back is things like travel. We can't send people to as many conferences and training opportunities as we would like. We used to send 7-8 people to the quarterly NAIC meetings, now we send 2-3. Those areas are where we're cutting back."

(None of the states' travel bans restrict travel necessary to visit companies and audit their books, as far as we know — any more than they limit the number of miles Highway Patrol troopers may drive to chase down speeders.)



With the cost of exams paid for by fees assessed to the company being examined, it has to be tempting for many states to cut back on the "softer" areas — things like consumer affairs, for instance. Yet McCarty, like other officials we talked with, insists that just about every area be maintained, even in these times.

"I can say with certainty that the regulatory activities that the department carries out have not suffered," McCarty said, "but we are cutting back as far as purchases of new equipment, travel, those things."

Two-thirds of the Indiana department's budget comes from the general fund, with the remaining third from a dedicated fund made up of filing fees. The state uses a lot of contracted examiners, as well as contracted actuaries.

"We had to do some pretty serious negotiations to be able to renew the actuaries' contracts," McCarty said. "So we've done away with some other contracting services."

For instance, the state dropped its contract with an attorney who did special projects, then used the savings to keep the actuaries.

"I can't say that we've reduced our staff," the commissioner added. "We were in a pretty streamlined position to begin with. We just haven't increased it any.

"We do have a hiring freeze on, so when we have a vacancy we have to get permission from a Strategic Hiring Freeze Committee. So far we haven't been turned down when we needed to replace someone," though they have lost several clerical positions.

So does Indiana have enough people to serve its constituents?

"I think we do," McCarty said. "Barely."

Colorado

In Colorado, the ratio between fee revenue and general fund is about 50-50. Which means that a recent 10% cut in state money translates into about a 5% cut in total revenue — for a total loss of 12 FTEs (full-time equivalents).

The cuts will be deeper still in the upcoming fiscal year. Deputy Commissioner Janet Byrne says her agency's approach has been to try to cut equally in every part of the Division of Insurance, something that may become more difficult after July 1.

So far, the only area that's been eliminated altogether was the public information officer, whose role has been spread around among a number of senior staffers.

The division, part of Colorado's Department of Regulatory Agencies (DORA), is also trying to make use of emerging technologies, in this case relying on its Web site to answer some consumer and press inquiries. The trouble is, hard time (and hard markets) tend not to lead to reduced numbers of complaints and questions.

"As much as we would like to think we've managed it as best as possible by prioritizing," Byrne said, "the reality is that today with the hard market, we're getting more consumer complaints, and consumers are waiting longer to have their complaints processed.

"But the key for us has been to look around at what

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Tight budgets force regulators into juggling act

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is statutorily required, and we're also all working harder today than we did in the past."

The bright side — if tough times can have a bright side — is that when tax revenues get back to normal, the division will have a better handle on what's most important.

"We hope that there's some natural prioritization that occurs, there's streamlining that occurs," Byrne said.

"As we get some of the FTEs back, hopefully we can focus them on doing effective outreach programs, doing more market analysis and many of the things that we've been trying to do, or that we would like to do because we think it will add to the effectiveness of our regulation."

> ***The reality is that today, with the hard market, we're getting more consumer complaints, and consumers are waiting longer to have their complaints processed.***
>
> **— Colorado's Byrne**

One long-term solution, in Colorado and elsewhere, would be to go to an Oregon-like system, with more fees and fewer tax dollars. That's being talked about, but so far it's only talk.

"I'm not sure at this point if it's going to happen," said Byrne. "It's not going to change overnight, that's the bottom line."

The division doesn't have to look west to see how nice it would be to not have to compete with other state agencies for funds.

"Within DORA, there are many agencies — there's the Public Utilities Commission, the Division of Banking, the Division of Registrations, Division of Civil Rights, Division of Securities, Division of Real Estate," said Byrne. "And civil rights and insurance are the only two that are reliant on the general fund."

Nevada

One of the hardest-hit states in the recent downturn has been Nevada, where a sizable percentage of state revenues come from tourists, via a casino tax.

Fortunately for insurance regulation, the Division of Insurance, part of the Nevada Department of Business and Industry, generates a majority of its revenues from fees.

"Have we been affected by the shortfall? Yes, very much so," said long-time commissioner Alice Molasky-Arman.

"Our budget for the next biennium is 3% less than in previous years, but we had to make that 3% cut this year. Nevada's governor did leave to the agencies how they chose to effect that difference. We're not cutting out any services. A number of vacant positions aren't being filled, plus cuts in certain other expenses — but not in services."

Besides using contract examiners, whose costs are completely paid by assessments on the companies being examined, the division has a number of separate fees.

"We have a fraud assessment that offsets our costs for fraud, and also pays for the fraud unit in the attorney general's office," said Molasky-Arman.

"We have a cost-stabilization fee that is assessed on all casualty insurers, for us to monitor the casualty market. Then we have an assessment of $15 on every producer and licensee; that is for our education fund, which is dedicated to educating the producers, educating our staff and educating the public.

"Then we also have our NAIC assessment, which is to offset the cost of the commissioner's participation in the NAIC.

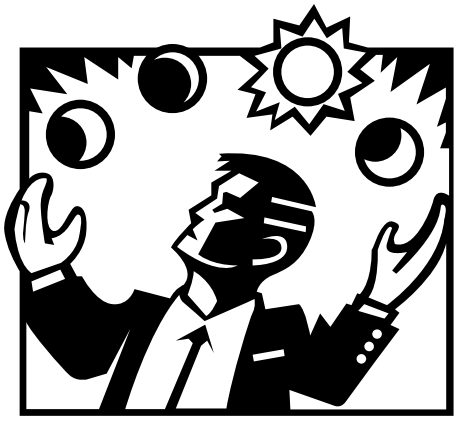
"And we have had and continue to have a 50% override on the examiners' per diem, and that is to pay for internal costs, because we have our chief examiner, our assistant chief examiner, who conduct the supervisory reviews."

The key is that, between all the fees and continued, albeit diminished, support from the general

fund, consumers and companies continue to be served. Molasky-Arman attributes her division's ability to keep up with demand to an understanding governor and an especially dedicated staff.

"Our governor has been very good to us," she said. "He recognizes the important nature of insurance. And in fact, during our special session, he supported the addition of several new staff.

"We actually have in our budget a new staff position, which is unusual. That's for an actuary to conduct research on the medical malpractice and construction defects issues. Our governor does recognize the nature of this agency and has been very open to permitting us to maintain most of our positions.



"We still have the same number of consumer officers," Molasky-Arman said. "We have four in our office in Las Vegas, and we have three up here in Carson City."

Sunbelt Nevada has seen a whole lot of growth in recent years, increasing demands on the division's staff — not to mention increasing the number of domestic companies — so it's not easy making do with less.

"I can tell you, I probably have one of the most dedicated staffs in the country," said the commissioner. "I'd say 95% of the people who are here are committed to what they're doing. We've been very lucky here."

The division has also been able to add an enforcement investigator and a legal secretary, though they had originally hoped to be able to add another attorney, another legal secretary and several other positions.

"We're holding our own," Molasky-Arman said. "We've always had to do that."

Keeping on keeping on

In these four states — and in numerous others, to judge from newspaper clippings and casual conversations — the message is that insurance regulators are muddling through.

When you think about it, though, even in flush times, it's never real flush for government agencies.

Most commissioners, and most examiners too, for that matter, could probably earn more in the private sector. But they believe in good, fair regulation and are willing to do whatever it takes to get the job done.

As Indiana's McCarty put it: "When you're an administrator in government, you have to go into it knowing that you're always going to have to do more with less.

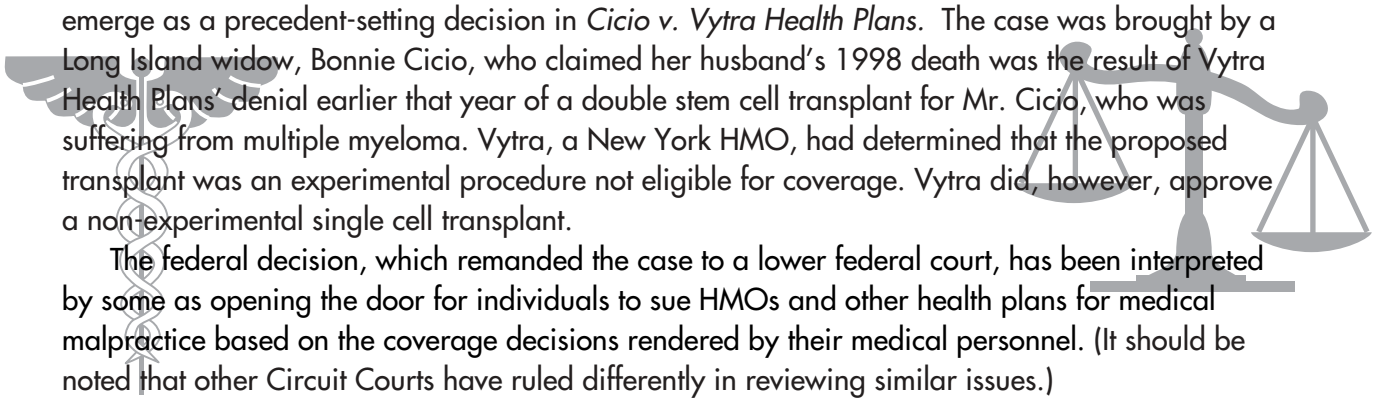
"That's the challenge of being a government administrator — in tough times and in good times." ■

Quote of the Month

"Why would you want to invest in a state that takes you to the cleaners? Why should we buy their municipal bonds?"

— Maurice "Hank" Greenberg, Chairman of American International Group (AIG), announcing the launch of an AIG advertising campaign that will rank states based on the effectiveness of their tort systems. The goal is to influence bond markets to invest in those states with the most responsible civil justice systems.

Should HMO coverage decisions be subject to medical malpractice lawsuits?



EDITOR'S NOTE: On February 11, the Second U.S. Circuit Court of Appeals issued what could emerge as a precedent-setting decision in *Cicio v. Vytra Health Plans.* The case was brought by a Long Island widow, Bonnie Cicio, who claimed her husband's 1998 death was the result of Vytra Health Plans' denial earlier that year of a double stem cell transplant for Mr. Cicio, who was suffering from multiple myeloma. Vytra, a New York HMO, had determined that the proposed transplant was an experimental procedure not eligible for coverage. Vytra did, however, approve a non-experimental single cell transplant.

The federal decision, which remanded the case to a lower federal court, has been interpreted by some as opening the door for individuals to sue HMOs and other health plans for medical malpractice based on the coverage decisions rendered by their medical personnel. (It should be noted that other Circuit Courts have ruled differently in reviewing similar issues.)

Below are articles by Stephanie Kanwit of the American Association of Health Plans and the Florida law firm of Perenich, Carroll, *et al.* responding to the question **"Should HMOs' and Health Plans' Coverage Decisions be Subject to Medical Malpractice Lawsuits?"**

Please note that New York State's external review law took effect in July 1999, subsequent to Vytra's coverage denial for the transplant.

NO: It Makes No Sense

by Stephanie Kanwit

A few state and federal courts have veered off on an unwise tangent and started to apply medical malpractice law to a wide range of health plan coverage decisions. Coverage decisions, of course, should be just that — interpretations of contracts as to what treatments and services are to be paid for by a health plan or insurer, and ultimately by the employers and individuals who pick up the tab.

But bending the law to turn "contract" decisions into possible *medical negligence* even when no doctor-patient relationship exists makes no sense either as a matter of law or public policy. Courts that go this route are condoning the trend toward out-of-control litigation, raising costs for everyone, while undermining a much better solution to coverage disputes adopted by almost every state — independent medical review.

Most critically, they're diminishing the quality of care by imposing our broken medical malpractice

YES: Punish Misconduct

by Perenich, Carroll, Perenich, Avril & Caulfield

Americans have come to expect that legal liability for medical malpractice should depend on whether or not the doctor or company was responsible for the substandard medical care that caused the unnecessary injury to the patient. It seems just that the doctor or company that wrongfully injures another should respond by compensating the victim for the injury and damages sustained.

Careless drivers are regularly held accountable in the American system of justice for the harm they inflict on the public. Likewise, a corporation that manufactures a dangerous product is required to pay for the injuries caused during the anticipated use of the product. These circumstances have served the public well in safer driving and safer products. The same benefit exists when doctors and corporations providing medical care that breaches the accepted standard of care are held accountable in our legal system.

NO: Kanwit

system on health plan administrative decisions — a malpractice system that forces doctors to practice "defensive medicine" to avoid being sued and is simply a "litigation lottery" that needs fixing.


Stephanie Kanwit

Cicio: Medical Decisions v. Plan Administration

A recent decision by the federal Court of Appeals for the Second Circuit, in New York, confused the distinct concepts of "medical" judgment and benefits decisions. In *Cicio v. Vytra Healthcare*, Dr. Spears, Vytra's medical director, made a "Utilization Review" (UR) decision of the type which health plans — whether private or public (such as Medicare or Medicaid) — use to determine whether a proposed medical treatment plan would be a covered service under the terms of the health insurance contract. In this case, he determined that an unproven and possibly inappropriate procedure was "experimental" and thus not covered under the insurance policy. Instead, Dr. Spears found that a single stem cell transplantation was covered by the contract.

Based on that decision, the court inexplicably converted Dr. Spears into a treating physician, and held broadly that state medical malpractice law would apply to a claim based on a UR decision made by a health plan medical director. The U.S. Supreme Court has never advocated the illogical approach of the *Cicio* majority, and in fact has made clear that "medical treatment" and "plan administration" are two separate concepts — and should stay that way.

While the court in *Cicio* believed that it was following Supreme Court precedent in the case of *Pegram v. Herdrich* (2000), it failed to recognize that *Pegram* involved a physician-owned HMO where *the same person*, the treating physician, made both the medical treatment and the plan administration decision.

Cicio itself promises to take more twists and turns. Perhaps acknowledging the weak precedent for its

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YES: Perenich

Into this instinctively fair and beneficial basis for legal liability has stepped the HMO. What is the just liability law for a managed care company, a Health Maintenance Organization? Should an HMO be held accountable in legal damages for the harm that it causes by its control over medical care provided to an individual patient?

Before the development of the HMO concept the physician determined the course and scope of medical diagnosis and treatment. He was aided by persons and institutions of his choosing, such as the local hospital or the local laboratory. The doctor and each person or company involved in the process was independently responsible for any injury caused by its breach of the accepted standard of care.

Everyone involved in providing medical care fully understood that any substandard conduct that resulted in injury was potentially a basis for a civil action for compensation. As a result, prudent providers of care sought to provide only quality care that met or exceeded the minimum accepted standards.

In the era of managed care the physician is obviously sharing the decision-making process for any particular patient with the employees of HMOs and HMO policies and procedures. It is difficult today to know exactly who is calling the shots when a physician decides on a course of treatment or declines to obtain an expensive test. Under the guise of cost control and benefit determination the HMO influences many of the medical decisions made by the physician faced with an injured or ill patient.

There are tools used by HMOs for supposedly good purposes that actually amount to the assumption of treatment authority over the patient. At times these tools appear to be purely administrative, but the impact upon the patient is to lessen medical choices and, usually, to diminish the quality of care.

From the perspective of the HMO it is necessary to have control over the use of heathcare facilities. This control is exercised via what is called *benefits administration*. Recognizing when *benefits administration* steps into or becomes a corporate form of *medical*

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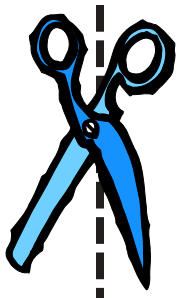
Know Your Insurance Commissioners!
A State-by-State Index



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SD	Wendell Malsam	Appointed	605-773-4104
TN	Paula Flowers	Appointed	615-741-6007
TX	Jose Montemayor	Appointed	512-463-6464
UT	Merwin Stewart	Appointed	801-538-3800
VA	Alfred W. Gross	Appointed	804-371-9694
VI*	Vargrave A. Richards	Appointed	340-773-6449
VT	John Crowley	Appointed	802-828-3301
WA	Mike Kreidler	Elected	360-725-7100
WI	Jorge Gomez	Appointed	608-267-3782
WV	Jane L. Cline	Appointed	304-558-3354
WY	Ken Vines	Appointed	307-777-7401

* **AS**: American Samoa; **GU**: Guam; **PR**: Puerto Rico; **VI**: Virgin Islands

SOURCE: National Association of Insurance Commissioners. Index is current as of April 15, 2003. Individual state Web site addresses available via www.naic.org. Compiled by Kathleen McQueen.

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The Signs of Excellence

Insurance Regulatory Examiners Society

Should HMO coverage decisions be subject to med mal lawsuits?

NO: Kanwit

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decision, the majority opinion itself mentioned that on remand the lower court may decide as a matter of fact that the procedure was, in actuality, experimental, and that the claim is a coverage decision.

In *Marks v. Watters*, a case similar to *Cicio* that was decided a few weeks later, the Fourth Circuit (covering Maryland, North Carolina, South Carolina, Virginia and West Virginia) got it right. It rejected a claim that a utilization reviewer of a PPO somehow can be liable for medical malpractice by simply referring a participant to outpatient psychiatric care.

Negative Impact of *Cicio*-Type Rulings

Court decisions such as the ruling in *Cicio* — expanding health plan liability to include adverse events resulting from a coverage determination — have the potential to adversely impact the effectiveness of health plan quality-of-care initiatives and efforts to reduce the use of inappropriate care. Review of a requested medical procedure such as occurred in *Cicio*, for example, attempts to ensure that the planned procedure is medically appropriate for a given patient, i.e., that it is the right procedure in the right setting at the right time.

But when we allow juries sitting in medical malpractice cases to have the ultimate say over the scope of coverage under a contract, health plans and fiduciaries cannot ensure that limited health care dollars are being spent fairly and equitably on medical treatments that are safe, proven, and effective. Any increase in costs as well as the uncertainty that accompanies litigation will force employers to confront the costs associated with the potential for large damage awards or settlements, and would discourage them from including broad categories of coverage, or from even sponsoring coverage for their employees altogether.

Expanded liability is never cost free, and inevitably decreases all Americans' access to insurance coverage. According to the U.S. Department of Health

YES: Perenich

continued from page 9

practice is sometimes difficult. However, there can be no doubt that today's HMOs are *practicing medicine* to the detriment of the patient.

Whenever the independent judgment of the treating physician has been molded or limited by the corporate policies of an HMO to the extent that it is no longer free to operate in the best interests of the patient, the HMO is *practicing medicine*. Worse, it is practicing poor medicine.

The primary tool used by HMOs in benefits administration is case management or utilization review. This is especially true in the complicated or costly medical situations. The case manager, who is employed by the HMO, is inserted into the decision-making process whenever treatment options are being planned.

> ***No organization should be granted immunity from the consequences of its misconduct, especially not organizations that control the medical care provided to most Americans.***
>
> **— Perenich**

The case managers, who are frequently nurses, monitor care and place it in the context of the benefits plan language and the financial bottom line. They become a permanent member of the decision-making team even though they are rarely seen by the patient. They chime in with so-called coverage opinions whenever they perceive one is necessary. The treating doctor, therefore, is regularly interacting with the case manager nurse to determine the treatment options that will even be presented to the patient.

In other instances, those in charge of managed care operations simply issue edicts that impact entire groups of patients. An example is the crafting of payment structures to participating doctors that encourage cheaper care and discourage more expensive care. An individual patient does not know that the doctor guiding his medical care has powerful incentives to

NO

and Human Services, medical liability will add between $60-110 billion nationally to the cost of health care this year — diverting money that could otherwise be used to fund health care for our 41 million uninsured or assure increased medical safety. Imposing law designed to deal with medical negligence on health plan coverage decisions is fitting a round peg in a square hole — with disastrous results for the individuals who depend on employer-sponsored health care.

It should be noted that the coverage decision that prompted *Cicio* preceded New York's independent medical review procedure, which allows difficult coverage decisions like this one to be determined by outside experts. External review is a faster, more efficient method than spending years in litigation to resolve coverage disputes. If the same fact situation were to arise now, New York's external review law would provide health plan enrollees with the opportunity to have an expeditious outside review without resort to litigation.

> ***The U.S.Supreme Court has never advocated the illogical approach of the Cicio majority, and in fact has made clear that 'medical treatment' and 'plan administration' are two separate concepts.***
>
> **— Stephanie Kanwit**

No one but trial lawyers benefit from protracted litigation. External review, on the other hand, is win-win for patients, health plans and employers. Patients are assured of receiving the right care at the right time; health plans can address coverage disputes through internal and external appeals; and employers and other plan sponsors will be confident that limited health care resources are being spent wisely, rather than on frivolous litigation. ■

Stephanie Kanwit is General Counsel and Senior Vice President, Public Policy and Research for the American Association of Health Plans, Washington, DC.

YES

avoid prescribing or recommending options that happen to be on the costly side of the ledger.

Whenever corporate policies or corporate employees cause doctors to narrow their choices of treatment options for a patient, an HMO is clearly practicing medicine in a very real sense. The corporate tools used to encourage or accomplish this narrowing vary somewhat from HMO to HMO, but they are generally working to the detriment of the patient.

Unfortunately, there is a major obstacle to developing case law in the federal ERISA law. This law was originally intended as a means to protect retiree pension plans from certain abuses. It also applies to self-funded employee health plans—plans that do not involve insurance but use their own funds to pay employee medical bills. The latter aspect of the law has created the obstacle to holding HMOs accountable in state courts for substandard medical care.

ERISA creates a federal preemption of all state laws that impact self-funded employee health plans. Sadly, in the place of the effective state law that would hold HMOs accountable, the federal statute provides very restricted rights for injured patients. For example, an injured patient is not able to seek compensation for future lost wages or emotional distress. And, under ERISA there is no right to a trial by jury.

No organization should be granted immunity from the consequences of its misconduct, especially not organizations that control the medical care provided to most Americans. ■

This article was prepared by personal injury attorneys at the law firm of Perenich, Carroll, Perenich, Avril & Caulfield, P.A.. The law firm, which started operations in 1955, is based in Florida's Tampa Bay area.

Insurers, regulators gather in Baltimore

10th annual IRES Foundation National Insurance School on Market Regulation

Insurance company officials, compliance consultants, attorneys and others came to the Hyatt Regency-Baltimore April 23-25 for the 10th annual National Insurance School on Market Regulation. Senior insurance department staff from across the country were on hand to brief attendees on current market regulation requirements in their states.

The program is sponsored annually by the IRES Foundation, which uses proceeds from the event to provide seed money for educational projects serving insurance regulators. The 2004 School will be April 18-20 in Tampa, FL.

Industry officials at one of the many breakout sessions on market conduct issues.

Students at the school receive a detailed binder packed with facts and figures about each state's regulatory requirements.

Friday morning's "round robin" breakfast allowed attendees to meet with the state regulators of their choice for informal, personal discussoins about compliance issues.

Michael Bownes of the Alabama Insurance Department (right) was named recipient of the IRES Foundation's 2003 Paul L. DeAngelo Memorial Teaching Award. At left is John Mancini, a member of the IRES Foundation Board of Directors.

New York Insurance Supt. Greg Serio delivers one of the School's keynote addresses. Behind him are the members of the state regulator "faculty" for this year's National Insurance School on Market Regulation. More than 200 insurers, attorneys and compliance consultants attended the meeting at the Hyatt Regency on Baltimore's Inner Harbor.

Conning study: Terrorism and insurance

continued from page 1

across countries, ethnicities, and religions, there is an expectation that soldiers will be ready to sacrifice their lives for their cause.

Despite all of the antecedents, suicide terrorism used to be directed at the heads of state, important people, and combatants, in time of war. Now terrorism seems largely indiscriminate and is driven toward inflicting the maximum amount of destruction.

Military strategists term this type of combat "asymmetric warfare" in that it is not bound by any rules or restraints. By contrast, governments are typically subject to the moral sentiments of the populace and by international laws. While it is easy to extrapolate man's worst impulses to the worst possible extremes, even this form of terrorism has limits.

As long as terrorists do not obtain weapons of mass destruction, it is reasonable to believe that these types of attacks will fade away. Extreme terrorism is repugnant to civilized people, and they will take whatever actions are necessary to defeat such enemies.

Insuring Terrorism Risk: The Answer or the Question?

Can insurance play a meaningful role in addressing terrorism risk? We would love to jump on the bandwagon and declare that terrorism is an insurable risk, but the reality is much more complex.

In many respects, terrorism losses are more of an uncertainty than they are a risk. While people can use various models to estimate the risk of terrorism loss, these models are more useful in assessing relative terrorism risk than they are at quantifying it in any absolute way. In the end, judgment is of paramount importance.

Even the definition of terrorism is fraught with peril. Without a universally accepted definition of terrorism, it is highly likely that politics will play an important role in determining the extent of insurance coverage, both before and after a loss occurs. The political nature of these crimes raises doubts about whether a private insurance mechanism can be successful.

Given that terrorist events can surpass even the largest natural disasters in terms of insurable losses, insurers must develop the tools necessary to understand potential concentrations of terrorism risk. The public perception is that terrorism risk is only important to the tallest buildings in the largest cities. If this is correct, it is possible that transferring this risk to a small number of relatively large insurers will only serve to concentrate this risk more.

How will insurers accumulate the capital necessary to fund such large losses? Given that insurers do not know how big this market is, what the potential for losses is likely to be, or the price that buyers are willing to pay for this coverage, it is unlikely that large amounts of new capital will be infused into the property/casualty insurance industry to fund this risk. It is also unlikely that insurers will be able to charge enough premium in the near-term to fund it.

Ultimately, the inability of insurers to fully fund such high severity events will make customers question the value of terrorism coverage. If the insured cannot be confident that the insurer has the resources to pay such large claims, how much is the coverage really worth? Uncertainties about the coverage definition, the frequency and severity of loss, and the financial strength of insurers will make terrorism coverage relatively unattractive to both insurers and insureds.

Initially, we expect that insurers will offer a wide range of premium rates for terrorism coverage. Over time, this range is likely to narrow as the market for terrorism coverage becomes more competitive and more specialized. However if more time elapses without the occurrence of another large terrorism loss, we expect that many customers will lose interest in this product, making it even more difficult to fund this risk.

The human dimension of terrorism and the extreme losses that can result from these crimes make terrorism unlike many traditional insurance hazards. It seems reasonable to assume that a new approach will be needed to effectively address this risk and that no one solution will be very effective. The trick will be to find the best combination of solutions to this problem using a game theoretical approach. ■

Conning Research & Consulting publishes proprietary financial services research and provides research consulting services to institutional investors. In February, Conning released two studies on terrorism risk insurance: "Terrorism Risk Insurance Act of 2002: Problem Not Solved" and "The Insurability of Terrorism Risk: It's Not That Simple." To find out more about these studies, visit *www.conningresearch.com.*

IRES State Chapter News

OREGON — Medical savings accounts (MSAs) were the focus of Oregon's IRES Chapter Meeting last March. **Sandra Coble** and **Jennifer Barrows**, representatives from Lifewise Health Plan of Oregon, Inc., discussed with IRES members how the accounts work, who qualifies, and associated tax benefits. The April meeting featured **Leslie Melville** of the National Flood Insurance Program and **Phil Benson** of the Oregon FAIR Plan.
— Gary Holliday

VIRGINIA — Thirty-seven members of the Virginia IRES Chapter recently attended the first educational meeting for 2003. At the meeting, two Department staff members discussed insurance-related bills recently passed by the Virginia Legislature. The next meeting, scheduled in May, will focus on Chapter activities for the remainder of 2003.
— Catherine West; cwest@scc.state.va.us

LOUISIANA — The Louisiana IRES Chapter met in January. **Rick Nauman**, Vice President of the Louisiana Medical Mutual Insurance Company spoke about medical professional liability insurance from the insurer's perspective. Rising costs and professional liability market withdrawals were discussed. In March, Attoney **Randal Beach** addressed a Chapter meeting. Mr. Beach discussed the benefits of the "policy form matrix system" that permits insurers to access legal requirements for each type of policy they issue. The system will help reduce the number of policy form reviews by the Louisiana Insurance Department. **Pam Williams** from the Office of Health assisted in the presentation.
— Larry Hawkins; lhawkins@ldi.state.la.us

COLORADO — The Colorado IRES Chapter hosted a presentation in December 2002 by **Ron Arthur** and **Reid Miller** of the CPCU Society. **Tom Able** of the Colorado Department also gave a short presentation on the Life Office Management Association (LOMA). The educational opportunities available through such organizations were discussed.
In the February class, Colorado's Chief Actuary **Victoria Lusk** discussed the impact of the federal Terrorism Act on the insurance industry and the Departmet. Twenty-six DOI staff attended the class.
— Vi Pinkerton

NEBRASKA — The featured speaker at the Nebraska IRES Chapter's February meeting was **Joe Elliott**, Account Executive with INSPRO, INC., an Omaha and Legislative Coordinator for Professional Insurance Agents of Nebraska. Mr. Elliot discussed Nebraska's tort system as well as providing an agent perspective on several pieces of key federal and state legislation. **Steve Hawkins**, Assistant Vice President for Marketing and Policyholder Service with Lincoln Direct Life Insurance, addressed the April meeting. Mr. Hawkins presentation, "Turning Your Customer Service Center into a Profit Center," focused on cross selling to current customers. *— Karen Dyke*

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 an unforgettable vacation for 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.

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 and tell them you are with the IRES group. You will find more info about the hotel at **www.scottsdale.hyatt.com.**

Welcome new members

Y. Rasheed Atkins, LA
Trent Beach, LA
Michell Bond, LA
Elizabeth Brodeur, MA
Dustin R. Browning, LA
Michael Louis Calamari, LA
Shirley L. Davis, DE
Eugene M. Jolivette, LA
Madonna R. Jones, LA
Larae Mason, AL
Trevor B. McCall, LA
John P. Miller, LA
Rebecca J. Nesheim, AK
Ronald R. Radtke, RI
Matthew C. Regan, MA
Sally A. Schaeffer, DE
Janet S. Schopp, AIE, FL
Angie Wages, AL
Sherry S. Williams, LA
Terry L. Wrobel, LA

IRES 2003 Career Development Seminar

JULY 27-29, 2003

HYATT REGENCY SCOTTSDALE

(The Hyatt Gainey Ranch Resort)

Official Registration Form

Fill out and mail to The Insurance Regulatory Examiners Society
130 N. Cherry, Suite 202, Olathe, KS 66061

Y es! **Sign me up for the Year 2003 IRES Career Development Seminar. My check payable to** IRES **is enclosed.**

Name

Title First name for Badge

Insurance department or organization

Your mailing address Indicate: Home☐ Business

City, State, ZIP

Area code and phone $ Amount enclosed

Seminar Fees

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

Check box that applies

- ☐ IRES Member (regulator) $285
- ☐ Industry Sustaining Member ... $460
- ☐ Non-Member Regulator $410
- ☐ Retired IRES Member $110
- ☐ Industry, Non-Sustaining Member $710
- ☐ Spouse/guest meal fee $80

Spouse/Guest name

Hotel Rooms: You must book your hotel room directly with the Hyatt Regency Scottsdale. The room rate for IRES attendees is $135 per night for single-double rooms. Call group reservations at 480-991-3388. The IRES convention rate is available until June 30, 2003 and on a space-available basis thereafter. Our room block often is sold out by early June, so guests are advised to call early to book rooms. See the hotel's web site at http://scottsdale.hyatt.com

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.

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

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

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

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

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

Insurance Regulatory Examiners Society™

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

REGULATORY ROUNDUP

by
Stroock & Stroock
& Lavan LLP

CALIFORNIA – Sharing of Nonpublic Personal Information by Financial Institutions

On March 3, 2003 the State Senate passed Senate Bill No. 1 aimed at limiting the extent to which California's banks could share financial data and giving consumers greater control, choice and notice about how their personal financial data is shared or sold by financial institutions. The term "financial institution" as used in this Bill refers to any institution whose business it is to engage in financial activities as described in Section 1843(k) of Title 12 of the United States Code and that is doing business in California. The Bill, introduced by Senators Speir and Burton, would enact the California Financial Information Privacy Act.

To disclose or share nonpublic personal information with non affiliated third parties, financial institutions would have to provide written notice to the consumer and then obtain the customer's consent. Financial institutions may not deny provision of a financial product or service to a customer on account of the customer's refusal to authorize such disclosure. Financial institutions would also be required to provide a written form to consumers to share the consumer's personal information with affiliates and may not disclose or share such information if the customer has so directed them, even if information is maintained in common databases to which employees of the financial institution and affiliate have access.

However, subject to specific requirements, the Bill allows financial institutions to disclose such information to an affiliate or non-affiliated third party to facilitate the performance of certain services for the financial institution. It would also be permissible for nonpublic personal information to be released in limited circumstances, such as for locating witnesses, parties to lawsuits and children. *For additional information on Senate Bill No. # 1, visit* ***www.leginfo.ca.gov***.

NEW YORK – Policyholders called to Military Duty

The New York Insurance Department recently issued three Circular Letters addressing issues relating to coverage of persons in active military duty. Circular Letter No. 5 (2003) addresses the designation of third party to receive notices from insurers. Property/casualty insurers are requested to notify policyholders as soon as practicable that — should they be called to active duty — they may designate an adult third party to receive insurance-related notices. Certain requirements must be met, including the submission to the insurer of a signed consent to be a third-party designee. Claims-made professional liability policies are also addressed. During the period of active duty, reporting of professional liability claims arising out of incidents prior to such period should continue. The policy should be suspended in all other respects. Coverage and payment of premiums would resume when the policyholder returns from military duty to professional practice.

Circular Letter No. 6 (2003) addresses war risks exclusions in life insurance policies. The Circular Letter reminds life insurers that they must notify the Superintendent before issuing life insurance policies that exclude or restrict payment of the benefit in the event of death as a result of war or the special hazards incident to military service. Circular Letter No. 7(2003) reminds insurers, Article 43 Corporations and HMOs that they must afford military personnel special rights of conversion, continuation and suspension of health insurance coverage in addition to the continuation and conversion rights otherwise provided. *For additional information on these Circular Letters, visit* ***www.ins.state.ny.us***.

NEW YORK — Rental Vehicle Coverage

Chapter 656 of the Laws of 2002 ("Chapter 656"), which pertains to rental vehicle coverage, was recently enacted. It amends Section 396-z of the General Business Law and became effective February 24, 2003. The new provisions introduced by Chapter 656 allow rental vehicle companies to sell "optional vehicle protection" at a maximum daily rate of either $9 or $12 depending on the manufacturer's suggested retail price of the vehicle.

This would provide the driver with coverage from liability for part or all of any damage to the rented vehicle. Customers must be advised by the rental vehicle company to ascertain whether their credit card or auto insurance policy already provides them with such coverage. If an authorized driver decides to purchase the protection, this

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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 Priya N. Pooran, an associate in the group. This column is intended for informational purposes only and does not constitute legal advice.

agreement must be in writing and provided at or before the rental agreement is executed. Chapter 656 also sets forth the limited situations in which a rental vehicle company or customer may void the protection, advertising requirements and the standards to be used in determining the maximum liability in the case of an authorized driver who does not purchase the "optional vehicle protection".

The $100 limitation on liability that rental vehicle companies could previously impose on customers for loss or damage to rented vehicles has also been removed. Accordingly, in the absence of optional vehicle protection or other coverage, a customer could be fully responsible for damage sustained to a rented vehicle. This change is addressed in the Eighth Amendment to New York Insurance Regulation No. 35-A (11 N.Y.C.R.R. 60-1). *For additional information on these Circular Letters, visit* ***www.ins.state.ny.us****.*

KANSAS -- House rejects credit scoring legislation

On March 28, 2003, the Kansas House of Representatives voted to reject Senate Bill 144, the proposed Kansas Insurance Score Act. Senate Bill 144 set forth various restrictions on the use of credit information in the underwriting or rating of risks covered under personal insurance policies (commercial policies were expressly excluded from the scope of the proposed legislation). For example, the bill would have prohibited any adverse action that is based solely on the fact that a consumer does not have a credit card account.

Similarly, Senate Bill 144 would have prohibited any adverse action based on credit information unless the underlying credit report or insurance score is calculated within 90 days from the date the personal insurance policy is first written or notice of renewal is issued. The bill defined an adverse action to mean a denial or cancellation of coverage, anything other than the best possible rate, or a reduction or other adverse or unfavorable change in the terms of coverage of any insurance.

Any insurer using credit information in the underwriting or rating processes would have been required to disclose this fact on the application or at the time the application is taken. Additionally, insurers taking any adverse action based upon credit information would have been required to provide detailed written notice of the action to the consumer. According to news reports, Senate Bill 144 was rejected by members of the Kansas House of Representatives due to the recent addition of certain controversial amendments, including an amendment to require the Insurance Commissioner to provide a report to the House of Representatives regarding various issues pertinent to the use of credit history, the cost of which would have been charged proportionately to those insurers utilizing credit scores in connection with the underwriting and rating of personal insurance. *To view the latest version of Senate Bill 144, visit* ***www.kslegislature.org/cgi-bin/fulltext/index.cgi****.*

MARYLAND — Insurance Administration issues bulletin regarding the certification of medical directors

The Maryland Insurance Administration issued Bulletin 2-2003 on February 27, 2003 concerning the certification of medical directors. The stated purpose of the Bulletin is to clarify (i) who is required to be certified as a medical director under Subtitle 10C (Medical Directors) of Title 15 of the Maryland Insurance Code, and (ii) who can be listed as a medical director in adverse decision notices and grievance decision notices provided to HMO members and health care providers. On the first issue, the Bulletin notes that Maryland insurance regulations require any person acting as a medical director to be certified as a medical director by the Maryland Insurance Commissioner. "Medical director" is defined in Maryland Insurance Code Section 15-10C-01(f) to include assistant and associate medical directors of HMOs. Maryland insurance regulations provide that a physician will be deemed to be an assistant or associate medical director if he or she has been delegated any of the functions of a medical director. Maryland Insurance Code Section 15-10C-01(f) sets forth the following medical director responsibilities: (i) the establishment or maintenance of the policies and procedures at the health maintenance organization for quality assurance and utilization management; (ii) compliance with the quality assurance and utilization management policies and procedures of the health maintenance organization; and (iii) oversight of utilization review decisions of private review agents employed by or under contract with the health maintenance organization.

According to Bulletin 2-2003, any physician of an HMO performing at least one of these activities will be considered to be an assistant or associate medical director who must be certified as a medical director by the Maryland Insurance Commissioner. With respect to the second issue above, the Bulletin explains that it is not enough to state on any adverse decision notice or grievance decision notice issued under Maryland Insurance Code Section 15-10A-02 the name of the physician who conducted the utilization review. Where the physician who performed the utilization review is not also a medical director, the adverse decision notice or grievance decision notice must also include the name of the medical director in charge of overseeing the work of the physician. *To view Bulletin 2-2003, visit* ***www.mdinsurance.state.md.us.***

CLARIFICATION: The January 2003 edition of "Regulatory Roundup" highlighted North Carolina Insurance Department Bulletin No. 02-B-9, which details electronic rate and form filing options available to life and health insurance companies. Please note that electronic rate and form filing options are also available to property/casualty insurers. *For more information, see Bulletin No. 02-B-8, available at* ***www.ncdoi.com****.*

BULLETIN BOARD

In the next REGULATOR:

✓A Look at State Regulation

✓Buffet on Financial Time Bombs

√ Best wishes to IRES Board Member John Reimer who retired in March from the Kansas Insurance Department. Mr. Reimer, who began work for the Kansas Department in 1984, also had been chair of the Society's Life-Health Section and planned many workshops for the Society's annual Career Development Seminar.

√ Stephen King, an independent examiner from Virginia and a longtime IRES Board member, has been elected to the IRES Executive Committee and named Education Chair. Mr. King replaces Ed Mailen, Kansas, who resigned from the Executive Committee due to a job change. Mr. King will serve until this summer's IRES annual meeting and Career Development Seminar, at which time new officers will be elected for the 2003-2004 operating year.

√ Huff, Thomas & Company, a regulatory consulting firm, is seeking experienced market conduct and financial examiners. Background should include a Bachelor's degree, an AIE, CIE, AFE or CFE, and 2-5 years experience participating in the examination of insurance companies. Contract and employee positions available.Travel is required. Relocation is not necessary. Please submit your resume with salary history and requirements to: HuffThomas, Attn: Human Resources Director, 4700 Belleview, Suite 208, Kansas City, MO 64112. Resumes may be faxed to 816-531-6613 or e-mailed to huffthomas@huffthomas.com.

√ Compliance Manager opening — Ensuring compliance with state insurance laws and regulations, as well as all federal and local laws. Coordinating NAIC, NAII and others regulatory compliance filings, circulars and notifications. Preparation and filing of licensing packages for appropriate states, responding to Department inquires and coordinating filing approvals. E-mail resume to mburns@inshse.com or fax to 770-858-0175.

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The juggling act: Tight budgets for state regulators. Story, p. 1

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