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State regulators searching for answers to lingering health insurance crisis

by Scott Hoober
Special to *The Regulator*

There's no question that the nation is facing a health care crisis — and along with it, a health insurance crisis. The cost of care keeps rising, and the cost of insurance jumps each year too, even as coverage is reduced and the employee's share goes up and up.

Average group premiums rose 14% this year nationwide and are expected to go up another 12% next year. Thanks to skyrocketing costs, plus a slow economy, fully 43.6 million Americans have no coverage at all, according to the latest Census Bureau data. That's 15.2% of the population, up from 14.6% in '01, though below the peak of 16.3% in '98.

Small businesses have been hit harder than most. One Kansas City printer is typical: He's already had to cut his staff from 13 to 9 as the economy contracted, and now is facing a 30% hike in health premiums for the coming year.

Don't just stand there

Sometimes, when the nation appears to be at a crossroads, Congress and state legislatures slide into gridlock and the status quo prevails (witness the 1993 health crisis). But by 2003, health care and health insurance had just become too visible, too much of a hot button issue, to be ignored.

After all, a recent Gallup poll found that among presidential candidates, voters ranked the importance of their position on health care just below terrorism or the economy, and significantly above the environment or taxes.

That's why H.R. 660, the Small Business Health Fairness Act, has a bipartisan roster of 130 sponsors in the House (not to mention support from just about every business-related lobbying group you can think of).

The bill would create association health plans (AHPs), allowing small businesses to join together, increasing their bargaining power with providers and lowering their overhead costs. **(Editor's Note:** See related story, p. 12.)

In addition, AHPs would be exempt from state mandates, further

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We haven't yet broken the mold dilemma

by Kirk Hansen

Undoubtedly, mankind has not always acted sensibly. In the Middle Ages, people were afraid to go outdoors when there was fog because they believed the mist was harmful. When tomatoes were originally imported into Europe, people preferred to starve rather than eat the tomatoes, which they believed to be poisonous.

Now that most people are better educated and have the benefits of technology, one would expect them to be better informed. Sometimes, however, it appears the opposite is true. There are occasions when the media reinforces a pack mentality and creates unnecessary alarm and even panic when health issues are inaccurately reported. Perhaps in an effort to spur ratings or circulation, or just to be the first on a breaking story, the media has exaggerated so-

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From the President

To make a long story short . . .

I would like to devote this month's President's column to professional development and how IRES can help you achieve it. No matter what else in your career and life might be demanding your attention, it's truly important to make room for expanding your professional knowledge. Continued learning is one of the most rewarding things you can do for yourself. Encouraging and supporting your staff and coworkers in such endeavors is also a great idea.

Meeting the challenges that regulators face on a daily basis is made easier by staying abreast of developments in our field and regularly interacting with our peers in other states as well as our own.

Some of those challenges have been around for a long time. Others are fairly new. Who knew 10 or 15 years ago that we would be dealing with such varied topics as viatical settlements, credit scoring (I'm still looking for a scoring model that gives bonus points for good intentions), PEOs, MEWAs, mold, terrorism, do-not-call lists, HIPAA, CLUE reports and privacy.

My advice is simple when it comes to professional designations, such as the CIE and AIE: "Go for it!" You'll be glad you did. The same holds true for taking that extra effort to attend the annual IRES Career Development Seminar. The CDS enables you to enhance your professional credentials, interact with knowledgeable people, and return home chock full of new ideas. What's more, you'll have a great time.

Recently, Jann Goodpaster, Kirk Yeager and I were fortunate enough to sit down with several

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President's Column ...

insurance commissioners and NAIC officers to exchange ideas about how IRES can assist with the overall continuing education and communication process. I left that meeting firmly convinced that our commissioners recognize the importance of continuing education and are committed to achieving it within their departments.

Much of what you have learned in your career can also be put to good use by sharing it with your fellow IRES members. Don't be shy about contacting your state chair or section chair if you have a special area of expertise.

An old saying goes something like this; "When a friend says, 'I'll make a long story short,' it's too late."

By the way, the same person who philosophized about the long story also said, "The brighter you are, the more you have to learn."

Bruce Ramge, CIE
IRES President

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And remember: The Regulator newsletter is free to all IRES members.

C.E. News

Did you miss the Continuing Ed Compliance Deadline?

AIE and CIE holders who missed the October 1 deadline (for reporting continuing education credits for the period Sept.1, 2002 to Sept. 1, 2003) will soon be receiving notices from the IRES CE Office that IRES will no longer recognize their designation.

To be automatically reinstated, designee holders must certify all past CE hours and pay a $60.00 reinstatement fee. Those who filed extensions prior to the deadline have one year to complete the required CE hours.

If insufficient CE hours were earned during the compliance period, a written appeal for reinstatement must be made in writing to the IRES Accreditation & Ethics Committee in care of the IRES CE Office, 12730 S. Pflumm Rd., Suite 102, Olathe, KS, 66062.

NEXT REPORTING DEADLINE IS OCTOBER 1, 2004

N · I · C · E

Regulators still groping for answers on health issues

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reducing premiums (though they would have to comply with any state or federal law requiring coverage of a specific disease or condition, such as maternity or mental illness).

Some people might think this sounds great. Until they're reminded that association health plans already exist. The last time they were authorized by federal law they were known as MEWAs — multiple employer welfare arrangements.

The new AHPs would have a few restrictions. For instance, an association that sponsors one must have been in existence for three years, self-insured AHPs must have at least 1,000 subscribers and dependents, they would have to have stop-loss and indemnification insurance to protect enrollees should the plan terminate, and the U.S. Secretary of Labor would act as trustee for any plans that do go belly-up. Under the proposed legislation, states will still regulate self-insured MEWAs that do not elect to become AHPs.

Yet the memories of MEWAs die hard. Many insureds, and many regulators, well remember the fraudulent plan administrators who pocketed premiums, then disappeared when the claims started to mount up. Even more important, though, they remember that despite all the fanfare, MEWAs didn't reduce the cost of health care nearly as much as promised.

Availability vs. affordability

"I think legislators confuse availability with affordability," said Mike Honeck, chief of Wisconsin's Life & Health Section.

"We've got guaranteed issue for small employers here in Wisconsin, and we still have small employers without insurance. Everybody goes: 'Why? You've got guaranteed issue.' But the issue isn't availability. It's affordability. And even with guaranteed issue there comes a point when premiums increase and the small players say 'I just can't afford it any more.'"

Indeed, a goodly percentage of those the Census Bureau found were uninsured probably had access to health insurance. They'd just rolled the dice and placed their bet, hoping against hope that they'd stay healthy.

Maybe we've learned our lesson and AHPs will be everything that MEWAs promised but didn't deliver. Maybe.

"Personally I don't think they will be any better," Honeck said.

"[AHPs] aren't going to help if you don't get a real broad spectrum of groups joining," he added. "What usually happens is that the good groups, the healthy groups, are going to continue to look for the best deal. And you'll end up with the groups that have poor experience, and no matter what the best intentions any of these plans have, the premiums will go up.

"Nothing's going to solve the problem unless somebody finds a way to put some containment on health care costs," said Honeck. "That will trickle down.

"They're trying to fix the problem from the bottom up, rather than from the top down."

If California is any indication, wishful thinking still dominates the debate.

The controversial bill that Gov. Gray Davis signed just before the recall election mandated increased availability of coverage for small businesses in the state. Will it work? According to one of the bill's cosponsors in the Senate, yes — if you believe in it strongly enough.

"This bill is not the total answer, but it's a start," said state Sen. Jackie Speier. "We can't just do nothing."

Sometimes you can do nothing. Sometimes the answer, as one of the characters in Alice in Wonderland put it, "Don't just do something, stand there."

Or better yet, do something constructive.

Supply vs. demand

By and large, insurance companies live in the real world, in an environment of supply vs. demand, of cost vs. benefit. If a department or a legislature mandates 1% annual hikes in, say, auto insurance premiums, the escalation of premiums will indeed slow. But if at the same time you don't attack underlying costs, insurers will start to lose money, and sooner or later they'll move out of that state and coverage will become less available.

That kind of rate regulation doesn't work in auto or homeowners, and its equivalent — mandated availability, questionable moves such as exemption from state mandates — won't work in health. In both cases, the reality of the cost structure will win out. In

auto and homeowners, insurers will begin dropping that line or that state. The same will be true of health carriers, and on top of that, hard-pressed AHPs will start to fold.

In the short term, though, the process creates sound bites that sound impressive on the evening news. It may help legislators and governors (and yes, commissioners) keep their jobs. But in all likelihood, that's all it will do.

"I think politically that legislators feel that they've got to do something," Honeck said. "If they can show people they're doing something — whether it works or not, that's another matter — but at least they can say, 'Yes, I authorized this or I voted for this.'

"You feel better that you're doing *something."*

Yet health insurance costs can be cut.

Take Wal-Mart. It's slashed its costs so much — 40% below what it costs the rest of American industry to insure its workers, and 30% below what its peers in the wholesale/retail industry are paying — that it's forcing other retailers, in particular, to rethink their own benefit packages.

> *"I think legislators confuse availability with affordability."*
>
> — Mike Honeck, Chief, Wisconsin Life & Health Section

Wal-Mart, with a U.S. payroll of 1.16 million workers, offers benefits to part-time workers, but it makes them wait six months. It doesn't cover retirees at all. And the retailer doesn't pay for preventive care — child vaccinations, eye exams, flu shots and the like — and won't pay for pre-existing conditions (though such provisions are getting rarer elsewhere) or contraceptives (though 80% of American workers are in plans that pay for them).

The United Food and Commercial Workers Union, which is trying to unionize Wal-Mart workers, says the retailer discourages workers from signing up for coverage in the first place. There may be some truth to the charge — 60% of eligible Wal-Mart employees sign up for benefits, compared to 72% for other retailers.

Yet Wal-Mart has succeeded in reducing its costs sharply, emboldening Target and other competitors to reduce their own employee benefits.

Another trend among corporate benefit managers is to seek to drop employees' spouses, either refusing to cover them or using surcharges to discourage signups. The Kaiser Family Foundation has found that family health coverage has dropped from 39% to 33% in just two years.

Refusing to pay for pre-existing conditions, discouraging spouses, even raising deductibles and copays may improve corporate bottom lines. But needless to say, they do nothing to reduce the overall cost of health care or health insurance.

Ted Hamby, supervising analyst in the managed care division of the North Carolina Department of Insurance, points out that many of the dollars-and-cents savings touted in the press are shifting costs, not saving costs.

"The cost of care isn't impacted at all" by moves of the sort that Wal-Mart has made, Hamby said. (At least not in the long run, when the effects of deferred care begin to be left among patients who haven't received preventive care.)

What works

In many states, another approach to reducing the cost of health care, and hence of insurance, has been to attack fraud by going after unlicensed, fly-by-night insurers.

New York's attorney general, in cooperation with the insurance commissioner and health commissioner, filed suit against a large family of unlicensed insurers masquerading as nonprofits and touting a roster of fictitious network of providers.

The Texas Department of Insurance has shut down 129 unauthorized plans during the past two years alone. The U.S. Department of Labor at last report had 107 civil and 19 criminal investigations under way in this area. And in Florida, legislators have enacted a law allowing operators of unlicensed plans to be charged with a felony.

"This is an extremely serious national epidemic," said Mila Kofman of Georgetown University's Health

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Regulators, insurers trying to break the mold problem

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called "bad science" stories, like the threat of radon seeping into our basements and electro-magnetic fields surrounding power lines. In time, many issues disappear and give way to newer, more sensational stories, much as the flavor of the day is replaced at the local ice cream shop.

Mold is the most recent example of media-generated hysteria. There are more than 100,000 species of mold and at least 1,000 different strains common to the United States. According to the Centers for Disease Control, there is always a little mold everywhere, including in fresh air. It has been around longer than mankind, and it is a fair bet that it will also outlast us. Over the years, we have all had mold in our homes. When we saw it, we would get out the bleach and clean up the problem.

Then suddenly, the media discovered the *Ballard* case. Melinda Ballard's initial $32 million dollar award was linked to the mold problem, though at its heart it was a bad faith claim. The award, since reduced to $4 million, made headlines throughout the country, and led to a media feeding frenzy.

We were suddenly subjected to a steady stream of television and print articles referring to "toxic" mold and questions of whether mold was "the new asbestos." Though there is no doubt that mold can aggravate conditions of people with pre-existing respiratory problems and heightened mold sensitivity, it is unfair and inaccurate to refer to mold as being "toxic." The truth is there is no evidence that anyone has ever died from exposure to mold in any household.

Not only did the *Ballard* case inspire a flood of media reports, it also encouraged a torrent of lawsuits, filed for the most part by opportunistic lawyers. There are now about 10,000 lawsuits, dealing with mold, pending in the United States. One prominent plaintiff's attorney recently estimated that over the next five to ten years, hundreds of thousands of cases alleging mold-related injury and property damage will be filed throughout the country. Texas and California have the dubious distinction of having more of these suits than any other states.

The Tide is Receding

Mold continues to be a significant public policy issue for both insurers and regulators as a result of large losses and media reports. Nonetheless, there are indications that we may have seen the worst of the problem.

In September 2002, the Texas Medical Association's Council on Scientific Affairs issued a report stating that adverse health effects from inhalation of mold spores in water-damaged buildings are not supported by medical literature. The possibility of causation or exacerbation of a medical condition due to exposure to mold in indoor environments exists only in rare cases. The report states that remediation of water damage in homes and other buildings should be based on non-clinical factors, unless clear medical evidence exists to demonstrate the role of mold in a particular case of illness.

The January 2003 issue of *Clinical Microbiology Reviews* includes a literature review of studies on the relationship between mold exposure and human disease. The article concludes that past studies suggesting a relationship between Stachybotrys and human disease uniformly suffer from significant methodological flaws, making their findings inconclusive. As a result, the authors could not find supportive evidence for serious illness due to Stachybotrys.

Furthermore, the May 2003 issue of *Journal of Occupational and Environmental Medicine* stated, "Current scientific evidence does not support the proposition that human health has been adversely affected by inhaled mycotoxins in home, school, or office environments."

Though two years ago the media was full of alarming articles about "toxic mold," as the issue has matured, cooler heads are starting to prevail. Television seems to have gone onto the next issue *du jour* and the print media now typically drops the adjective "toxic" from its articles.

Kirk Hansen is Director of Claims for the Alliance of American Insurers in Downers Grove, Ill. The Alliance is a national trade organization representing 340 property-casualty insurance companies. He can be reached via e-mail at khansen@allianceai.org.

The Mold Problem

There is no doubt that mold adversely affects individuals with heightened mold sensitivity, but the biggest danger mold poses is probably not to health, but to buildings. Serious problems can occur when molds are allowed to grow unchecked. Mold growth can damage carpets, sofas, and cabinets. In time, unchecked mold growth can even damage a building's structural elements.

In both homes and commercial buildings potential mold problems can begin under sinks, behind wallpaper, under floorboards, between walls, … anywhere water can collect. It can grow from a sudden and accidental release of water, or it may result from a slow and steady leakage lasting days, months or even years.

Buildings are particularly susceptible to mold in the aftermath of floods. In houses, mold grows best on wood and drywall surfaces, which can soak up and retain water like a sponge.

Insurance Forms

In the face of mounting mold claims, insurers have sought to address the problem in their policy forms. The Insurance Services Office, Inc. (ISO) mold exclusion has been widely adopted, although with modifications in some states. The acceptance of the ISO forms, as well as other filings, lessens the threat of legislators initiating new proposals interfering with the freedom of insurers to underwrite and perhaps compounding the problem.

According to the ISO, the Departments of Insurance in 41 states and territories have approved ISO Homeowners mold exclusions. Departments of Insurance in 47 states and territories have approved ISO General Liability mold exclusions. Departments of Insurance in 41 states and territories have approved ISO Property mold exclusions. ISO forms allow limited coverage for mold, including testing, for losses resulting from covered perils.

The mold issue impacts consumers, regulators, legislators, insurers, real estate agents, builders, and others. It is a complicated issue. So much so that we will explore it in a detailed question-and-answer format in the next issue of *The Regulator*.■

Editor's Note: *IRES members with specific questions on mold are encouraged to e-mail Kirk Hansen at* khansen@allianceai.org. *Answers will appear in the January issue of The Regulator.*

During 2003, 57 mold-related bills were introduced in 21 states. Though most were not enacted, the following summarizes those that were:

California Gov. Davis has signed into law **SB 331**, which establishes a separate trigger for the two-year statute of limitations for a civil action for injury or illness based upon exposure to a hazardous material or toxic substance other than asbestos.

Indiana enacted **HB 1515**, creating the Home Inspectors Licensing Board to regulate home inspectors and associate inspectors.

Louisiana HB 1328 requires the licensing of individuals engaged in the practice of mold assessment and mold remediation. **HB 1681** requires the Louisiana Real Estate Commission to issue a mold informational pamphlet.

Montana HB 536 involves mold disclosure statements in real estate transactions.

The legislatures in **Illinois**, **Oklahoma**, and **Rhode Island** passed resolutions to create task forces/commissions to investigate the mold issue and make recommendations.

Texas, never taking a back seat to anybody, considered no fewer than 15 mold-related bills during 2003. Three bills were passed:

- **HB 329** requires the regulation of mold assessors and remediators, and prohibits an insurer from making an underwriting decision regarding a residential property based on previous mold damage if the mold had been remediated and the property does not contain evidence of mold damage.
- **SB 127** mandates that insurers file underwriting guidelines for water claims with the Department of Insurance and prohibits for rating or underwriting purposes the use of "appliance-related" claims that were properly remediated by the policyholder.
- **SB 599** establishes extensive procedures for the licensing of public adjustors and requires the Texas Department of Health to test the indoor air quality of state buildings.

U.S. Supreme Court Round-Up, 2002 – 2003 Term

by Mark Gardner

The U.S. Supreme Court confronted a number of insurance-related issues in its 2002-2003 term, a few of which are likely to have implications for insurers in all 50 states. Specifically, the Court confronted the always-explosive punitive damages issue, but again failed to develop some definitive rule-of-thumb guidelines for lower courts to follow. In addition, the Court opined that just the *fear* of a serious disease might, under certain circumstances, warrant the payment of damages by property/casualty insurers.

The Court also established that even a body as powerful as the California Legislature cannot dictate this country's foreign policy, and it further delivered a blow to Kentucky health insurers by affirming a state's right to enact *Any Willing Provider* laws. All in all, it was an active and productive year, insurance-wise, for the Court.

The following are the most important insurance-related cases of the 2002-2003 Supreme Court session. IRES members are reminded that this article reflects my thoughts and opinions regarding these cases, and should not, under any circumstances, be used to substitute for the full text of the decisions.

Excessive Punitive Damages Awards

The most important case that affected the insurance industry — *State Farm v. Campbell* — was indeed a bombshell. Many remember the case of *BMW of North America, Inc. v. Gore*, in which the Supreme Court found unconstitutional a $2 million punitive damages award that corresponded to a $4,000 compensatory damages award. In that case, BMW was punished for concealing the repainting of the plaintiff's car to correct damages to the car from acid rain.

In the most recent *State Farm* case, the Court buttressed its *BMW* decision by, in effect, asserting that a compensatory damages award of $1 million was insufficient to support a $145 million punitive damages award.

In *State Farm*, the plaintiff, Curtis Campbell, was ultimately found to be at fault in a 1981 auto accident that resulted in the death of one person and the permanent disability of another (the two injured drivers were in separate vehicles). However, State Farm refused to settle the claim for the $50,000 policy limit, instead taking the case to trial in Utah. The Utah jury subsequently returned a judgment for over three times the $50,000 policy limit. State Farm declined to appeal, deciding instead to simply pay the $50,000 policy limit to the plaintiffs. Campbell then sued State Farm, for bad faith, fraud and the intentional infliction of emotional distress.

A jury awarded Campbell $2.6 million in compensatory damages, and $145 million in punitive damages. The judge reduced those awards to $1 million and $25 million, respectively. However, the Utah Supreme Court ultimately reinstated the $145 million punitive damages award, establishing a whopping 145-to-1 punitive-to-compensatory damages ratio. State Farm appealed that decision to the U.S. Supreme Court.

In reviewing the decision, the U. S. Supreme Court applied the test that it developed in *BMW*. In applying this standard, the Court found that, "this case is neither close nor difficult." The Court held that the award of punitive damages was excessive and unconstitutional under the Due Process Clause of the 14th Amendment. Interestingly, the Court observed that the Utah Supreme Court attempted to use the decision, "as a platform to expose and punish the perceived deficiencies of State Farm's operations throughout the country."

For property/casualty insurers, this case is encouraging because it reinforces the decision in the earlier *BMW* case, and should send a signal to both judges and juries that stratospheric awards for punitive damages will be reduced upon appeal. However, the discouraging aspect of this decision is that there is (again) no simple litmus test that can be used to calculate reasonable punitive damages awards. However, it does appear clear that neither the conduct of a defendant outside the state's borders nor the relative wealth of such defendant should be considered when calculating punitive damages awards.

Damages for *Fear* of Cancer?

The Supreme Court did devise a clear litmus test for awarding certain damages in *Norfolk & Western Railway Co. v. Ayers*. In that case, the Court held that a worker who has been diagnosed with asbestosis could be entitled to additional mental anguish damages as a result of a *fear* of developing cancer in the future. Such damages, the Court reasoned, could legitimately comprise a component of a noneconomic, *i.e.*, pain and suffering, award.

In this case, six railroad workers sued their former employer (a railroad) in West Virginia because they

had been negligently exposed to asbestos and subsequently developed asbestosis. Specifically, the workers sought to be compensated for their fear of developing mesothelioma — a fatal cancer of the lining of the lung or abdominal cavity. The railroad objected to this demand, and moved to exclude all cancer-related evidence.

When the railroad lost its motion to exclude any reference to cancer, the plaintiffs/workers then introduced evidence that asbestosis sufferers with smoking histories have a significantly increased risk of developing lung cancer. Of the six workers, five were smokers, and two had continued smoking after their asbestosis diagnosis. A jury ultimately awarded the workers approximately $4.9 million, an amount that was reduced due, in part, to the comparative negligence of the smokers.

Upon appeal by the railroad, the U.S. Supreme Court reiterated a previous finding that a claim for mental anguish damages as a result of mere exposure to a carcinogenic substance, *without subsequent disease or injury*, would not be permissible. (*See Metro-North Commuter RailRoad Co. v. Buckley, 521 U.S. 424 (1997)*). However, the Court said that ruling did not apply to the railroad workers' claims for damages from emotional suffering that are *tied to a physical injury*.

> ***"It was an active and productive year, insurance-wise, for the Court."***

This case is likely to further exacerbate the asbestosis-related woes of property/casualty insurers. If the Court had rejected the workers' claims, it may have helped, in some small measure, to stabilize the total asbestosis claims exposure of the P&C industry. Instead, the Court has clearly acknowledged a fear of illness, in certain circumstances, as a legitimate source of damages awards. The decision could create an entirely new area of exposure for the property/casualty industry.

Holocaust Survivors

California Holocaust survivors and their heirs who were hoping to gain easier access to the identities of their insurers were disappointed by the Supreme Court's decision in *American Insurance Association v. Garamendi*. In this case, the Court rejected a California law intended to compel insurers doing business in California to produce information about insurance policies they sold in Europe between 1920 and 1945.

The Court held that California's law essentially interfered with the President's ability to conduct United States' foreign policy, and thus was pre-empted by federal law. This decision will benefit both European insurers and life insurers. Since the California law was intended to obtain information about policies issued to European residents, European insurers would have felt the greatest impact had the Court ruled otherwise. Life insurers will benefit because the California law, although broad in scope, was designed to target life insurers that had paid the proceeds of life insurance policies to the Nazi government.

The Nazi government, incidentally, did not just seize the benefits payable *under life insurance policies.* The 11th and 12th Decrees of the "Reich Citizenship Law," established during Hitler's reign, basically enabled the German government to confiscate from banks and insurers the assets of Jews who had either died or been transported to concentration camps.

Another illustration of the seizure of insurance assets by the Third Reich was its confiscation of all claims payable to anyone for property damages caused during the infamous *Kristallnacht* of November 1938. A Reich decree issued immediately after that night of mayhem compelled property/casualty insurers to pay all insurance claims resulting from the damage caused that night directly to the Reich Treasury.

More recently, in 1999, the California Legislature passed a law that required insurers to produce information about insurance policies issued to "persons in Europe" during 1920 through 1945. This law stated that any insurer that refused to comply would have its license suspended. Despite the Deputy Secretary of the Treasury's writing to the California Insurance Commissioner shortly after the law was passed indicating the law was in conflict with federal initiatives intended to redress the Holocaust insurance proceeds issue, the law was implemented by the California Insurance Department.

A trade association of property/casualty insurers consequently sued the California Insurance Depart-

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U.S. Supreme Court Round-Up, 2002 – 2003 Term

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ment to block implementation of the law. The U.S. Supreme Court ultimately reversed the lower California court rulings upholding the statute. Since the law interfered with the foreign policy of the Executive Branch, and "undercut the President's diplomatic discretion," the California statute was found unconstitutional, pre-empted by federal law.

Any Willing Provider

The Kentucky Legislature fared better with the Supreme Court than California's Legislature. The case of *Kentucky Association of Health Plans v. Miller*, stemmed from a Kentucky law that compelled health insurers to accept any physician who sought to become a "participating provider" and join a managed care plan. Unlike the result in the *American Insurance Association* case above, the Supreme Court upheld the state law, finding that the state law did not pre-empt federal law.

In 1996, the Kentucky Legislature passed an *Any Willing Provider* law. *Any Willing Provider* laws generally require a health insurer to accept into its provider network any participating provider (*e.g.*, a doctor, hospital) that seeks to join. The underlying principle is that as long as the provider agrees to the terms and conditions for participation established by the health insurer/HMO, the provider should be able to participate in and receive payment from the insurer.

The plaintiff in the action, the Kentucky Association of Health Plans, is a Kentucky–based group of health maintenance organizations. It objected to the *Any Willing Provide*r concept and sued the Commissioner of Insurance in 1997. It argued that *Any Willing Provider* laws are pre-empted by ERISA because ERISA, as a federal law, pre-empts all state laws that affect employee benefit plans. The Insurance Department countered with the argument that ERISA does not pre-empt state laws that regulate insurance. The Association then countered by arguing that even if the latter is true, the statute did not regulate insurance.

Mark Gardner, a frequent contributor to *The Regulator*, is a former Deputy Superintendent of the New York State Insurance Department and currently works in the insurance industry.

The Court held that the *Any Willing Provider* law did regulate the business of insurance and hence was not pre-empted by ERISA. Although this was a "win" for the Kentucky Legislature, it was a "loss" for Kentucky health insurers. They had argued that the law adversely affected their ability to limit the number of doctors and other providers that could join the "provider networks" and will raise costs for enrollees.

Without the authority to limit providers, health insurers argued that they would be unable to promise doctors already in the network a sufficiently high volume of business to offset their reduced managed care fees.

This case is especially important in that roughly half the states have enacted *Any Willing Provider* laws.

For the Future

In sum, while all three branches of the insurance industry (life, health and property/casualty) escaped largely unscathed during the 2002-2003 term of the Supreme Court, the four decisions summarized above clearly had an impact on the insurance industry and state regulators. These important cases may not have had the impact of the 2002-2003 Court's affirmation of a college's right to employ affirmative action initiatives in their admissions process or its decision to recognize a "right of privacy" of sorts for gays. However, the Court's insurance-related decisions, particularly *State Farm v. Campbell*, should have a pronounced impact on insurers for years to come.

Postscript

The decision on *Kentucky Association of Health Plans v. Miller* apparently prompted the Arkansas Attorney General's Office to seek reinstatement of Arkansas' 1995 *Any Willing Provider* law which was struck down by federal courts in the late 1990s. Health insurers, which had successfully challenged the original law, are expected to fight the Attorney General's move.

Attorneys representing State Farm are arguing in a Utah court that punitive damages in *State Farm v. Campbell* should be reduced to $1 million in keeping with the U.S. Supreme Court decision. Lawyers for Campbell's widow, Inez, (Curtis Campbell died from causes unrelated to his 1981 accident) are seeking $17 million. ■

Casual Observations

Teens & Insurance

Teenagers are constantly thinking about cars, but if you ask them about auto insurance: *fuggedaboutit.* Even students with a working knowledge of calculus don't know squat about insurance. That's why Missouri has introduced a new Web page devoted exclusively to teenagers (**www.insurance.state.mo.us/consumer/teens**). At Missouri's site, young drivers learn that top students can save serious coin, that loaning your car to your best bud may cost you, and that most Missouri auto insurers aren't into granting grace periods. The Web site — written in an informal, youth-oriented style — not only covers auto insurance, but health and homeowners/rental coverage as well. Kudos to Missouri for paying attention to this frequently neglected market segment.

D.C.'s Grand Experiment

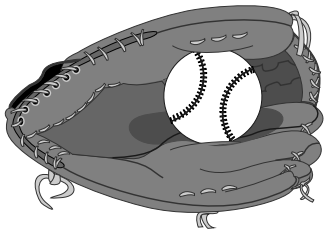
Could it really be so easy? Washington D.C. is now licensing non-domestic insurers that are licensed in another state and present proof of good standing from their domestic state. In August, Fidelity Insurance Company, a Maryland health insurer, became the first company licensed under these new Washington, D.C. Due Deference Initiative (DCDD) guidelines. The effort is intended to address federal concerns about the current multi-state licensing system. D.C. Commissioner Lawrence Mirel called DCDD a "pioneering effort" that will "demonstrate that states can work together to improve licensing efficiency without federal intervention." Certainly, the eyes of insurers, the federal government and all 50 states will be fixed on this D.C. experiment during the upcoming year.

Check Your Pension

If you're looking forward to a comfortable pension when your regulator days are over, we'd suggest keeping a close look on how your pension is being funded. Thanks to years of underfunding and a declining stock market, lots of states are considering entering the bond market to finance their current and future pension obligations. Wall Street loves the idea, but states like New Jersey that tried it in the mid-'90s got burned badly. With current taxable 30-year bond offerings yielding about 6% (such offerings must be taxable because their proceeds are invested), pension funds must earn about 8-9% over the three-decade period for the gambit to work. Of course, if states and municipalities had contributed more during those flush years in the 1990s, none of these risky offerings would be necessary.

Insurance Runs

Both the Chicago Cubs and Boston Red Sox failed to adequately protect themselves in their quest for a pennant this year. Boston's last World Series appearance was in 1986; while the Cubs haven't participated in a Fall Classic since 1945. This year, each team was three runs ahead and each had only five outs to go to secure a World Series berth. Neither of them made it, of course, having failed to score enough insurance runs. The Cubs didn't count on an overzealous fan snatching the ball from their left fielder, while in the Bronx an overtired Boston pitcher once again succumbed to Yankee magic. It just goes to show, there's no such thing as too much insurance, particularly if you're cursed. ■



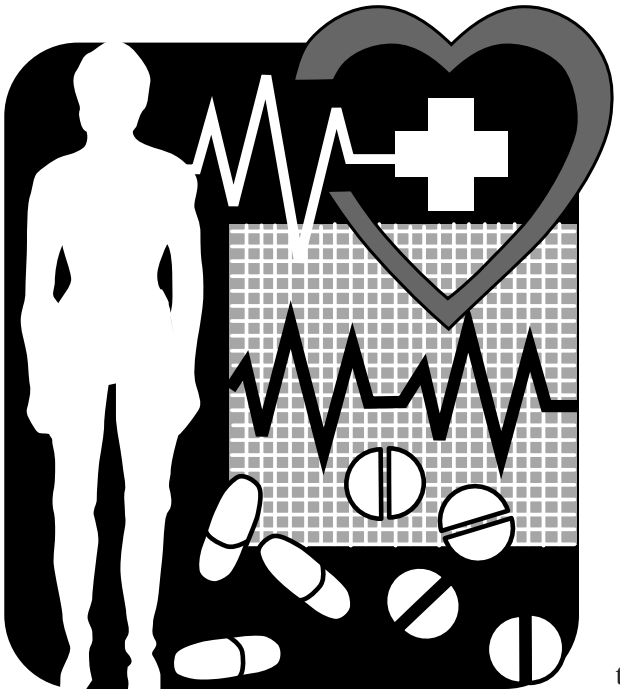
Five concerns about Association Health Plan legislation

by Sandy Praeger
Kansas Commissioner of Insurance
(on behalf of the NAIC)

Editor's Note: *The following article was drawn from testimony delivered by Commissioner Praeger earlier this year before the U.S. Senate's Small Business and Entrepreneurship Committee. Speaking on behalf of the NAIC, Commissioner Praeger voiced opposition to legislation before Congress that would authorize Association Health Plans (AHPs). For more information on AHPs, see Scott Hoober's p. 1 article.*

1. Undermining State Reforms

Before state small group market reforms were implemented, the small group market was fragmented into various pools based on risk. If a small employer had healthy employees in a relatively safe working environment the employer could easily find coverage at a good rate.



However, if one of the employees became sick, the employer would be shifted to a higher risk pool and often priced out of coverage. Those who started with sicker or higher risk employees were often priced out of the market from the beginning.

State small group market reforms forced insurers to treat all small employers as part of a single pool and allow only modest, and in some states no, variations in premiums based on risk. This spreading of risk has brought some fairness to the market. The AHP legislation in Congress would undermine state reforms and once again fragment the market.

Each association would create its own risk pool that, due to the benefits provided, types of businesses in the association, or area serviced, could have significantly lower risk than the general market. While the bill does make some effort to reduce "cherry picking" the NAIC believes the provisions would be inadequate.

In Kansas, we have association health plan legislation introduced this session that, without the proper safeguards in place, could disrupt the market. In fact some in the industry have proposed abolishing the small group reform in Kansas if we allow this kind of erosion into that market.

2. Undermining HIPAA Reforms

The guaranteed issue requirements of the Health Insurance Portability and Accountability Act of 1996 allows small employers to switch from one plan to another without denial. If the AHP legislation were to pass, small employers would be able to purchase less expensive association health plan coverage that does not contain mandated benefits or comply with any other state requirements.

When an employee needs better coverage, the employer would be free to enter the regulated small group market and be guaranteed the coverage under HIPAA.

This self-selection is extremely disruptive to the marketplace and will create a very unstable situation in an already fragile small group market, likely reducing the number of insurers willing to offer coverage in the general market. Insurance is of little use unless the costs of caring for the relatively few can be distributed among the many who are healthy. This is one of the key tenets behind HIPAA.

3. Increased Plan Failures and Fraud

Proponents of the AHP legislation claim that the Department of Labor already has sufficient resources to oversee the new plans and will be able to prevent any

insolvencies or instances of fraud. This simply is not the case. The Department of Labor has neither the resources nor the expertise to regulate insurance products.

The states have invested more than 125 years in regulating the insurance industry. State insurance departments nationwide employ over 10,000 highly skilled people, and the combined budgets of state insurance departments total more than $700 million. The AHP bill provides no new resources for regulating these plans.

While we acknowledge State regulation does increase costs, it exists to protect consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed.

This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-state association plans, out-of-state trusts, and other schemes to avoid or limit state regulation.

Within the last year, 16 states have shut down 48 AHP-like plans that had been operating illegally in the state, many through *bona fide* associations. Association plans in several states have gone bankrupt because they did not have the same regulatory oversight as state-regulated plans, leaving millions of dollars in provider bills unpaid.

Each time oversight has been limited the result has been the same – increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims.

4. Important Patient Protections Eliminated

Included in the current AHP legislative proposals is the broad preemption of consumer protection laws. Proponents of AHPs will argue that state mandated benefit laws must be preempted so that AHPs do not have to provide coverage for expensive benefits. However, states have a complex regulatory structure in place for insurers.

Not only will mandated benefit laws be preempted, but other laws protecting patient rights and ensuring the integrity of the insurers would be preempted as well.

A small sample of these laws and actions follows:

- Internal and external appeals processes.
- Investment regulations to ensure that carriers only make solid investments.
- Unfair claims settlement practices laws.
- Advertising regulation to prevent misleading or fraudulent claims.
- Policy form reviews to prevent unfair or misleading language.
- Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.
- Rate reviews.
- Background review of officers.
- Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a patients' rights are violated by the plan. State insurance regulators act on millions of consumer complaints every year and work hard to protect the rights of patients. AHP participants should have access to the same protections and complaint process.

5. Impact on High Risk Pools and Guaranty Funds

While the latest version of the AHP legislation would allow states to impose premium taxes on AHP plans – to the extent they are imposed on other insurance plans – it preempts other state assessments. States often use health insurance assessments to fund such important entities as high-risk pools (which provide coverage to the uninsurable) and guaranty funds (which help cover claims if a plan is insolvent.) Such programs are vital to the stability of the small group and individual markets and to the protection of consumers – they must not be undercut by federal preemption. ■

Sandy Praeger is the Kansas Commissioner of Insurance and serves as Chair of the NAIC's Health Insurance Task Force. She previously served in both the Kansas Senate and Kansas House. Her full testimony can be found at www.naic.org.

Regulators still groping for answers on health issues

continued from page 5

Policy Institute. "No state has been immune."

Unfortunately, under the law of unintended consequences, passage of the federal legislation that permits AHPs is expected to increase the number of fraudulent entities.

Demographics aren't looking up either.

As the baby boom generation retires, Medicare becomes a more and more critical piece of the health insurance puzzle. And Congress is having a hard time coming up with a workable solution.

In the meantime, the number of old, old Americans — not just elderly, but those above 85 — has been growing sharply, increasing dependence on costly but life-extending therapies. The number of people with Alzheimer's is expected to rise sharply, for instance, doubling by 2004. Currently, of course, that means extra burdens for families and increased costs for custodial care unless researchers come up with a treatment for the condition (and if they do, you can pretty much count on it being expensive).

So what do we do about this growing crisis?

"You're asking questions that a lot of people in the health industry are scratching their heads about," said Hamby in North Carolina. "I'm not sure what the answer is. If I knew the answer, I'd probably be a rich man."

Perhaps the answer lies not in insurance underwriting or insurance regulation, but in health care itself.

Years ago, with short hospital stays and other innovations, HMOs wrung out a lot of the excess cost in health care. Are there any other cost savings to be had?

One recent study found that preventable injuries to hospitalized patients result in 2.4 million extra days in the hospital and $9.3 billion in extra costs each year. Perhaps better management can recover some of those dollars (not to mention save some of the 32,000 Americans lives that are lost annually to such errors).

Of course, while we're seeking out savings like that, pharmaceutical companies and medical-device manufacturers are going to keep on churning out expensive therapies that patients and their families will surely want to make use of.

"We had a meeting here in the department just last week, and all these subjects were very much on the minds of a lot of people there," Hamby said.

"People are looking for solutions, but they're very difficult to find." ■

All Persons Without Health Insurance*
United States, 1993-2002
(numbers in thousands)

		Uninsured	
	U.S. Population	Number	Percent
2002	285,933	43,574	15.2
2001	282,082	41,207	14.6
2000[r]	279,517	39,804	14.2
1999[r]	276,804	40,228	14.5
1998	271,743	44,281	16.3
1997	269,094	43,448	16.1
1996	266,792	41,715	15.6
1995	264,314	40,581	15.4
1994	262,105	39,718	15.2
1993	259,753	39,713	15.3

Source: Estimates are from Current Population Survey (CPS), 1993-2002, U.S. Bureau of the Census.

*The CPS counts as insured those individuals with (1) employment-based health insurance coverage; (2) individual health insurance; (3) government health insurance such as Medicaid or Medicare; (4) military health coverage such as CHAMPUS; and (5) health insurance purchased through associations or organizations. An uninsured person would be one without any of these coverages.

[r] revised by Bureau of the Census

Name that Regulator

Our mystery regulator is a former Missouri examiner, a founding father of IRES and an IRES past president.

For answer, see bottom of p. 19

Does one of your co-workers deserve special recognition?

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

AL GREER ACHIEVEMENT AWARD

Insurance Regulatory Examiners Society

Quote of the Month

"The NAIC believes much progress can be made to achieve the goals of efficiency . . . . However, the NAIC does not overlook the fact that insurance must be regulated to protect local consumers. Regulatory efficiency for its own sake should not undermine the credibility and effectiveness of state regulators charged with enforcing consumer protection laws."

— From the NAIC's comments to *Common Standards and Improved Coordination Needed to Strengthen Market Regulation*. The Report, issued in September 2003 by the General Accounting Office (GAO), calls for more uniform standards and procedures for market conduct examinations conducted by state insurance departments. Full NAIC comments are included in the GAO Report (www.gao.gov).

The 2003 IRES application for AIE-CIE

The AIE designation will be automatically granted to regulators who have a minimum of 2 years full-time regulatory experience and who have obtained a CPCU, CLU, or FLMI designation. **You must send proof of your designation along with this application.**

Property and Casualty Educational Path These may be taken in any order. *Passage of **any eight** of the following ten courses is necessary to obtain your AIE.**

1) INS 22— Personal Insurance

2) INS 23 — Commercial Insurance

3) AIC 34, 35 or 36 — **Claims (may only count 1)** AIC 34 Workers Comp and Managing Bodily Injury Claims, AIC 35 Property Loss Adjusting, AIC 36 Liability Claim Practices

4) CPCU 510 — Foundations of Risk Management, Insurance and Professionalism

5) CPCU 520 — Insurance Operations & Regulation

6) CPCU 530 — The Legal Environment of Risk Management & Insurance

7) CPCU 552 — Commercial Liability Risk Management & Insurance

8) CPCU 560 — **F**inancial Services Institutions

9) IR 201 — Insurance Regulation

10) AIAF 111 — Statutory Accounting for Property & Liability Insurance

*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 Operations [HS 323,324,325]
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 [HS 323]
2) FLMI 290 — Life and Health Insurance Company Operations [HS 323, 324, 325]
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 [HS 324]
- FLMI 320 – Marketing Life and Health Insurance
- FLMI 330 – Management Principles and Practices
- 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
- NAIC Systems Proficiency Exam – Covers ACL and and NAIC's Information Systems Questionnaire (ISQ)

*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

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REGULATORY ROUNDUP

by
Stroock & Stroock
& Lavan LLP

CALIFORNIA— Legislation Enacted To Mandate Employer Health Insurance Coverage.
Senate Bill 2 was recently signed into law by the Governor and is now Chapter 673 of the Laws of 2003. Chapter 673 requires "medium employers" and "large employers" to provide health insurance to their employees either by directly purchasing a level of coverage specified by Chapter 673 or by paying an annual fee to the State Health Purchasing Program ("SHPP"), which would coordinate coverage for employees. "Medium employers" are defined as having between 20 to 199 employees and are required to provide coverage to their employees in accordance with Chapter 673 by January 1, 2007. "Large employers" are defined as having 200 or more employees and are required to provide coverage by January 1, 2006. Unlike medium employers, however, large employers are required to provide coverage to both employees and their dependents. Employers who provide health care coverage directly to their employees would receive a credit against the annual SHPP fee.

The SHPP would be managed by the Managed Risk Medical Insurance Board (the "Board"), who would administer a purchasing pool to provide coverage. Small employers (*i.e.*, employers with 2 to 19 employees) are exempted from the coverage mandate and from the SHPP fee. Chapter 673 requires the Board to determine the SHPP fee to be paid by employers, and provides that employee contributions, which employers would be required to collect from employees, may not exceed 20% of the employer's fee. The SHPP fees, including employee contributions, are to be deposited into the purchasing pool and are to be continuously appropriated to the Board to administer the SHPP. Chapter 673 also authorizes the Board to coordinate coverage under SHPP with coverage available under exisiting public health insurance programs, including the state's Medcaid and child health insurance programs. For more information on Chapter 673, please visit **www.leginfo.ca.gov**.

FLORIDA—Workers' Compensation Reforms Signed Into Law.
Legislation to reform Florida's workers' compensation system was recently signed into law by the Governor. Chapter 412 of 2003 contains the following key provisions: (i) eligibility requirements for permanent total disability benefits are revised by providing that to be considered eligible for permanent total disability benefits, an employee must have either a catastrophic injury or be unable to uninterruptedly engage in at least sedentary employment; (ii) permanent total disability benefits are payable until the employee reaches age 75. If an employee is injured on or after age 70, benefits are payable for a maximum of 5 years following the determination of permanent total disability; (iii) the amount of the annual permanent total disability supplemental benefit is reduced from 5% to 3% of the employee's compensation rate and the supplemental benefit ceases at age 62; (iv) permanent partial disability benefits increase from 50% to 75% of the employees' temporary total disability benefits; (v) the duration of permanent partial disability benefits for employees with an impairment rating between 1% and 10% is reduced, while the duration of such benefits for employees with an impairment rating of 11% or greater is increased; (vi) permanent partial supplemental disability benefits are eliminated; (vii) permanent partial disability benefits are reduced by 50% for each week where the employee has earned income equal to or greater than the employee's average weekly wages; (viii) permanent impairment benefits for permanent psychiatric impairment are limited to 1%; (ix) caps on chiropractic treatments are increased from 18 to 24 visits and the number of weeks of treatments are increased from 8 to 12 weeks; and (x) benefits for funeral expenses are increased from $5,000 to $7,500 and death benefits are increased for dependents from $100,000 to $150,000.

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

Chapter 412 also provides that benefits for training and education authorized by the Florida Department of Financial Services and funded by the Workers' Compensation Administration Trust Fund may include payment to attend a community college or vocational-technical school. To view Chapter 412, visit **www.flsenate.gov**.

MAINE – Universal Health Care Plan Enacted.
The Governor has recently signed legislation to create a universal health care plan for Maine residents within five years. Chapter 469 of the Laws of 2003 will create a state sponsored health plan to be called the Dirigo Health Plan (the "Plan") and will offer health insurance to uninsured residents and small businesses. The Plan will offer preventive and primary health coverage. Funding for the Plan will be provided by premiums collected from individuals and small businesses, federal Medicaid matching dollars and an assessment on private health insurance premiums.

Employers that elect to participate in this plan are subject to a minimum required contribution of 60% of the premium and must certify that at least 75% of their employees are enrolled in the Plan. Individuals who do not have health insurance through their employment are eligible for a subsidy on a sliding scale basis subject to certain criteria. A Board of Directors consisting of five persons will administer the Plan.

Chapter 469 also establishes the Dirigo Health Fund for the deposit of funds advanced for initial operating expenses, payments by employers and individuals, and payments and funds received from public and private sources. To view additional information about the Plan, visit **www.state.me.us**.

NEW HAMPSHIRE—Legislature Enacts Property/ Casualty Insurance Rates Modernization Bill.
The Governor recently signed into law House Bill 684, which repeals existing New Hampshire Insurance Code Chapter 412 and replaces it with brand new provisions governing property and casualty insurance forms and rates. The bill also adds a new Chapter 412-A governing the filing of aircraft insurance policies. Among other provisions, the bill generally extends the 30-day file-and-use system to personal lines rates. Rates information for personal risk policies generally must be filed with the New Hampshire Insurance Department at least 30 days before the effective date. Rates information for commercial risk policies, except those issued to a large commercial policyholder, generally must be filed within 30 days of the effective date. Rates applicable to large commercial policyholders remain exempt from prior filing requirements under the new legislation.

However, House Bill 684 significantly expands the definition of "large commercial policyholder." Under the new definition, the minimum net revenue or sales threshold has been reduced from $100 million (annually) to $5 million. Further, the minimum number of employees requirement has been reduced from 500 to 25 employees per individual insured and from 1,000 to 50 employees per holding company. The minimum aggregate insurance premiums threshold has also been reduced from $500,000 to $100,000. The disclaimer to be provided by insurers with respect to insurance policies issued to large commercial policyholders is also more extensive under House Bill 684 than under current law. For example, the disclaimer required under the new legislation requires a statement, in bold-faced type, that the policy applied for is not subject to rate and form requirements of the state and that the policy may contain differences relative to a policy that has been subject to all provisions of the New Hampshire Insurance Code. The disclaimer must set forth possible differences in policy conditions, forms and endorsements, and must be signed by the large commercial policyholder and kept on file by the insurer. House Bill 684 becomes effective on January 1, 2004. To view the legislation, visit: **www.gencourt.state.nh.us**.

NEW YORK—"Civil Authority" Insurance Legislation Introduced.
Senate Bill 5390 has been introduced to amend the New York Insurance Law. If enacted, the legislation would create a new line of insurance allowing insurers to provide coverage to New York businesses for loss of income after a disruptive event resulting from acts of civil authority. Civil authority insurance would differ from business interruption insurance coverage of standard property policies in that it provides coverage with or without the threat of loss of or damage to property or actual loss of or damage to property. The bill would also permit civil authority insurance to be offered by licensed excess line brokers. Generally, under the New York Insurance Law, property/casualty insurance which is offered in the admitted market also is available through duly licensed excess line brokers in the non-admitted market. Business interruption insurance is one such coverage offered by excess line brokers. S. 5390 was referred to the Senate Committee on Rules during the 2003 Legislative Session and remains eligible for consideration in 2004. To view S.5390, visit: **www.senate.state.ny.us**.■

Name that Regulator — ANSWER: Brad Connor

BULLETIN BOARD

√ IRES NEEDS YOU — The IRES Finance Committee has authorized the creation of a special task force to prepare an annual Financial Review of IRES income and expenses for 2003. Volunteers will be asked to donate a few hours of time reviewing and verifying documents and records, and assisting in the preparation of a report to be submitted to the Finance Committee of the Board of Directors. This review is expected to begin in February 2004. Interested members should contact either Doug Freeman at dfreeman@mail.state.mo.us or Nancy Thomas at nthomas@voicenet.com.

√ American Express Tax and Business Services Inc. seeks experienced insurance examiners to perform financial and market conduct examinations and other regulatory consulting services for state insurance departments. Requirements include a Bachelors degree and 2-6 years of financial or market conduct examination, public accounting or other insurance audit experience. AFE, CFE, AIE, CIE designation preferred. Position requires significant travel and no relocation. Visit our job website at www.americanexpress.com/jobs to submit an online application.

√ Globe-Pequot Press has published "A View from the Heartland," a new book authored by our very own **David Chartrand**. The book — a moving, humorous paean to the American family — is available at fine bookstores everywhere as well as, of course, Amazon.com. Nice going, Dave!

In the next REGULATOR:

✓ Arnold's governor, but what about California's workers' comp system?

✓ Kirk Hansen answers IRES member questions on mold

(For details, see bottom of p. 7)

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Health Insurance: the regulatory struggle goes on and on.
Story, p. 1

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