INSURANCE REGULATORY EXAMINERS SOCIETY

From turmoil and crisis comes reform for California's workers' comp system

by the Rate Regulation Staff
California Department of Insurance

One thing is abundantly clear in California — employer groups, chambers of commerce, rotary clubs, insurance professionals and other stakeholders are angry about the workers' compensation crisis, and they are mobilized.

Politicians are heeding this message. Reform of the broken workers' compensation system is one of the top four priorities of Insurance Commissioner John Garamendi, as well as an important plank in Governor Arnold Schwarzenegger's platform.

The Governor and the Commissioner

The urgency of this issue jolted the California Legislature into action, as they adopted significant medical cost containment proposals advocated by Commissioner Garamendi and contained in Assembly Bill 227 and Senate Bill 228.

These bills, which former Governor Gray Davis signed into law in September, were the centerpiece of the first phase of workers' compensation reform. Debate has ensued over the savings to be realized from this reform, and new questions have been raised.

What does the future hold now that the political playing field has been altered in Sacramento? Is the reform real? Should rates be more tightly regulated or perhaps lowered below market levels? But before getting to these questions, consider what led to the latest crisis.

Rate Deregulation and Predatory Pricing

The recent outcry over job losses and businesses leaving the state harkens back to the recession of the early 1990s and the heavy layoffs suffered in the aerospace industry and other types of manufacturing. Those job losses, coupled with double-digit minimum workers' compensation rate increases, led to the passage of open rating reforms.

Ironically, the switch to open rating left the state with virtually no

continued on page 10

I-FILE & SERFF:

Can competing e-filing systems really co-exist?

by Scott Hoober
Special to *The Regulator*

Much of insurance regulation has long been genuinely Kafkaesque, with mounds of paperwork and row after row of clerks adding to the pile. That's why the development of SERFF — NAIC's System for Electronic Rate and Form Filing — was such a welcome change.

The amount of paperwork would be reduced, materials would come in from companies in electronic form, the process would be speeded up, and all parties would be better served.

And sure enough, a decade after development of SERFF began, all 50 states, plus D.C. and Puerto Rico, are set up to use it, and nearly 1,000 insurers have committed to electronic filing.

The number of filings submitted via SERFF totaled 25,528 in 2002, a

continued on page 16

JANUARY 2004

President's Column 2
Continuing Ed News 3
IRES Needs You! 4
IRES Membership Application 5
Mold Q&A 6
Asbestos Reserves 8
Register for Denver CDS 19

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From the President

IRES Long-Range Goals

After last year's CDS, a committee of IRES members and officers gathered together to discuss strategic planning and establish long-range goals for IRES. The result was a commitment to establishing specified, measurable goals for IRES to use as a yardstick by which to assess the organization's future success. The three goals established by the committee, in order of importance, are:

1) Attain and maintain an IRES regulator membership of 925 and a sustaining membership (*i.e.*, corporate membership) of 200.

2) Develop, implement, and market an award-winning market conduct certification program that provides hands-on training, and begin developing similar certification programs for other regulatory disciplines.

3) Develop, implement, and maintain an IRES marketing strategy via a task force or committee that promotes IRES in various ways. The strategy should include a plan to organize regular liaison between IRES senior officers and the top leadership of the NAIC, particularly at quarterly NAIC meetings.

We hope that each member will assist us in achieving these goals. Encouraging co-workers and associates to become active in IRES is a great way to start. (An application form is included on page 5 of this issue of *The Regulator*.) I strongly believe that the value IRES offers to its members is now more relevant than ever.

In past years, one of the greatest challenges for insurance regulators was to keep abreast of new insurance products, methods and delivery systems. Right now, some of the immediate challenges to IRES members include keeping current on, and adapting to, regulatory reforms.

Through the NAIC, state commissioners recently

continued on next page

President's Column ...

developed *"A Reinforced Commitment: Insurance Regulatory Modernization Plan."* I encourage you to read the plan which appears as Appendix A in NAIC Commissioner Mike Pickens November 5, 2003 testimony before a U.S. House of Representatives Subcommittee. The testimony is available on www.naic.org/pressroom/testimonies/03/docs/11-5_pickens_testimony.doc.

The plan calls for some very specific changes in how we as regulators operate. It also calls for regulators to implement methods that are still in the development stage. IRES will serve an important role in assisting its members in understanding and meeting the challenges posed by this reinforced commitment. One only needs to look to the annual CDS to understand how IRES can enhance regulators' ability to meet the challenges posed by these reforms.

Keeping IRES strong through your support and involvement is crucial.

Bruce Ramge, CIE
IRES President

Welcome New Members

Larry L. Beadles, VA
Marilyn Duke, KY
Joseph D. Finnegan, FL
Lorette D. Gendron, NH
Geraldine Hato, Netherland Antilles
James L. Hattaway, III, AL
Allan J. Hayes, AIE, GA
Michael J. McNulty, CO
Neva A. Moydell, CIE, OK
Dora A. Sims, AIE, OK
Susana R. Stevens, DE
Connie Ward, NV

C.E. News

IRES soon will be conducting a brief survey through the Accreditation and Ethics Committee to ask members about the need, if any, to modify the way Continuing Education credits are tracked and accepted for those holding the AIE and CIE designations.

Currently, AIE and CIE members must acquire 15 credit hours per year (Sept. 1 through Sept. 1). Members who fall short can obtain an automatic extension of 12 months if they file a request by Sept. 1.

The survey will be sent soon via e-mail and will ask members whether this program should be changed or modified. We want those who receive it to take a few minutes to respond so we can report members' opinions.

The survey will ask whether IRES should amend the CE rules to permit AIE and CIE holders to "carry over" a limited number of surplus credit hours from one year to the next, whether we should keep the present system, or whether other alternative changes should be considered.

The survey will be sent electronically to those with current e-mail addresses on file with the IRES office. Watch for this survey sometime in the next month.

Susan Morrison, long-time IRES office manager, has assumed supervision of the continuing ed program. She takes over from Joy Moore, who did an incredible job managing the C.E. program since its inception. Joy remains on staff with Chartrand Communications, the IRES management firm. Assisting Susan on the C.E. program is Elaine Bickel. Call them at 913-768-NICE.

Susan Morrison

Next compliance period is 9/1/03 - 9/1/04.
Reporting deadline is Oct. 1, 2004

IRES needs your help!

by Stephen E. King CIE
Membership and Benefits Committee

Yes, you're right . . . that's an IRES membership application on the facing page. It's not a mistake; we intentionally inserted this form for your use.

Now I'll explain why you've found it in *The Regulator*.

During this past year, IRES has seen a rather significant decrease in membership.Our membership numbers (874 members) clearly show the impact the economy has had on state budgets and personal budgets. Yet IRES remains a strong organization.

However, if our membership continues to "slide," programs that are currently being funded will have to be downsized.

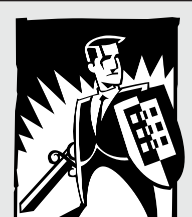
For instance, the 2004 Career Development Seminar (CDS) in Denver may well see a slight decrease in services, when compared to past seminars. And yet to keep dues and fees reasonable, the IRES Executive Committee has said "no" to an increase in upcoming membership dues and CDS registration fees.

So . . . what can you do about it? I'm glad you asked. We need to put this membership drive on a more personal basis and not solely on the shoulders of your IRES state chair.

We are asking each of you to talk to a potential IRES member in your department/division and encourage that person to join IRES. By doing this, we personalize the process of gaining members and also develop a new or renewed level of awareness in IRES. Always keep in mind, that IRES is an organization for all regulators, from Forms and Filing, to Producer Licensing, to Market Conduct.

Given our current base of members, I feel our goal of 925 members for 2004 is attainable. However, if we as members don't begin to take a more active role and show more ownership in IRES, membership will continue to erode.

IRES continues to be a strong and respected organization because of the regulators that represent it. Now is the time to step forward and help your organization. Get involved! Be an active part of IRES!



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

12730 S. Pflumm Rd., Suite 102, Olathe, KS 66062 PHONE (913)768-4700 FAX (913) 768-4900

APPLICATION FOR MEMBERSHIP

(Please Print)

Name:

PERMANENT address at which we may communicate with you (if a business, please provide the business' full name and mailing address)

____
____
____
____

PERMANENT Telephone Number	PERMANENT Telefax Number	PERMANENT E-Mail Address

Job Title	Employer

State/Federal Agency Declaration (see instructions #2 below)

Type of Membership Applied For (check one)

❑ **New General Member — DUES $70.00***

❑ **Former General Member Reactivating Membership**(See instruction #3, below)

❑ **Current Member Applying For "Retired" Status**
(see instruction #4, below and provide a brief description below of your current situation)

Additional Information

I hereby certify that I am currently involved in the regulation of insurance company operations or products with the above-named agency, and that at least 75% of my professional time is spent working on behalf of a state or federal insurance regulatory agency.

____

Your signature Date

* Annual renewal dues are payable January 1. Dues payments made after October 1 will cover membership through the end of the next full calendar year.

Instructions

1. **Salaried government regulators** Any person employed by or employed on a salaried basis with a state/federal insurance regulatory agency is eligible for membership, provided said person's responsibilities include examination, either in the field or the office, of insurance company products and/or operations.
2. **Contract regulators** A regulator employed under contract or appointment by a state/federal regulatory agency, as defined in the Society's bylaws, may also seek membership if such employment represents at least 75% of the examiner's work. Each applicant for IRES membership must designate a primary state for which the applicant does regulatory work, even if the applicant is an independent examiner whose work assignments change regularly.
3. **Former members** Those former members of IRES holding AIE or CIE designations who wish to re-join IRES will be required to pay dues fees designated for AIEs and CIEs, and to comply with all current mandatory continuing education requirements in order to maintain such designations. Questions regarding the National IRES Continuing Education (N.I.C.E.) Program may be directed to the special N.I.C.E. telephone number at the IRES office at 913-768-NICE (6423).
4. **Retired status** IRES "retired" status is reserved for any member who has ceased to be actively engaged in any aspect of the field of insurance. Retired Members are entitled to reduced annual dues (see below).
5. **Non-Voting Member** General Members of IRES who leave regulation to work in the insurance industry may apply for non-voting general membership. Non-voting members pay full annual dues. They also may maintain their AIE/CIE designations, providing they remain in compliance with IRES continuing education requirements.
6. **Dues levels** A check made payable to INSURANCE REGULATORY EXAMINERS SOCIETY should accompany each application. Annual dues are: $70 for a general member without a designation: $95 for a general member with an AIE designation; $105 for a general member with a CIE designation; and $40 for a retired member.

rev. 10/1/03

Mold dilemma may fester in some states

by Kirk Hansen
Director of Claims
Alliance of American Insurers

Editor's Note: In the November 2003 issue of *The Regulator*, Kirk Hansen of the Alliance of American Insurers provided an overview of the mold issue for IRES members. The article prompted several questions from readers. In this article, Mr. Hansen answers these questions.

Q: *Mold has been around for thousands of years, why are we hearing so much about the damage it causes only in the past few years?*

A: According to the United States Chamber of Commerce and the Manhattan Institute's Center for Legal Policy, the insurance industry has paid billions of dollars for mold claims and more than 10,000 mold cases are pending nationwide. Most of these claims have been filed after *Ballard v. Farmers Insurance. Ballard* was a Texas lawsuit, initiated in 1999, that alleged insurer bad faith in claims handling and mold damage remediation and that led to an award of $32.1 million (subsequently reduced). Studies show a 300% increase of mold claims since 1999.

Q: *Your last article in* The Regulator *stated that you are anticipating that the number of mold-related claims will decline? What is the reason for this?*

A: The industry has taken proactive steps to limit mold coverage in an attempt to control the cost of insurance. If insurers continued to pay claims that were not originally contemplated in insurance policies, the price of home insurance would inevitably rise.

Q: *Will the recent changes in the treatment of mold claims limit exposures in most states? Is it a safe assumption to believe that mold claims will be a thing of the past within the next three years?*

A: We have probably already seen the peak in the frequency of mold claims. It is likely that newly approved limits on mold coverage will also limit costs of mold claims. Mold-related claims, however, are with us to stay. According to Theodore R. Henke, Senior Vice President of Atlantic Mutual Companies, "Even before the *Ballard* case, the insurance industry had been facing mold claims. Many of them were very expensive. The frequency of mold-related claims has risen dramatically over the last few years. Even with newly allowed policy limitations, it is doubtful, however, that we will ever see frequencies dip to pre-*Ballard* levels, at least in the foreseeable future."

Q: *It appears that the states of Texas, California, and Florida have been on the front end of the mold claims. Can other states expect similar actions?*

A: Other states can expect significant mold damage claims and have already seen claims coming through the doors of insurers. Mold damage claims have received a great deal of publicity in states such as Florida, Louisiana, and in Texas, particularly along the Gulf coast. There is no state, however, that is immune. Extremely dry states such as New Mexico and Arizona have experienced relatively high volumes of mold claims. Even states with cooler climates such as Alaska and North Dakota have buildings infested with mold.

Q: *Prior to the new limitations on mold coverage, didn't most homeowners and commercial policies exclude coverage for damage*

Kirk Hansen is Director of Claims for the Alliance of American Insurers in Downers Grove, Illinois. The Alliance is a national trade organization representing 340 property/casualty insurance companies. He can be reached via e-mail at: khansen567@hotmail.com

that results from "mold and mildew?" If so, why are insurers paying claims for mold damage?

A: Before the current frenzy over mold, coverage for damage resulting from mold was never contemplated in the policy contracts, though not specifically excluded. Mold is usually a result of maintenance issues and was therefore not covered under most insurance policies. Routine maintenance and prompt common-sense repair measures taken by home and building owners are very effective in preventing mold growth. Whenever mold coverage is mandated, it results in increased claims costs, which are ultimately passed on to consumers in the form of higher insurance premiums. Due to some unusual jury verdicts and judicial interpretations some insurers paid or settled disputed claims. To avoid confusion, some insurers have inserted clarifying language into their insurance policies.

> ***"43 states and territories have approved ISO Homeowners Mold Exclusions."***

Q: *How have insurers tightened up the mold exclusion language in their policies?*

A: 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 ISO, the Departments of Insurance in 43 states *and territories* have approved ISO **Homeowners** mold exclusions. Departments of Insurance in 49 states and territories have approved ISO **General Liability** mold exclusions. Departments of Insurance in 42 states and territories have approved ISO **Commercial Property** mold exclusions. ISO forms allow limited coverage for mold, including testing, for losses resulting from covered perils.

Q: *How can you tell if you are being exposed to mold? Does air sampling help? How should policyholders help remediate a potentially serious mold condition if they aren't aware the condition exists?*

A: Most people can be in a building with high levels of molds and not feel any effects. According to "A Scientific View of the Health Effects of Mold," commissioned by the United States Chamber of Commerce and the Manhattan Institute's Center for Legal Policy, about 20 percent of the population may be affected by mold allergies and feel effects such as asthma and runny noses. Air sampling will only demonstrate how much mold is in the air at a *particular* moment of time. It can be likened to a "snap-shot." Since different amounts of mold affect different people in different ways, it is probably not necessary to obtain air sampling unless individuals are already experiencing otherwise unexplained cold symptoms that are indicative of mold allergies.

Q: *Are new buildings and structures more or less likely to be prone to mold than old buildings? Why?*

A: Both old and new buildings are susceptible to mold. All molds need moisture to grow, and both old and new buildings are susceptible to water damage. In most 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. Homeowners should regularly check for signs and sources of indoor moisture. The sooner the affected areas dry out and the source of the leak is repaired, the better the chances of minimizing damage to property.

Q: *Will states such as New York that have not taken steps to allow insurers to exclude mold coverage be inundated with mold claims in the near future?*

A: New York is actively considering the ISO

continued on page 14

Reserves need strengthening

Asbestos wave is rising; crest yet to come

by Gerard Altonji
Senior Financial Analyst
A.M. Best Co.

In May 2001, A.M. Best Co. increased its estimate of ultimate asbestos losses for the U.S. property/casualty insurance industry to $65 billion and reaffirmed its estimate of ultimate environmental losses of $56 billion. With incurred-to-date losses of $45 billion (asbestos) and $31 billion (environmental), A.M. Best's estimate of unfunded asbestos and environmental liabilities as of year-end 2002 is $20 billion and $25 billion, respectively, for a total of $45 billion, down from $53 billion at year-end 2001.

While a number of insurer groups have significantly raised their asbestos reserve levels in recent years, many more have yet to fully fund their obligations. In addition, environmental survival ratios are weakening as reserves continue to be paid down without further strengthening. This outlook is based on A.M. Best's analysis of year-end 2002 Footnote 29 data.

U.S. asbestos losses have surged dramatically in recent years, with incurred losses more than doubling to over $4 billion in 2001 before doubling again to $8 billion in 2002, while The Hartford alone posted a $2.6 billion addition to asbestos reserves in early 2003. A number of other insurers have also moved to strengthen their asbestos reserves during the current year.

In 2002, insurers and U.S. asbestos producers entered a number of high-profile asbestos-related settlements. Also during 2002, several large-scale reserve additions were made to recognize the trends in asbestos-related losses. Travelers took a pretax charge of $2.9 billion for its asbestos liabilities, along with a $150 million charge for environmental losses, while ACE boosted its asbestos reserves by roughly $850 million and its environmental provision by nearly $240 million, with most of this strengthening taking place in the group's Brandywine run-off unit.

Allianz added $750 million to its U.S.-based Fireman's Fund subsidiary for asbestos losses and then transferred $1.3 billion in A&E (asbestos and environmental) reserves to the German parent. Another German insurer, Munich Re, added $295 million for asbestos-related reserves (with $85 million also added to environmental reserves) as part of its $2 billion capital infusion to its U.S. subsidiary, American Re. Hartford Financial Services reallocated $600 million to A&E reserves (from other reserves), including more than $500 million for asbestos exposures. This same insurer took an additional pretax charge of $2.6 billion for asbestos losses, net of reinsurance, in early 2003.

Last year, Chubb and St. Paul took asbestos charges in excess of $655 million and $625 million, respectively, while no less than nine other insurers took asbestos charges in excess of $100 million each. A growing number of noninsurance companies are also finding that their existing asbestos reserves are proving insufficient in the face of rising asbestos claims. Some of these companies are filing for bankruptcy protection to preserve assets and wall off their balance sheets against further erosion from asbestos claims.

Perhaps the most significant driver behind the asbestos litigation in the United States is the complicating interaction of 50 differing state laws and the lack of effective federal law. This increases the incentive for plaintiffs' attorneys to "forum shop" for the states with the most liberal jury awards. It also leads to significant inequality of awards among plaintiffs in differing states, high transaction costs for defendants and insurers, and excessive court delays.

Over the years, a number of attempts have been made to "federalize" asbestos and other mass-tort actions. The most recent attempt involves Sen. Orrin Hatch's (R-Utah) proposed legislation to set up a national trust fund in excess of $100 billion to pay for asbestos claims. The legislation (the Fairness in Asbestos Resolution Act of 2003, or "FAIR Act"), which initially received wide support from a number of key industry players, including the U.S. property/casualty industry, appears headed for possible defeat as a result of "deal-breaking" amendments that would substantially increase the potential liability to U.S. insurers.

Despite the industry's attempts in recent years to slow the onslaught of asbestos-related claims, A.M. Best's outlook for the insurance industry's exposure to accelerating asbestos losses remains negative. Based

on this negative outlook as well as year-end 2002 data, A.M. Best projects the industry's unfunded asbestos position to be roughly $20 billion, with unfunded environmental exposures of approximately $25 billion.

While asbestos losses continue to haunt the industry, environmental exposures remain in "sleep" mode. The industry has incurred relatively inconsequential environmental losses for three consecutive years now, with losses of just $51 million posted in 2002, following a meager $325 million in 2001. The 2002 loss actually is understated as five groups posted an aggregate negative incurred loss of $775 million, with Allianz's Fireman's Fund unit recording a negative $421 million as that group transferred a substantial amount of its A&E liabilities back to its German parent.

The vast majority of groups with environmental exposures continue to report negligible losses, with a significant number posting small-to-modest negative incurred losses. Such losses are down sharply from the mid-to-late 1990s, when insurers rushed to strengthen environmental provisions in the face of potentially enormous site clean-up costs. In recent years, it has become apparent that many sites might be remediated at lower-than-anticipated costs. In addition, some insurers have been aggressive at buying out their policyholders at a discount to remove the threat of additional losses in the future.

> ***While a number of insurer groups have significantly raised their reserve levels . . . many more have yet to fully fund their obligations.***

Conclusions

Two years ago, A.M. Best expressed the opinion that asbestos losses for the insurance industry would accelerate as companies came under increased pressure from rating agencies, regulators, investors and other constituents to more fully fund their asbestos exposures. The dramatic increase in such losses since 2001 has borne out this prediction. As losses associated with peripheral defendants—those that did not produce asbestos but rather used it in their products and/or had it on their premises—continue to grow, a groundswell of public opinion appears to have prompted the judiciary and, perhaps, the government, to attempt to enact some type of reform to preserve funds for those plaintiffs who are truly ill.

While it is still too early to count the latest federal legislation (the FAIR Act, sponsored by Sen. Hatch) as dead on arrival, it would appear that promising reform still remains a distant hope. Fundamental disagreements among plaintiffs' attorneys, insurers and U.S. industry continue to stymie attempts to provide proper compensation to injured parties while ending the drain on available resources to fund such compensation. As this saga continues into yet another year, A.M. Best will continue to evaluate insurers' balance-sheet strength based on our estimate of their full A&E exposures, supplemented by fresh ground-up loss reserve evaluations, while further investigating any potential impact from the developing silicosis litigation.

While environmental exposures appear to be manageable in the near term, there might be upward pressure on this component of A&E liabilities as well. A.M. Best remains concerned over the long-term prospects of environmental losses as federal and state governments, trial attorneys and the courts attempt to shift some of the burden of cleaning up the nation's "spills" to the private sector—and by implication, to its insurers.

Groups that have greater unfunded and uncertain A&E liabilities, in relation to surplus and future earnings, remain subject to downward rating pressure. Given the ongoing relative weakness in the industry's core (non-A&E) reserves, still-diminished investment opportunities and uncertainty over economic conditions, the ability of some groups to come to terms with their A&E exposures remains questionable. ■

A printed copy of the 14-page special report, "Asbestos Wave Rises; Crest Yet to Come," can be downloaded for $50 or a combination of the printed report plus a spreadsheet file of the report data for $125 from the A.M. Best Web site, www.bestweek.com. In addition, complete footnote 29 data is available. Call customer service for more information at (908) 439-2200, ext. 5742.

From chaos to reform in California workers' comp system

continued from page 1

rate oversight and is partly to blame for the current situation. Under the open rating system established by SB 30, the rate floor was set so low and the law so constrained the Department that a rate filing could not be disapproved *unless it threatened the solvency of the entire group of insurers on an all-lines, countrywide basis.*

There was no provision for rate adequacy. The clear intent was to let the free market battle it out in the name of rate reductions. It should be noted that net rates (*i.e.*, final rate after application of all rating plan adjustments) first began dropping by a dramatic 20% in 1994 before open rating even began, partly as a result of anti-fraud initiatives enacted in 1993. Rates dropped another 30% in 1995 under the first year of open rating, and they declined another 10% through the end of 1998.

More than two dozen carriers were declared insolvent in California or other jurisdictions.

Actual final rates charged in the marketplace ranged from 94% to 97% of the prevailing approved loss cost and were, therefore, not sufficient to cover claims costs let alone underwriting costs and commissions. The culprit was rating plan discounts, including schedule rating, premium discounts, group discounts, and selected class discounts.

Failed Business Plans & Reinsurance Pools

Coinciding with rate deregulation were failed business plans, reinsurance schemes, and runaway loss costs. The common characteristics among many failed carriers were their positions as domestic, California specialty writers of workers' compensation, their business strategy to grow market share by increased writings and acquisitions, and their cut-rate pricing through excessive discounting.

Cheap reinsurance lulled these companies into complacency as they ceded off large portions of their business. The business ultimately generated loss ratios well in excess of 100%.

At the worst stage of the crisis in 1999, when combined ratios peaked at 175% for the industry as a whole, a reinsurance scandal began to unfold involving the Unicover Reinsurance Pool. Several of the troubled companies had ceded large portions of their losses to the pool, but in turn had reinsurance obligations under the arrangement. The nature of this arrangement left many of the troubled companies in the dark as to the extent of their obligations. After the dust settled, the reserve deficiencies of the troubled companies were, in some cases, double the carriers' most conservative estimates.

The prevailing political attitude at the time suggested that the free market would resolve the problems. The Department, under the new rules, had few tools to enforce adequate rate levels.

The first large carrier to be declared insolvent was Golden Eagle, whose reserve discounting had become suspect due to ownership interests in its reinsurer. And not until the interim administration of Commissioner Harry Low did the Department begin capping schedule rating plans at 25% in a uniform approach.

At the end of 2000, the Rate Regulation Division and Financial Analysis Division of the California Insurance Department adopted a coordinated three-pronged approach: 1) pure premium rates would be increased dramatically because carriers weren't charging 100% of the loss cost as their final rate; 2) new accounting procedures would track liabilities ceded to reinsurance pools; 3) schedule rating credits would be capped at 25%. It would take another year for rates to stabilize and for carriers to charge at least 100% of the loss costs in the marketplace. But there was another problem emerging on the horizon – loss costs were increasing at alarming and unpredictable rates, and the Department did not exercise jurisdiction over the benefits side of the equation.

Loss Trends

With rates at historic lows and loss costs increasing at an alarming pace, estimated ultimate losses tripled from $5 billion in 1995 to at least $15 billion in 2003.

Although the number of claims filed decreased in four of five years ending in 2002, the average cost per claim increased dramatically from $15,000 in 1989 to $53,000 in 2002. Medical costs associated with workers' compensation treatment increased at approxi-

mately 17% per year, far outpacing the Consumer Price Index and general medical inflation.

Recent studies conducted by the California Commission on Health and Safety and Workers' Compensation attributed the causes of loss severity to medical over-utilization, specifically the number of visits per claim, and the intensity of treatment per claim, both of which far exceeded national averages. The average number of chiropractic visits per claim in California was 34, as compared to a national average of 17. The average number of physician visits was 12 in California versus 8 nationally. The average number of physical and occupational therapist visits was 17 in California versus 12 nationally.

Insolvencies

Before long, escalating loss costs coupled with declining net rates showed up on the balance sheets. Eventually, more than two dozen carriers were declared insolvent in California or other jurisdictions, or were placed under state supervision. These companies owned assets worth approximately $20 billion at their peak. The crisis virtually eliminated the California workers' compensation specialty market and a local source of tax revenue and jobs.

As the remaining private carriers reduced their writings or left the state altogether, the market share of the State Compensation Insurance Fund (SCIF), California's workers' compensation insurer of last resort, grew from 25% to over 55%. SCIF's ability to serve its customers was strained, and its reserve and surplus positions were pushed to the limit. Soon it would have to increase its rates to cover the reserve inadequacies caused by exponential growth and reserve inadequacies in prior years.

Reinsurance & September 11

Following the September 11, 2001 terrorist attacks, the reinsurance market was in turmoil, and capacity was severely restricted. Reinsurance rates increased dramatically and those increases exacerbated rate increases charged by the direct writers. The workers' compensation market had completed the transition from predatory pricing and excessive discounting to a genuine hard market.

Rate Increases & Job Losses

Since the height of the crisis in 1999, workers' compensation carriers have raised their rates from 9% to 22% on average every year. Final rates actually charged in the marketplace, as a percentage of loss costs, increased from 97% in 2000 to 131% in 2003. The industry's combined ratio improved from 175% in 1999 to 120% in 2002.

Rate increases came at a time when the economy had entered another recession, and they had a devastating effect on hiring. Costco Wholesale Corp. considered moving some of its 29,000 jobs out of California, as one-third of its national premiums were spent on coverage for its California operations alone.

Smaller employers also felt the squeeze as private carriers refused to insure them, leaving them subject to hefty increases in premiums for coverage at SCIF. SCIF's rate increases in 2003 totaled 37% on average.

The Legislative Responses:

• Assembly Bill 1985

The California Legislature began responding to the crisis in 2002 with a rate adequacy requirement contained in Assembly Bill 1985. This established a floor, or theoretical minimum rate, which requires insurers to charge sufficient collectible premiums in the aggregate to cover losses and expenses. More importantly, SCIF was subjected to Risk Based Capital requirements, giving the Department authority to set SCIF's minimum reserve levels and require corrective action plans.

In hindsight, as far as rate authority was concerned, Assembly Bill 1985 was too little and too late.

• Assembly Bill 749

Governor Davis signed AB 749 in February 2002 providing increased temporary disability and permanent partial disability and death benefits, with additional benefit increases phased in over several years. The Workers' Compensation Insurance Rating Bureau (WCIRB) estimated the cost of the benefit increases to be $3.2 billion, or a 17.8% increase to pure premium rates over four years ending in 2006. California has the dubious honor of

continued on next page

From chaos to reform

continued from previous page

having the nation's highest rates with some of the lowest benefit levels.

• **Senate Bill 227/AB 228**

The crisis became a major issue during the recent recall election.To his credit, Commissioner Garamendi advanced a reform proposal shortly after assuming office, and the momentum picked up in the months following. A flood of 60 workers' compensation bills floated around the California Legislature.

In order to deal with the onslaught, a bipartisan conference committee was established to consolidate the proposals.

The result was a medical cost containment reform package, very similar to that proposed by the Commissioner, which does the following: establishes for the first time an outpatient surgical fee schedule, equal to Medicare Fee plus 20%; caps chiropractor and physical therapy visits at 24 per claim; establishes a pharmaceutical fee schedule; requires utilization reviews; repeals the existing vocational rehabilitation statute; and increases the maximum fine for workers' compensation fraud from $50,000 to $150,000. Reform savings were ultimately pegged at $5.6 billion on an ongoing, annual basis and $5 billion in one-time savings.

A Significant First Step

Given the fact that the workers' compensation system cost $15 billion in 2002 and is expected to grow to $29 billion through the end of 2003, a $5 billion savings could hardly be characterized as trivial. Even if low-end industry estimates of the savings amounting to $4 billion materialize, the package is still significant.

The legislation has retroactive impact and would alleviate reserve deficiencies to some extent, relieving some pressure on SCIF. Its impact on loss costs was estimated to be -8.2% by Department actuaries and -5.3% by industry actuaries. Carriers followed suit by filing rates for the Jan. 1, 2004 renewal cycle.

To date, 95 filings have been received with an average decrease of -4.8% for private carriers and -3% for SCIF. Absent reform, the Department would likely have granted a pure premium rate increase of +5% of the 12% requested by the WCIRB.

Therefore, there was at least a 10% reduction in actual rate levels, before and after reform. After four years of consecutive, double-digit rate increases, a 10% turnaround is noteworthy due to the change in direction and shift in momentum. Most importantly, Commissioner Garamendi, Gov. Schwarzenegger and the Legislature seem to agree that this first step requires additional action and a second round of reform.

Senate Bill X4

Governor Schwarzenegger is advocating additional cost containment provisions, through Senate Bill X4, to cut another $11.3 billion in costs. While the package contains many of the consensus proposals supported by Commissioner Garamendi, it goes farther.

Consensus elements include the following proposals: revising the permanent disability rating system to develop more equitable and consistent benefit calculations based on objective assessments of disability; developing a strong definition of "reasonable medical treatment"; adopting an independent medical review system; enhancing the utilization review provisions contained in the first round of reform, and strengthening anti-fraud measures.

Somewhat more controversial proposals (from the labor and applicant attorney perspective) include the following: switching from a proximate cause to a predominant (>50%) threshold for claims compensability for permanent disability and death benefits; repealing the employee's right to pre-designate his or her physician, changing the standard in determining permanent disability to "adaptability to perform a given job."

If the second round of reform does not materialize, the Governor is certain to pursue a ballot initiative for voter approval.

The Future

The Legislature is also seriously considering adopting rate controls that would, in effect, drive rates down and guarantee that savings are passed to policyholders.

The Commissioner has stated his opposition to such proposals, expressing his concern that rate controls would provide a disincentive to private carriers that are contemplating a return to the California market — an understandable position given how difficult it is to attract capacity in the current open rating environment.

Reforming this system will continue to be a controversial high-stakes poker game. ■

IRES State Chapter News

Colorado — At our IRES-sponsored training session, **Bob Pierce**, Program Director of the Senior Health Insurance Assistance Program (SHIP) gave a presentation on Medicare Supplement Insurance. Upcoming classes will address long-term care insurance and using diplomacy in enforcement actions. We also held our annual holiday party.
— *Dayle Axman; dayle.axman@dora.state.co.us*

Louisiana — **Pika Sdrougias** conducted a PowerPoint presentation concerning the "Health Care Consumer Billing and Disclosure Protection Act" during the Louisiana chapter's most recent meeting. Another recruitment campaign is being developed to add new IRES members.
— *Larry Hawkins; lhawkins@ldi.state.la.us*

Nebraska — **John Rink**, Assistant Actuary with the Life and Health Division of the Nebraska Department of Insurance, spoke at the November Chapter meeting. John gave an informative discussion on various key issues before the NAIC and the Nebraska Department of Insurance.

Congratulations to **Michelle Muirhead** for being elected President of the Eastern Nebraska Anti-Fraud Association. Michelle is a former Nebraska Market Conduct Examiner and is now in the complaints and fraud area in industry. She has been and still is very active in the IRES organization.

The next meeting will be in February. Details will be posted on the IRES Web site.
— *Karen Dyke; kdyke@doi.state.ne.us*

Oregon — In November, **Catherine Britain** of the Telehealth Alliance of Oregon spoke to the Oregon Chapter. She discussed the benefits for insurers and consumers from Telehealth and Telemedicine in Oregon. We also heard from **LeRoy Billings** of Plexis Healthcare Systems, Inc. He discussed the current health claims software that his company is marketing to insurers and TPAs. Elections were held and IRES Chapter officers for 2004 are:
Chairperson**: Gary Holliday**
Co-Chairperson**: Carol Simila**
Secretary**: Brenda Etzel.**
— *Gary Holliday; gary.r.holliday@state.or.us*

Utah — The Utah IRES Chapter held its combined Annual Business Meeting and Quarterly Educational Meeting in November. Chapter members as well as nonmembers who were interested in learning about IRES attended. The Utah Insurance Department's Fraud Division Director, **Joe Christensen**, provided a Power Point presentation on insurance fraud in the nation and Utah, how to detect insurance fraud, and the coordination of efforts to combat insurance fraud.
— *Randy Overstreet; roverstreet@utah.gov*

Virginia — The Virginia IRES Chapter recently held its quarterly meeting. Thirty-four members gathered to listen to reports from the Scottsdale CDS. The discussion was led by four of the Department's staff that had attended the Scottsdale CDS. The topics included anti-money laundering efforts, uniformity, terrorism, suitability, and the use of credit scoring in the underwriting/rating process.
— *Catherine West; cwest@scc.state.va.us*

Wahington D.C. — The DC IRES Chapter has been discussing recruitment strategies and the possibility of participating in regional meetings.
— *Betty Bates; betty.bates@dc.gov*

Mold questions & answers

continued from page 7

mold exclusions, however, whenever mold coverage is mandated, it results in increased claims costs, which ultimately is passed on to consumers in the form of higher insurance costs.

For example, according to the Texas Insurance Department's data, mold claims by Texas policyholders jumped dramatically between the first quarter of 2000 and the fourth quarter of 2001. During that time mold coverage was mandated in Texas and the following occurred:

- The total number of mold claims grew from 1,050 to 14,706 — a 1,300% increase.
- The average cost per Texas policyholder per year grew from $23.32 to $300.50, a 1,189% increase;
- Texas, which makes up only 7.5% of the U.S. population, accounted for 70% of new mold claims in 2001;
- The cost of the average mold claim in Texas was found to be about $18,000, which was 4.7 times the cost of an average homeowner's claim and 5.6 times the cost of an average non-mold related water damage claim; and
- The Department estimated that Texas consumers would face double-digit rate increases for several years if mold coverage were left unchanged with no opportunity for insurers and consumers to limit mold coverage.

In the face of escalating claims costs, the Texas Department of Insurance started approving mold exclusions. The Texas experience serves as a laboratory for the rest of the nation.

Q: *According to a consumer advocacy group,* Texas Watch*, Texas homeowners pay the highest premiums in the U.S., although that is disputed by the Texas Insurance Department. Do Texans really pay the highest homeowner premiums?*

A: According to the National Association of Insurance Commissioners (NAIC), for the year 2000, the most recent year for which data is available, the highest average homeowners premium was $723, for the state of Texas. The countrywide average was $402. ■

Quote of the Month

"A federal agent told me he doesn't know why anybody would rob a bank these days. All they have to do is open up a no-fault facility. They are not going to suffer bodily harm. The prison sentences are more limited. And they can make a ton of money."

— Insurance lawyer Skip Short, discussing no-fault automobile insurance fraud in New York State

IN MEMORIAM James Gardiner, who was profiled in the January 2001 issue of *The Regulator (The Country's Oldest Working Life Actuary)*, died Dec. 11 following a brief illness. Mr. Gardiner had worked 42 years as a life actuary with the Metropolitan Life Insurance Company and an additional 30 years for the Life Insurance Bureau of the New York State Insurance Department. While with the New York Department, Mr. Gardiner was instrumental in ensuring that public pension funds under the Department's jurisdiction were funded on an actuarially sound basis. Jim Gardiner would have been 97 on January 20, 2004. He will be sorely missed by his friends and co-workers.

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SERFF: What's next for electronic rate filing?

continued from page 1

691% increase over 2001, and the first 11 months of 2003 saw more than 70,000 filings through SERFF.

“SERFF really just speeds up the rate and form filing process between insurance companies and the state insurance commissioners' offices,” said John Lamperez, NAIC's outside sales manager.

And it does it for every state.

“SERFF is licensed in all states, so no matter what state you're doing business in, you can log on and send your filing through it,” Lamperez said. “Each state builds its own requirements on the system. Everything is done electronically.”

The Pennsylvania Insurance Department, for instance, has been using SERFF since '99, more than doubling the number of filings received through the system over the past year. (It also accepts filings via e-mail and fax.)

“The system is very effective for tracking the timeline of the filing from the point of receiving it to final disposition,” said Rosanne T. Placey, department spokesman. “The key for us is accessibility [both by department personnel and by the public] as well as uniformity.”

The first 11 months of 2003 saw more than 70,000 filings through SERFF.

But there's a worm in the apple.

Florida has developed its own electronic filing system, I-File, and at least two other states — Texas and California — are about to adopt it. What's going on here?

The enemy of the good

It all depends on who you talk to, but here's what appears to be happening. When the technology came along that made it possible to automate rate and form filing, NAIC jumped in. But then the development process got overtaken by the old cliché that says that the perfect is sometimes the enemy of the good.

Throughout the '90s, as SERFF was going through several iterations, Florida, apparently deciding that a more limited version of SERFF — with fewer bells and whistles, perhaps, and one that admittedly met the needs of only one state — could be developed fairly quickly.

“We needed to move something along because we were under a lot of pressure from our local market, our Florida regional-based market, to put something together,” said Michelle Newell, assistant director of the Florida Office of Insurance Regulation.

Where SERFF has been under development for about a decade now, with a committee working to come up with a sophisticated package that will work for everyone, Florida put a very similar idea into practice in just under a year. And it's been in operation for about two years now.

Since last July, all of the 3,500 or so companies licensed in the state have been required to use I-File (compared with just over 1,000 signed up to work with SERFF).

Newell insists that creation of I-File, which began several years ago when SERFF was still being perfected, definitely wasn't an anti-NAIC move.

“It wasn't a mission to upset anyone's system,” Newell said. “It's just that we had a need that we had to fill on the local level, and we had a responsibility to our marketplace and our industry to really get some efficiencies built in for us.”

Lenore Marema, vice president of the Alliance of American Insurers, says insurers are huge fans of electronic filing. And though SERFF is a bit top-heavy with features that benefit regulators, rather than companies, they're big fans of the idea.

“SERFF was designed by and for the regulators,” she said. “The states love it, and I don't blame them.

“They have the API [application program interface], so they can hook it up to their back-office systems. Every single state that's ever signed on to SERFF loves it. It has all the metrics on it: It counts, it tracks the filing. They don't have to make copies, they can send it around the office — it's great for them.

“And now we've got to make it great for the industry.”

Despite misgivings about some parts of SERFF, Marema says insurers are more upset at the prospect of two incompatible systems (not to mention the fact that participation in I-File is mandatory for Florida companies).

“We feel the thing between SERFF and I-File is very unfortunate, because we don't need two systems,”

she said. And besides, "it's not regulatory modernization if two-thirds of the states mandate SERFF and a third of the states mandate I-File."

The back end

One of Florida's original goals in developing its own mini-SERFF was a quest for additional features.

"We needed to get our system up and functional on a faster timeline than SERFF," she added, "and we also were looking at some more robust back-end functionality that — at the time SERFF was being developed — wasn't part of the program."

For those of us not into computer jargon, "back-end functionality" refers what happens after the filing arrives.

In the first generation of SERFF, the filing came in electronically. But then it had to be put back into the system — scanned, key-stroked, whatever — or else printed and worked as if it had come in the old-fashioned way, on paper.

"SERFF was the highway," Newell said. "It was really the means through which you transmitted. It was kind of like an Internet connection. It was originally designed before everybody had Internet connections and high-speed connections, so it was innovative and unique.

"We've come a long way in technology, and we felt we needed to have an electronic workflow, so that a filing comes in and gets dumped into the workflow. The actuary gets their piece, the analyst gets their piece, and it's a simultaneous activity. And it just takes away a few of those steps. It gets it right into your system. At the time, SERFF did not have that."

That was then. Nowadays, SERFF has that same kind of back-end functionality. Yet that doesn't mean that I-File is going to fade away.

The reason that I-File has so many more companies using it relates, needless to say, to the fact that all Florida companies are required to use it. The department is currently receiving something like 15,000 filings a year via I-File.

Although insurance companies automatically hate mandates, Marema of the Alliance says that SERFF would work better if, one way or the other, it was used more heavily. But her mandates would be upon the departments, not the companies.

"The states are all licensed, but they're not accepting [filings via SERFF] for all lines," she said.

"The number of filings is increasing, as more states accept it for more lines. We have some large members who are using it, and they say that if nothing else, SERFF does cut down a lot of the transaction time — it cuts two to three weeks off for the department to get it, figure out what it is, make all the copies, shuffle them around."

NAIC's Lamperez says the average turnaround for SERFF filings is an astonishing 21 days.

"It does cut out that time," Marema agrees. "The Alliance has always called that, however, speed to destination, not speed to market."

Call it what you will, cutting weeks off the approval time for new rates and forms can't but help the industry's — and NAIC's — dedication to speed to market.

Speaking of mandates, SERFF was always intended to be voluntary, though some states are more aggressive than others in encouraging (but no, not mandating) participation. The New York Department of Insurance, for instance, issued a circular letter back in September setting Jan. 1, 2004 as the target for P&C companies to file electronically.

"Filings made on or after that date should be made using SERFF," said the formal announcement, carefully saying *should,* not *must.* "This schedule, while aggressive, was designed to focus the industry's attention on a matter of critical importance to the modernization of regulation and [to] encourage industry migration towards electronic filing."

Mini-compact

Despite that aggressiveness, I-File is set to grow in impact.

The recent NAIC quarterly meeting saw approval of what some are calling a mini-compact: an agreement among Florida, California and Texas to develop uniform standards for form filings in annuity products.

A lot of the speed-to-market pressure has always been in the area of life and annuity products. The three states, three of the largest markets in the U.S., see big advantages in going beyond the mandate of SERFF and seeking unified standards for such filings — not changing statutes and regulations so companies can file with complete uniformity in all three states (nor, as some have proposed, coming up with a single set of national standards), but using software to allow for coordination of existing standards.

"We really felt that if you could capture the elements of some of the larger market states, who do a fairly thorough analysis of those forms, you would end up with something that maybe other states could develop some type of reciprocity with," Newell said.

Besides coming up with a set of shared standards that incorporate the individual standards of the three

continued on next page

SERFF: What's next for electronic rate filing?

continued from previous page

states, the mini-compact allows insurers to file just once for all three states. The system, which is entirely voluntary for companies, calls for the participating states to share information with one another, and for a lead review state to be designated for each category of product.

Believe it not, they expect to be working through their first filings in the first quarter of this year.

If the idea catches on, and all those filings come in via I-File, it could make the Florida-based system still more popular and no doubt reduce the number of filings coming in via SERFF. But if you're keeping score in that fashion, stop it right now!

From some of the rhetoric, you'd think Florida's I-File will mean the death of NAIC. Since the association is the main bulwark of state-by-state regulation, our main defense against centralized federal regulation, being anti-NAIC is indeed a big deal.

And yet, irony of ironies, I-File is also a sign that state regulation is still alive and well.

In point of fact, Newell feels that SERFF probably works very well for most state insurance regulators.

"It's a very similar idea," she said. "It's just a matter of which highway you're using, and how much functionality you have on the back end.

"You can receive anything electronically, but what you do with it, how much you have to process and handle it to get it into a system [makes all the difference]. For a lot of states, I think SERFF probably works really well for them. For us, we had some more sophisticated needs, and at the time, SERFF did not have those capabilities."

Except for bragging rights, there really isn't much competition between SERFF and I-File. At least not for much longer.

Getting together

When you come right down to it, the two systems do the same thing, and they do it in pretty similar ways.

Sure, you could look at it as a contest, with one system left standing at the end, and the other lying bleeding on the sand. Or you could envision some kind of merger of the two.

"I can't predict the future," said Newell, "but I think that in any situation, you always want to look at what are the best practices — what is working — and take the best from both. And hopefully you'll emerge with a superior product."

And yet moving to best practices doesn't necessarily mean uniformity.

"There are certain things that you can't standardize," Newell said. "There are certain processes and certain approaches to things that you can, but then that's the value of state regulation. You need to have regulation that's responsive to the market, and the uniqueness of each state.

"It's a challenging time," she added. "There are a lot of competing and conflicting goals. But I think overall, most states agree that you want to foster a marketplace, you want to be able to have companies get their products into the market quickly. But it's also got to be a system that allows for the uniqueness of each state and its demographics."

So how do you allow for that uniqueness, yet apply best standards?

Easy. You persuade I-File and SERFF to talk to one another. And that's just what's happening.

The two systems can't understand each other today, but NAIC and Florida people have been meeting to remedy that.

"We have worked with the SERFF staff to develop what they call a two-way API — that's so the two systems can talk back and forth and feed each other information," said Newell. NAIC's Lamperez expects all the bugs to be worked out, and the two-way API to be up and running sometime in '04.

So whether you're an insurer that's licensed in Florida or you want to sell a new annuity product in every state of the union and need to use I-File — or you're a regional company based in Wisconsin or Utah and happy as a clam to be using SERFF — pretty soon it won't matter.

Pick the system to prefer, and then port the data from it to the other one as needed. Better yet, that kind of process might one day soon make it easier to file in more than one state with greater ease — and speed.

Now, this is the kind of story we like to tell. It's got a happy ending. ■

Regulatory Roundup?

There was no room for Regulatory Roundup this month, but the feature will return in the next issue of *The Regulator.*

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Your registration fee minus a $25 cancellation fee, can be refunded if we receive written notice before July 15, 2004. 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, 2004.

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

BULLETIN BOARD

√ 2004 IRES Board of Directors Elections — Feb. 20 is the deadline to get your name on the ballot for the 2004 Board of Directors elections. All incumbents whose terms expire this year, as well as any new candidates, must request an official nomination form from the IRES office. Just call 913-768-4700 and ask for Susan or David. Board terms are for four years and members are required to attend the annual Board meeting each summer at the Society's Career Development Seminar.

√ 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 DouglasFreeman@insurance.mo.gov or Nancy Thomas at nthomas@voicenet.com.

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√ IRES dues notices went out the end of December and the deadline for paying dues is February 15. If your dues payment is not received, you run the risk of having your designation suspended.

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Story, p. 1