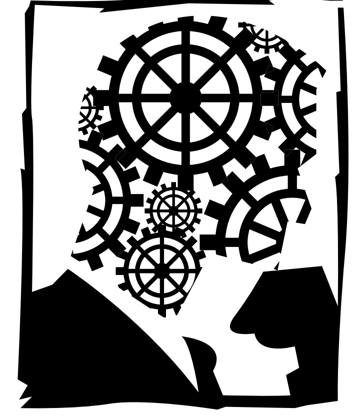
INSURANCE REGULATORY EXAMINERS SOCIETY

Time to re-think finite risk insurance

by Scott Hoober
Special to *The Regulator*

Insurance companies perform myriad activities, from underwriting and rate setting at one end of the spectrum to evaluating and paying claims at the other.

But none of those makes an insurer an insurer. Only one thing counts, only one thing allows for the regulatory scrutiny insurers receive and for all the tax advantages that accrue to their balance sheets: the assumption of risk.



An employer might hire a third-party administrator to assume all kinds of insurer-like roles in its self-funded workers comp program, from risk reduction to claims. But without taking on the risk itself, the TPA can't call itself an insurer and the employer's payments can't be called premiums.

Banks take on risk too, when they make loans to their customers, but it's usually pretty easy to tell a loan from an insurance policy.

In general, we know what an insurance company is, and what an insurance product is. The line is bright and clear.

The 10/10 rule

Or is it?

As you may have heard by now, there are a host of insurance products that don't always transfer much risk.

Whether sold by insurance companies to corporations or by reinsurers to insurers, these policies — often known as financial insurance or finite risk insurance — have been accused of being more about smoothing out financial results than about risk-sharing.

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Spitzer probe: What are lessons for regulators?

by Karl LaFong

It was only a few months ago that the insurance regulatory community was slumbering peacefully in the shade of that massive financial services sector, the insurance industry, waking only periodically to shoo away the gnats of some insignificant insurance industry practice.

Then, suddenly, with an earth-shaking rumble, the Attorney General of New York, Eliot Spitzer, shattered that peaceful repose by initiating the biggest insurance investigation in decades.

On Oct. 14, Eliot Spitzer rocked the insurance industry, and the insurance regulatory community, by announcing he had filed an unprecedented lawsuit alleging questionable practices by the insurance industry.

Why did it take an elected official, empowered in the domain of law enforcement, to sound the siren on

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From the President

Returning from the NAIC meeting, I tried to digest all of the activities of the week in terms of "What does all this mean to IRES members?" At the risk of venturing into a diatribe of rambling opinions, there are a number of observations I would like to share. Keep in mind that these are my observations and do not necessarily reflect the opinions of IRES, the NAIC or the Colorado Division of Insurance.

The discourse at the recent NAIC meeting continues to emphasize the intensity of the pressure for change in compliance and enforcement activities. However, the changes that are expected by the various groups are inconsistent. The NCOIL model and the SMART Act require further streamlining of regulatory processes and greater efficiency through risk-based analysis. "That sounds great," say many progressive regulators, "because that's what we've been working on for the past several years."

However, with the fallout from the Spitzer investigations of broker compensation, some consumer advocates are saying that only by prior-approving rates would regulators be able to identify the unsavory practices uncovered by Spitzer. They add that the move toward market analysis will create a regulatory system destined to fail consumers.

Thus, state regulators are caught between a rock and a hard place. On one hand, industry stakeholders threaten to throw their support to the federal government if their needs for efficiency aren't met, and yet, the consumer groups threaten to derail significant change if even greater bureaucratic processes aren't implemented.

What's a regulator to do?

Well, is it possible that the regulators have been doing the right things all along? The shift toward market analysis and allocating resources toward prioritized issues really does appear to be working. At recent collaborative actions meetings, state regulators shared information regarding companies of concern, planned collaborative examinations, and met with company representatives who were willing to voluntarily set and achieve compliance objectives. Wouldn't you know that the regulators' best work occurred behind closed doors in Executive Session, free from outside influences?

As much as we try to streamline and search for more efficient processes, it appears that the traditional market conduct audits and reviews of rates and forms will always have a place in a post-NCOIL world. As we move toward deregulation and narrowly targeted exams, regulators are expressing concerns that eliminating some of the traditional processes would leave state regulation subject to criticism for not discovering those issues previously discovered through traditional regulatory practices.

Now such criticism is being heard before we can even get the first edits completed on the Market Analysis Handbook. Note specifically the comments from consumer advocates who advise that the compensation and bid-rigging scandals would have been avoided with more intense review of commercial rate filings.

Well, maybe, and maybe not, but it is interesting that the expectations of our stakeholders are becoming more divergent with each meeting, and most likely the needs of neither can be met. What is the message for the regulators? Perhaps we are simply being told that criticism is everywhere, and to "just do the right thing."

It appears that insurance regulators have several challenges arising from the national NAIC meetings. First, flexibility is essential. As the states struggle to find their way to respond to criticisms of the state-based system and to meet the expectations of consumers, all regulators need to adapt to an ever-changing environment. To do so, regulators must constantly expand their knowledge of political and economic forces impacting insurance issues. Additionally, regulators must "sell" what they do. Consumers, industry, and legislators must begin to see the logic and hard work that are the hallmark of state insurance regulation.

We regulators have no lobbyists or professional advertising firms to "spin" our work. We must do it on our own. How? Perhaps one of the best ways is to become involved in professional organizations such as IRES.

Through your professional organization you can become a teacher, a mentor, a student, an author, and a national meeting planner. You can meet with peers from across the country and share ideas and concerns, and search for solutions.

Please, become involved and stay involved! IRES needs you and the state-based regulatory system needs IRES. The future of state-based regulation will be decided not only in the halls of Congress, but by the daily activities of state regulators themselves.

Kirk R. Yeager, CIE
IRES President

Welcome, new mem-

Rachelle Carter, Louisiana
Sonya W. Dungey, Michigan
Raquel Ortiz, California
Lisa M. Smego, AIE, Washington

Recruit new members and win $$
see page 15 for details

Rethinking finite risk insurance

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That would seem to make it easy for regulators: just seek out those transactions that don't involve risk — transactions representing some $50 billion in annual U.S. premiums in all, by one estimate — then go after the insurer or reinsurer that sold them.

Perhaps at one time there were companies selling clearly bogus products. But over the years, insurers and reinsurers have learned to stay in bounds. Or at least to mask those instances when they go over the line.

"There are no easy answers," as one regulator put it. "These are very complex products, and if you want to know whether the assumption of risk is appropriate, you're going to have to really work to figure it out."

The accountants say there has to be a "reasonable level" of risk transfer, which isn't of much help. As a rule of thumb, risk in a finite can be measured by the 10/10 rule — there has to be a 10% chance that 10% of the premium is at risk. But of course, two different actuaries or accountants could look at the same transaction and come up a 9.5%, 10% or 10.5% risk. Or 8%. Or 16.32%.

So remember that, as Robert Hartwig, chief economist with the Insurance Information Institute (I.I.I.), put it, "if insurance is anything, it's not certain."

"Fundamentally, when a company buys insurance, what it does is transfer the risk off to someone else," Hartwig added. "Whatever loss is sustained instead becomes a loss for the insurer, [and the policyholder] can record that insurance recoverable immediately as an asset on its balance sheet."

One of the things that makes finites complicated is that they *do* tend to provide some protection over time: not just to smooth out the income statement by taking a large loss (or a large recovery) and spreading it over the next few years, but by explicitly recognizing the time value of money.

For example, a finite agreement often includes sharing of investment income, and even of any profits that stem from the transaction.

"There's a lower risk being assumed by the insurer, but it's not zero risk," said Hartwig.

The controversy comes from those instances where the finite insurance policy looks more like a loan than a true insurance contract.

"Is it really a loan that smoothes financial results over a few periods?" Hartwig added. "There's nothing wrong with that fundamentally, but from an accounting perspective, loan proceeds are recorded differently from the buyer of this policy's standpoint. And so the loan proceeds would have to be recorded over the span of, say, four years, whereas if it's insurance, it's recorded all at once."

Side agreements

To muddy the water still further, there's the matter of side agreements, confidential understandings that say, though never in so many words, "Trust me."

"The issue is whether either of the parties involved has an obligation to disclose the existence and terms of such agreements," say Michael J. Barry, a managing director at Fitch Ratings, and three of his colleagues in a special report issued this past November.

In some cases, a side agreement — which can negate some of the elements of the public finite agreement — has come to light only after an insurer has been placed into receivership.

"Fitch believes the existence of confidential side agreements is a definite red flag and great cause for concern," the report continues, adding that aside from questions of disclosure, the rating firm "cannot see a valid reason for a side agreement of this nature."

Another problem is that many such arrangements involve reinsurers, which tend not to be as carefully scrutinized by regulators as insurers are.

The good news, though, is that reinsurance agreements that do not transfer insurance risk from the ceding insurer to the reinsurer do not qualify for credits on their quarterly and annual NAIC statements, as Kashyap Saraiya, AIE, and Wayne Cotter, CIE, of the New York department point out in an article they wrote for a reinsurance primer published recently by I.I.I. (These credits can reduce the ceding insurer's loss reserves, thus increasing surplus.)

Speaking of reinsurance, the Fitch study points to one sort of transaction that should be above reproach — catastrophe coverage, seemingly the ultimate in

unpredictability — and yet can be called into question via finite transactions.

If a finite policy is used as a financing mechanism, the actual risk of catastrophe loss could be transferred to the reinsurer, yet remain with the ceding insurer.

"Traditional reinsurance transfers a loss from the ceding company to the reinsurer," says Fitch. "Finite risk insurance allows a loss to be retained by the ceding company, with the loss spread by that ceding company over multiple years' reporting periods.

"It is how the loss is covered that should be analyzed when making the determination whether the arrangement is finite or traditional reinsurance."

The downside of finite

Fitch Ratings has been a particular critic of finites and their kin. Though their concern has to do with the way such policies mask what's really going on, making it hard for raters (and investors) to compare apples with apples, their criticism has much to say to regulators.

In the first place, finites' primary noninsurance role is to lower reported losses or inflate reported surpluses, or both, something of interest to both raters and regulators.

> ***"Perhaps regulators bless a lot of these products because of the end result: Making sure that a company stays solvent."***

"There are no bright lines in making the determination whether the transferred risk is certain or uncertain," says the Fitch study, which focuses on reinsurance (and which is available on the company's Web site).

"At some level determining when losses are certain and when they are not is an uncertain process itself."

But the level of uncertainty isn't the only issue. There's also time.

As the study says, "The time value of money dominates in finite risk reinsurance. . . . In the case of traditional reinsurance, the uncertainty surrounding the absolute amount of the losses is the primary driver of the premium calculation. However, under finite risk reinsurance, where the losses are limited, the primary driver is the timing of the losses. The premium charged by the reinsurer reflects the anticipated investment income on that premium as the primary profit driver.

"Thus the premium is typically set to the present value of ceded losses (excluding profit considerations)."

One point on which the rating agency — which is more interested in company-to-company comparisons than in the performance of a specific insurer — might disagree with regulators and others is on the core issue of the smoothing of earnings.

Says Fitch: "Some might consider all earnings smoothing to be abusive. Others might consider the spread loss contract to be an acceptable way for a company's management to reflect the long-term average expected cost of events that occur infrequently.

"In any event, Fitch recognizes that a spread loss contract can result in two similar insurers reporting the impact of the same event quite differently, hampering the ability to conduct a proper relative value analysis."

Whether bought by a healthy company to smooth earnings or by a troubled one seeking to mask the unpleasant truth, the study's authors say there's a cost to going finite:

"Most finite risk reinsurance contracts involve an upfront accounting benefit that in many ways mimic the upfront benefits of loss-reserve discounting.

"When substantial periods of time are involved, the discounted value of reserves can be significantly lower than the nominal value. In the United States and many other jurisdictions, most loss reserves are required to be recorded at their nominal value. Thus, if a primary insurer can cede losses at their nominal value and pay a premium based on their discounted value, then the primary insurer will realize an underwriting gain. . . .

"[But] the ceding company has increased its current underwriting income by lowering its future investment income. As a result, finite risk reinsurance represents a real economic cost to the ceding company."

Whatever the problems with finites, Fitch's Barry has one solution. In an interview, he said that if only

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Rethinking finite risk insurance

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10% needs to be truly at risk, why not treat the other 90% as if it were in fact a deposit ?

It would certainly be a lot simpler if all finite policies were scams, pure and simple.

That way, every time examiners ran across one, they could immediately assume the company involved had something to hide. Unfortunately, policies of this sort — whatever they're called — are extremely common.

"Among companies that use it for earnings smoothing, it is widespread and would probably not have that concern — although again, we think that it's creating a disconnect between the accounting and the economic reality," said Barry.

"However, there are some companies that are in some type of stress position, and their use of finites is just hiding that stress — and I'm not too sure the accounting profession intends for their pronouncements to be used to mask the true credit position or the true financial health of a company."

What to do

Besides being completely legal, such transactions only occasionally indicate something's amiss. What's a regulator to do? Take the company auditor's word for the percentage of premium at risk?

Barry says he's heard on the street that regulators may be giving companies a pass, since finites can have a positive effect on solvency — or at least the appearance of solvency.

"Perhaps regulators bless a lot of these products because of the end result: making sure that a company stays solvent, maybe through a difficult time," he told us. "Or maybe the regulators have a sense that, Hmm, let's let them enter this finite transaction because they'll work their way out of the hole that they're currently in.

"The finite transaction, from an accounting perspective, will allow them to report a certain amount of surplus to stay solvent."

But what if the transaction merely masks the size of the hole?

In that case, Barry said, "the use of finite will prevent the regulators from stepping in early enough, before the hole gets too big, and cure things. The finite masks the size of the hole early on, and by the time the regulators step in, it's too late to fix it, it's incurable."

What regulators need is a clearly defined set of markers to separate the good from the bad.

The most obvious agreements to evaluate closely, besides ones with insufficient transfer of risk, would be products that cover known losses (a fair number of legitimate finites cover retroactive losses, but customarily only for lines like workers comp or med mal, with long tails) or undisclosed side agreements.

Regulators in Tennessee and Virginia have already sued Gen Re alleging "non-contractual understandings" and two unreported side agreements in transactions involved in the bankruptcy of Reciprocal of America (ROA). (Gen Re's chief executive, Joe Brandon, says the alleged side deals are in fact typical amendments to existing reinsurance contracts, and not "understandings that changed the terms of our reinsurance contracts with ROA.")

As Donald Light, a senior analyst with consultancy Celent Communications, told *Best Week:* "The real question now is, are there smoking guns, such as backdating of agreements, or agreements that say the calculation of premiums is done in such a way that the reinsurer can't lose? If that's true, there is no real transfer of risk — no risk that the reinsurer will take a loss on the policy.

"Or there might be side agreements that say if, in fact, the reinsurer sustains certain kinds of losses, there will be an extra payment of some kind."

Those are practices that would be "clearly over the line," Light said. "But I have no sense that those situations are common, or are becoming more common. The danger the insurance industry as a whole has is that you can get overly aggressive regulators or class-action lawyers charging securities fraud.

"It may be a stretch," he said, "but the claim could be made that the companies buying such products are

producing misleading financial statements, engaging in fraud or violating the Sarbanes-Oxley Act."

Though some people claim there are obvious red flags that should alert a regulator to improper finites, several regulators we've talked with say it's never as clear-cut as that down in the trenches.

One solution that's been proposed would be to somehow ensure than the economic substance of any reinsurance agreement be fully documented in the ceding insurer's underwriting folder — with regulators then being given full, unfettered access.

Documentation would include the insured's loss history, comparable quotes, rate history, the intent of the transaction and all pricing information. This would allow regulators to better understand whether and how risk is being transferred in a particular transaction.

Underwriting folders currently are prepared as a prudent business practice. As a result, for contracts that appear to be finites, the underwriting folders are often inadequately documented or they're not readily available during financial examinations.

One way to address the problem, one regulator offered, would be to modify the NAIC's Statement of Statutory Principles No. 62 (Property and Casualty Reinsurance) to ensure that companies maintain meaningful underwriting folders on the risks they cede.

The NAIC proposed at its recent quarterly meeting that insurers develop a model rule requiring more disclosure of controversial finite reinsurance products, though Steve Broadie of the Property Casualty Insurers Association of America said many finite products are already properly disclosed.

In the end, though, as I.I.I.'s Hartwig says: "There's nothing fundamentally inappropriate about finite insurance or reinsurance products.

"It's simply differences of opinion as to what constitutes a significant transfer of risk, and also a difference of opinion as to what the distinction is in some cases between a loan and reimbursement from an insurance policy."

It will come as no surprise to most insurance regulators that in the end, the uproar over finites isn't likely to make their job any easier. But it could well make things harder. What's new about that? ■

Carol Newman is new chair of IRES Foundation

NEW ORLEANS — Carol Newman has been elected chair of the IRES Foundation. Newman is a vice president and associate general counsel for Fireman's Fund Insurance in Novato, Calif.

Dave Kenepp, manager of regulatory affairs for Liberty Mutual, Boston, was elected president. The Foundation elected new officers and board members here during the NAIC's annual winter meeting.

Carol Newman

Other officers elected were: Vice chair: Damian Sepanik, Sepanik Law Offices; Vice president: Bennett Katz, Farmers Insurance Group; Secretary: Fred Kottmann, Mutual of Omaha; Treasurer: Jim Fryer, Promissor.

Board members elected to new three-year terms were: Bennett Katz, Farmers Insurance Group; David Abel, Abel & Lantis; Carol Newman, Fireman's Fund; David Kenepp, Liberty Mutual; Joe Bieniek, CCH Insurance Services; Ken Cooley, State Farm; Wanda Smith, Primerica Life Insurance: Jon Brynga, St. Paul-Travelers.

The IRES Foundation is a non-profit organization devoted to funding educational and training programs in the field of insurance regulation. It sponsors the widely acclaimed National Insurance School on Insurance Regulation, which will be held May 1-3, 2005 in San Antonio, Texas.

For more information on the IRES Foundation, see ***www.ires-foundation.org***

Spitzer lessons

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improprieties in the insurance industry? Where was the insurance regulatory community?

The insurance regulatory community certainly was out there policing the solvency, underwriting practices and claims-paying practices of the insurance industry, but was it simply going through the motions? After the Spitzer announcement and some prodding by the media, the insurance regulatory community seemed to rise up to scrutinize the industry anew. The NAIC is now abuzz with activity. Individual insurance departments have launched their own investigations and hearings. Even other states' Attorneys General have picked up the scent.

But is this reinvigorated sense of purpose a result of the revelations uncovered by Spitzer's investigation? Or is it merely a self-serving reaction acted out against the backdrop of renewed interest in the creation of a federal system of insurance regulation and the emergence of the SMART Act?

Perhaps more importantly, are there any lessons that the insurance regulatory community has learned from the Spitzer investigation? Specifically, what are the lessons that should be on every regulator's calendar for 2005 and beyond?

There are at least three lessons that are vital to the survival of the existing system of state insurance regulation.

Be Aggressive

Regulators must adopt an increasingly aggressive approach in the supervision and sanctioning of insurance companies, producers and other regulated entities. The practices that gave rise to the troika of price-fixing, steering and bid-rigging existed long before Eliot Spitzer entered the scene, yet no one in the insurance regulatory community identified or investigated these problems.

The insurance regulatory community has contentedly remained in a goose-stepping march of market conduct examinations, financial examinations, agent investigations, fraud inquiries and other traditional regulatory activities. One could argue that for many years there has been no energy or enthusiasm, and perhaps no appetite, in the community to investigate and probe for major regulatory violations.

The same selection of warmed-over regulatory topics seems to continuously simmer on the stove of insurance regulation. In addition to the time-honored activities noted above, there is continual discussion of the insolvency of the carrier *du jour;* tort and class action reform; trust account requirements on alien accredited reinsurers; and, of course, whether the hard market is softening.

Yet, based on the public's reaction to Spitzer's investigation, what seems to be desperately needed is a new, hard-driving, fast-paced approach to insurance regulation.

One specific area in which radical change is needed is the imposition of fines and penalties. Rather than imposing paltry fines that might have frightened insurers in the late 1970s, the insurance regulatory community needs to speak softly and carry a really, really big stick. The four-figure (or even five-figure) fine seems like a throwback to the Carter Administration in light of the multi-million dollar penalties imposed on the Enrons, WorldComs and Adelphias.

Some recent progress can be seen in this area, most notably the $15 million fine imposed on UnumProvident in November by state regulators and the U.S. Department of Labor.

Even more important than any monetary penalty, however, is the attendant publicity. State insurance regulators must establish the creditability and public relations acumen to attract media attention. Many of the problems unveiled by New York's Attorney General were initially uncovered by the regulatory community years earlier, but were greeted by the media with yawns, and the issues quickly moved to the back burner.

Avoid Industry Influence

Reforms are needed in the area of insurance regulatory community/insurance industry relationships. No, there is no need to foster more communication and increased contacts. To the contrary, the coziness that seems to characterize industry/regulator relations needs to be examined. The fraternization between regulators and regulated entities needs to be restricted insofar as that relationship affects or impairs the ability of regulators to properly supervise regulated entities.

Central to this area of reform are the "revolving

door" restrictions that operate to prevent regulators from joining the private sector and immediately lobbying former coworkers in an insurance department. The same restrictions are needed in the converse situation, to wit, a private sector employee who joins an insurance department must be prevented from granting favors to his former employer.

New York long ago enacted a law that bars insurance department staff from lobbying the New York State Insurance Department (NYSID) for a period of two years after leaving the Department. That law also imposes a lifetime bar on the staffer from lobbying the NYSID on any issue on which he/she specifically worked while at the Department.

The adoption of such revolving-door legislation in all states is crucial to prevent the types of abuse that can arise when an individual passes from the hallways of the regulator to the hallways of the regulated.

A recent scandal at Boeing provides an excellent example (albeit, in a noninsurance setting) of how important it is to avoid conflicts of interest, and even the appearance of a conflict. In the Boeing case, a Boeing executive made an offer to hire an Air Force official while she was still employed by the Air Force.

The Air Force official was at the time handling billions of dollars of contracts on which Boeing was bidding. She was also covered by the federal "anti-revolving door" law that requires government officials working on contracts worth $100,000 or more to immediately report job offers made by bidding companies, and to either disqualify themselves from further work on the bid, or reject the offer. The law also forbids government officials working on contracts worth $10 million or more from accepting any compensation for one year from the company that was awarded the contract.

In this case, both the Boeing executive and the Air Force official pled guilty to felonies. State legislatures need to determine whether effective laws are in place to address this type of situation in the insurance industry.

Create a Single Voice

The NAIC — which is separate from, but really comprises the insurance regulatory community — needs to both install a permanent national voice, preferably in Washington, and exponentially accelerate the speed with which it conducts its affairs.

The NAIC must either: (1) install a visible spokesperson in Washington to speak out on all significant regulatory issues or (2) designate its permanent Director to become that voice. To name a new Commissioner each year as the spokesperson for the NAIC is an ineffective approach to creating a respected voice for state regulation.

Each new NAIC President brings his or her new personality and agendas to the table, and offers no consistent message or tone. The result is, at best, a muted, unpersuasive series of forgettable statements. At worst, the result is a message that may contradict the organization's long-standing goals and philosophy. Either the permanent Director should assume this role, or the NAIC should hire a person who can communicate a loud, consistent message.

Additionally, the NAIC can no longer conduct its quarterly meetings like installments of a long-running soap opera. One can attend an NAIC meeting, return four years later, and discover that little has changed with most of the major issues remaining on the table. A sense of urgency must be instilled at the meetings.

Committees, subcommittees and task forces should meet as frequently as needed throughout the year to ensure that only final votes are taken at the quarterly meetings. A failure to speed up the NAIC's interminable discussions and debates will undoubtedly lead to increased calls for the federal regulation of insurance which, as we well know, have already begun.

Final Thoughts

I believe our state-based system of insurance regulation is preferable to any federal alternative or any federal-state hybrid. However, I also believe that over the years, insurance regulators have become too passive, too cozy with those they are charged to regulate, and too unfocused in their message.

Regulators should take a long, hard look at industry practices. If they legitimately believe that such practices are fair to consumers, they should voice their support. If, on the other hand, regulators believe that such practices are unethical (even if legal) they should forthrightly express their concerns to the industry, the legislature, the media and the insurance-buying public.

Karl LaFong is a pseudonym. The author, a former regulator, currently works in the insurance industry and is an active supporter of New York State's Attorney General. The views expressed in this article are strictly those of the author.

Virtual adjusting is here!

by Kirk Hansen

The insurance industry, in order to remain competitive, has continuously kept pace with advances in technology. Insurers have been moving toward paperless files and "virtual" claim departments. In recent years, insurer use of automated systems in the claims handling process has occasionally come under the scrutiny of the National Association of Insurance Commissioners. There is a perception that in some cases software programs create "one size fits all" approaches, making claims handling a more automated, less personal process.

Technology and computerization, however, have allowed innovation and efficiencies that were barely imagined a decade ago. Property claims handling is now making its next advance. Service providers to the insurance industry have developed and employed new systems to assist insurer productivity. Increasingly, insurers are turning toward "virtual adjusting" to meet the challenge of strategic claims management.

What is it?

In current applications, virtual adjusting is accomplished by sending a trained and certified cleaning and restoration professional, equipped with an Internet-compatible video camera, to a property claim site. The camera is plugged into a phone jack or into a high-speed cable connection. The camera sends live streaming video over a password-protected Internet site.

Audio communication with the adjuster is accomplished with a cell phone. Insurers log onto the Web site and inspect the damage in real time. Since adjusters can direct the course of the inspection, they are not just observers but instead are participants. The cleaning technician can be asked to pan the camera to the right or left or to zoom in on specific objects of interest. From the comfort of the office, adjusters can agree on the scope of loss. If a picture is worth a thousand words, live streaming, full-motion video is priceless.

In the right hands, virtual adjusting is much more than the use of a webcam. The virtual adjusting process can allow images to be digitalized and stored in insurer claim files. It is also enhanced by web-enabled two-way communication, pre-recorded video, digital photos, diagrams, and estimates.

The almost instant communication reduces "leakage" caused by time-related expenses in the claims process. When time is wasted, vital information is often lost. The ability to eliminate travel time-related expenses enables insurers to be more productive.

Virtual adjusting is not virtual reality. It is not science fiction. What virtual adjusting is, is the next technological advance to assist insurers to act in a quicker, more efficient, and cost-effective manner. It does not adjust claims for adjusters. Instead, it gives adjusters more complete information so that they can do a better job of adjusting.

While some initiatives in claims automation have created the possibility of decisions becoming more removed from insureds and claimants, virtual adjusting is actually more inclusive and can make insureds and claimants an integral part of the adjustment process. It provides an unprecedented level of interaction among the cleaning and restoration company, the insurance company, and the insured, as all parties are involved with the claim and are communicating with one another from start to finish.

The process allows adjusters to promptly identify problems and focus on the best solutions – making a significant difference in how effectively and quickly they can close a file. Since virtual adjusting speeds up the adjustment of claims, in most cases it expedites the payment of claims.

Virtual adjusting is being pioneered in the fire and water restoration industry, but the technology is likely to spread to other industries because there are an almost unlimited number of potential applications. Eventually, the concept of virtual adjusting will certainly be applied to other types of claims. In the property insurance realm the technology could be adapted by roofers, plumbers, and perhaps even arborists for trees that

fall on buildings or power lines. The concept could be used for vehicle appraisals and re-inspections for fleet claims. There are even possibilities in the realm of bodily injury claims. Virtual adjusting technology could also be employed for demonstrations by accident reconstruction firms when giving demonstrations for their corporate clients.

Looking to the Future

Of course, technology is not a complete solution unless it is employed by competent individuals who assist, rather than bog down, the claims process. As the insurance industry moves ahead with virtual adjusting technology, it should make certain that contractors utilizing virtual adjusting are competent in the set-up and use of the technology. It would be a mistake to hire firms without proper certifications and training. Contractors need to be fully trained and equipped to interactively develop the scope and estimate with adjusters within hours of the loss – an essential ingredient to prevent water-damage claims from worsening due to a delay in mitigation.

Wireless communications are likely to enhance the flexibility and utility of virtual adjusting. The beauty of technology is that as it improves, it becomes more cost-effective. Virtual adjusting reflects this trend. It is likely that contractors and service providers will incorporate this technology into their day-to-day service at no additional charge. In fact, it is likely that in a few years, many insurers will refuse to do business with service providers that do not offer virtual adjusting. Resolving claims without virtual adjusting will be as unthinkable as conducting business without a cell phone, fax machine, e-mail, or laptop computer.

Because of its obvious advantages, virtual adjusting is certain to be a part of the future of the claims adjustment landscape.

Kirk Hansen is the Vice President of Insurer Relations for IMACC™ (Independent Mitigation and Conservation/Cleaning Network), which currently provides virtual adjusting technology. The firm is based in Naperville, Illinois. The author can be reached at khansen@imacc.net

Quote of the Month

"Agents, producers of all types, have got to decide, who's your master? The good book says you can't have two masters, and by God, if you're going to try to have two masters, you've got to get permission, and you've got to disclose it. And that has got to be the gospel according to the NAIC."

— Georgia Commissioner John Oxendine commenting on producers who collect commissions from both the insurer and the insured.

√ ***Working on your AIE or CIE? An amended IRES accreditation curriculum takes effect this month. Call the IRES office for details, or see "C.E." news on page 15 of this issue.***

State Regulation at the Crossroads? (Pt. 2)

Editor's Note: *Following the Commissioners Roundtable that kicked off the August 2004 CDS, the four commissioners participating in the Roundtable gathered for a wide-ranging interview with* The Regulator. *Taking part were* ***Doug Dean****, Commissioner of host state Colorado;* ***Ernst N. Csiszar****, former Director of Insurance in South Carolina and NAIC president;* ***Jim Poolman****, North Dakota's Commissioner of Insurance; and* ***Sandy Praeger****, Commissioner of Insurance in Kansas. The first part of the interview appeared in the September 2004 issue of* The Regulator. *Note that due to space limitations, some responses have been shortened. (This interview was conducted two days prior to Mr. Csiszar's announcement that he had accepted a position as head of the Property & Casualty Insurers of America)*

Commissioners (from left) Csiszar, Praeger, Poolman and Dean at Denver CDS last August.

Regulator: *One of the suggested alternatives to the Terrorism Risk Insurance Act (TRIA) is to allow p-c insurers to establish tax-deferred catastrophic reserve funds. Insurers were supposed to look at various alternatives to TRIA during the three-year period following its enactment, but to my knowledge little has been done in this area. What are your views on permitting these types of reserve funds as an alternative to TRIA?*

Csiszar: We've had, as you know, a catastrophe [working] group in place at the NAIC for decades. This has been a subject of discussion for decades. So it's not a lack of being informed that's the problem. The problem is the IRS. Ultimately, if you're going to succeed in this, you've got to bring the IRS around to allow this kind of deferral.*

That might resolve some of the natural catastrophe issues, but I still think ultimately that isn't going to resolve the terrorism issue. If you look at the nightmare scenarios of a one megaton dirty bomb in the middle of Manhattan and the hundreds of billions in damages that you could end up with, no tax deferral of cat reserves is going to cover that so you're still back to how do you specifically handle terrorism . . . something like a dirty bomb.

I know we don't like to think this because it seems so foreign to our way of life, yet it is a reality that some incident of that sort could happen. No TRIA will ever handle that. No tax deferral of cat reserves will ever handle that.

Regulator: *We have two elected commissioners here today and I was wondering how difficult it is to deal with budgetary issues as an elected commissioner? Is it easier or more difficult to expand your budget as an elected commissioner?*

Praeger: We've been very fortunate in Kansas. We're fully fee-funded, so we don't have to go and ask for any state general funds. We're the third largest generator of state revenue . . . we still have to go and defend our budget request but the fact that I'm one of them — I'm elected also and have to answer to the same constituency — puts us more on an even playing field.

Poolman: I think even more [than] elected or appointed commissioners, former legislators probably have a pretty good sense of relationships . . . in the Legislature. I can call somebody down there because I already know them, I served with them, we've talked over other issues unrelated to insurance. I can ask them for

*Editor's Note: The NAIC voted, during the December 2004 quarterly meeting, to begin talks with the U.S. Treasury Department on various tax issues, including tax-deferred catastrophe reserving.

help not only in defense of the budget but [also] for potentially added resources.

Praeger: It's a political process and anything can happen and it can be totally unrelated to the kind of job they think you're doing as the insurance regulator so you have to be ready for potential land mines in the political process.

Regulator: *This is kind of an off-beat question directed to the Colorado Commissioner . . . I see smoking is still permitted in most Colorado restaurants, motorcycle helmets aren't mandated, little kids are mutton-busting (riding sheep) at rodeo competitions. We're so concerned with liability issues in much of the counjtry that sometimes I think some of the fun is taken out of life and we're slowly losing a lot of our freedoms. In Colorado it seems that perhaps there's a little different attitude.*

Dean: That's one of the things I like about Colorado. We have a very independent streak. It took several years and pushing very hard by the Governor until just this past year they lowered the blood alcohol level to 0.08 from 0.10 [under the drunk driving statutes], but at the same time the Legislature said, "OK we're going to give you that, but at the same time, we're going to tack on an amendment that says if you buy a bottle of wine at a restaurant you don't have to drink the whole thing there, you can put a cork in it and take it home."

One time someone suggested we might impose a helmet law for skiers and [the immediate response was] "No that's a big tourist draw for Colorado; we're not going to make our skiers [wear helmets]" and that idea just fell flat on it face. As you said, we don't require motorcyclists to wear helmets. Colorado's more of a "live and let live" kind of state . . . .

As a legislator, I voted against seat belts for children in the back seats of cars. Why? Is it because I'm pro-accident? No, it's because I make sure my kids wear seat belts; I always make sure they're buckled up. And I wear my seat belt, but I don't want the government telling me that's the way we have to live. In Colorado that attitude seems to be more prevalent than in a lot of other states.

Some municipalities, like in Boulder, have passed anti-smoking ordinances. They were doing something like that in Denver, but it failed. That's one of the things I like about Colorado. Incidentally, the kids riding the sheep you spoke of usually wear football helmets and they're experienced.

Regulator: *Yes, the kids were wearing helmets, but it looked like the sheep needed them too. They looked more scared than the kids. We'll move from mutton busting now and conclude by asking if there are any questions that weren't addressed in this morning's CDS session that you feel strongly about or think our* Regulator *audience should be aware of?*

Csiszar: The only area we didn't touch on is some of the work in the international area. I think your readers ought to be aware of some of the significant work that's being done on the accounting side because it's going to turn our world upside down if it goes the way it seems to be going. Anything we have in place is based on U.S. GAAP [Generally Accepted Accounting Practices] or SAP [Statutory Accounting Practces].

On the International level, you have IASB, the International Accounting Standards Board, which is working with a 2007 timeline for a revamping of the accounting rules that would make both sides of the balance sheet market-value based. That would obviously mean discounting reserves, arriving at proper market value for reserves and liabilities.

How you're going to do that is difficult to conceive, but there seems to be a clear train in motion. Our U.S. FASB has come up with a treaty with the IASB and . . . made it very clear that when these rules are worked out, the U.S. will adopt these rules. That will force the NAIC to revisit, God forbid, codification.

Regulator: *That is a big issue that hasn't been getting much attention.*

Csiszar: It's not getting much attention because accounting is another one of these things where your eyes glaze over, but it's the language we speak when it comes to solvency.

Regulator: Thank you, commissioners.

IRES State Chapter News

Colorado — In our November meeting, Deputy Commissioner **Susan Gambrill** presented *"The Top Ten Things You Need to Know about Reading a Bill."* In a similar vein, **Julie Hoener**, Director of Legislative Policy offered *"How a Bill Becomes a Law."*
— Dayle Axman; Dayle.Axman@dora.state.co.us

Louisiana — The October State Committee Meeting was held to discuss methods to increase membership in IRES.
— Larry Hawkins; lhawkins@ldi.state.la.us

Nebraska — Our November meeting focused on the Department's Life and Health Division. Speakers included **Jeanne Daharsh**, Actuary/Administrator, **John Rink**, Actuarial Assistant, **LeAnn Hammar**, Life/Health Analyst, **Ron Lobb,** Life/Health Analyst and **Deb Cunningham**, Staff Assistant. They presented an overview of the Life and Health Division and the form/rate filing and review process. The next meeting will be in February. Details of future meetings can be found on the IRES Web site, as they are scheduled.
— Karen Dyke; kdyke@doi.state.ne.us

Oregon — In October, **Jeanette Williams** of the Oregon Dental Service (ODS) Companies gave a presentation on healthcare fraud in Oregon. She discussed some of the fraud practices that are ongoing in healthcare insurance. The Investigation Unit of the Oregon Insurance Division provided a review of its current activity with insurance producers in Oregon. They summarized cases involving the Oregon Insurance Code and discussed possible administrative actions. Insurance producers also received continuing education credits for attending the presentation.

In November, **Scott Seedorf** and **Judy Owen** of the Employee Benefits Security Administration of the U.S. Department of Labor gave a presentation on Multiple Employer Welfare Associations (MEWAs). They also discussed some of the other services offered by the Employee Benefits Security Administration. The Oregon Chapter is in the middle of nominating our 2005 Chairperson, Co-Chairperson and Secretary.
— Gary Holliday; Gary.R.Holliday@state.or.us

IRES membership drive: Earn a free CDS registration!

by Doug Freeman, CIE
Chair, IRES Membership & Benefits Committee

IRES dues notices were mailed out to all current IRES members in December. To avoid a late fee, 2005 IRES dues payments must be received in the IRES office by March 1, 2005.

In order to promote an increase in new IRES regulatory and sustaining (industry) members, the IRES Membership and Benefits Committee has created a financial incentive program.

The person who recruits the most new IRES regulatory or sustaining members from January 1 to July 1, 2005, will earn a free registration to the IRES 2005 Career Development Seminar (CDS) in Tampa! A minimum of five new IRES members must be recruited to qualify for the award.

It's simple: If you have someone who might be interested in joining, send an email to Susan at the IRES office, iresusan@swbell.net. She will send the person a membership application. On the form will be a place for the new member to identify the person who recruited them — you.

The registration fee for the 2005 CDS is $285 for a member regulator and $460 for a member from industry (sustaining member).

If you would like a supply of membership application forms, Susan can send them to you from the IRES office. Or you may print them directly off the web site.

Membership in IRES has many benefits. You are currently reading *The Regulator,* which is mailed to all members and includes the latest in insurance regulatory issues. IRES also provides a forum throughout the year, highlighted at the CDS, where regulators and industry gather to discuss the major insurance issues of the day and the methods and means to provide a level playing field for insurers and protect consumers.

Through its seven standing committees, numerous CDS sections, hundreds of volunteers, state chapters, and dedicated staff, IRES promotes professionalism and the highest quality continuing education through the Accredited Insurance Examiner (AIE) and Certified Insurance Examiner (CIE) designations.

IRES is an important part of the insurance regulatory field and we need you! For further membership information, please contact the IRES office at 913-768-4700 or IRES Membership and Benefits Committee Chair Doug Freeman at (636) 236-9642 or via e-mail at ***Douglas.Freeman@insurance.mo.gov.***

C.E. News

January 1 – Everyone should have received their 2005 dues notices in the mail. There was no increase in dues this year. Be sure and pay your dues before March 1. Part of your designation requirement is to keep your membership current.

May 1-3 – The National Insurance School on Market Regulation will be in San Antonio, TX this year. Attending the full school will earn you 12 CE hours.

July 31-August 2 – The IRES Career Development Seminar will be in Tampa, FL, this year. If you stay until the end and pick up your certificate, you can earn 15 CE hours.

NEW COURSE WORK CHANGES FOR AIE/CIE DESIGNATIONS

Due to changes in LOMA courses effective Jan. 1, 2005, IRES has updated the Accreditation Application. New forms can be found on the IRES Web site at *www.go-ires.org.*

In brief the changes are:

Life and Health Path

LOMA 310 has been changed to LOMA 311- Business Law for Financial Services Professionals.

LOMA 340 has been dropped and IRES will add FLMI 301 – Insurance Administration.

Property and Casualty Path
CIE required courses

FLMI 340 has been dropped and IRES will add FLMI 330 Management Principles and Practices.

National IRES Continuing Education
The mandatory continuing ed program for AIE and CIE designees

Regulatory Roundup

by
Stroock & Stroock & Lavan LLP

MAINE – Bureau of Insurance issues Bulletin on credit scoring

On Oct. 26, the Maine Bureau of Insurance issued Bulletin 329, which provides interpretive and implementation guidance to insurers regarding the credit information and scoring provisions of Section 2169-B of the Maine Insurance Code (MIC). The Bulletin notes, for example, that MIC Section 2169-B(2)(C) states an insurer may not base renewal rates on credit information without consideration of other applicable independent underwriting factors. It is the Bureau's position that, if credit information or an insurance score is the only element that has changed at renewal, rates may not be changed at that time unless the insurer has given consideration to other applicable factors. The Bulletin also indicates that MIC Section 2169-B(2)(E) sets forth that an insurer may not consider the absence of credit information, the number of inquiries or the inability to calculate an insurance score to underwrite or rate personal lines insurance policies, unless the insurer can demonstrate that those factors are relevant to the risk underwritten or rated and the Maine Superintendent of Insurance has approved the use of such factors. "Inquiries" as used in that section, however, is not defined and although the Bulletin does not provide an affirmative definition of "inquiries" it does specify several kinds of inquiries that an insurer may *not* use as a negative factor in preparing an insurance score algorithm or computer model or generally in connection with the insurance underwriting or rating process. Among other inquiries, an insurer may not consider any inquiries requested by an insured for his or her credit information, credit inquiries not initiated by the consumer, inquiries related to insurance coverage and promotional inquiries. The Bulletin also offers interpretive guidance regarding MIC Section 2169-B(5), which requires an insurer to re-underwrite or re-rate a policy within 30 days of receiving notice that the insured's credit information was incomplete or incorrect. The Bureau interprets MIC Section 2169-B(5) to require an insurer to re-underwrite or re-rate *even if* the incomplete or incorrect credit information was not used by the insurer in making its previous decision. *To view Bulletin 329, visit **www.state.me.us/pfr/ins/bulletins/bull329.htm.***

NEW JERSEY – Both houses pass legislation revising property/casualty and surplus lines guaranty fund statutes

As of Nov. 15, both houses of the New Jersey Legislature had passed Senate Bill 702, which amends certain statutes governing the New Jersey Property-Liability Insurance Guaranty Association. The Bill's primary revision affects the definition of "covered claim," which, as revised, excludes first- and third-party claims brought by or against a high net worth insured. A high net worth insured is a person or entity (other than a public entity) that, together with its affiliates as calculated on a consolidated basis, has an aggregate net worth of more than $25 million.

As of Oct. 25, both houses of the New Jersey Legislature had also passed Senate Bill 1581, which amends the New Jersey Surplus Lines Insurance Guaranty Fund Act. Of particular note, the Bill changes the definition of "covered claim" to clarify the scope of covered claims, damages and expenses. For example, counsel fees and other claim expenses incurred prior to the date of insolvency are now expressly excluded from the definition. First-party claims by high net worth insureds (*i.e.*, those with an aggregate net worth in excess of $25 million) are now also excluded from the definition of "covered claim." Senate Bill 1581 further authorizes the Surplus Lines Insurance Guaranty Fund to recover claims paid to or on behalf of high net worth insureds or any person who is an affiliate of an insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made by the Surplus Lines Insurance Guaranty Fund.

The stated purpose of Senate Bills 702 and 1581 is to dissuade high net worth consumers from purchasing insurance from insurers that under-price their insurance coverage. High net worth insureds, according to the Statements accompanying each of the bills, are sophisticated consumers with the resources necessary to shop around for properly priced insurance co verage. *To view Senate Bills 702 and 1581, visit **www.njleg.state.nj.us.***

The New York-based Stroock & Stroock & Lavan LLP Insurance Practice Group includes partners Donald D. Gabay, Martin Minkowitz, William D. Latza and William Rosenblatt. The Insurance Practice Group also includes insurance finance consultants Vincent Laurenzano and Charles Henricks. They gratefully acknowledge the assistance of Robert Fettman, a law clerk, and Todd Zornik, an associate in the group. This column is intended for informational purposes only and does not constitute legal advice.

NEW JERSEY – Department of Banking and Insurance issues Bulletin regarding producer conduct requirements

On Oct. 22, the New Jersey Department of Banking and Insurance issued Bulletin 2004-20 regarding insurance producer conduct requirements. The Bulletin is intended to reiterate producers' obligations following the recent allegations of producer wrongdoing by New York's Attorney General and several insurance departments. Among other requirements, the Bulletin reminds insurance producers that they are required to act in a fiduciary capacity in the conduct of their business. The Bulletin also draws attention to New Jersey insurance regulations that require an insurance producer to obtain a written agreement from insureds and prospective insureds in connection with any fees. The agreement must include a clear statement of the amount of the fee, the nature of the service being provided and whether the producer will receive a commission from the insurer upon the purchase of the insurance. The Bulletin also reiterates that fees must not be discriminatory and must bear a reasonable relationship to the services being provided and no fee may be charged for services that are not actually performed. Service fees in connection with property/casualty and personal lines/surplus lines insurance may not exceed $20; however, a person acting as a broker or consultant upon placement of a renewal may only charge up to a maximum of $15, subject to certain exceptions. No service fee may be charged in connection with life or health insurance. The Bulletin states that the Department has in the past and may in the future impose penalties on producers "who intentionally misrepresent the terms of a contract, commit any insurance unfair trade practice or fraud, or use any fraudulent or coercive or dishonest practice." *To view Bulletin 2004-20, visit* ***www.state.nj.us/dobi/bulletins/blt04_20.pdf.***

NEW YORK – Legislation governing the use of credit information enacted

New York Assembly Bill 04754, which adds a new Article 28 to the New York Insurance Law governing insurers' use of credit information, passed both houses of the New York State Legislature and was forwarded to Governor Pataki on July 15. According to a representative at the Legislature, the Bill automatically became law on July 27, 2004 after the governor declined to sign it. The Bill's provisions will become effective 270 days after that date. Assembly Bill 04754 imposes on insurers various requirements providing consumers with protection in connection with the use of credit information. For example, an insurer may not deny an application for personal lines insurance coverage solely on the basis of credit information. In addition, an insurer may consider the absence of credit information or the inability to calculate a credit score in the personal insurance underwriting and rating process only in limited circumstances (for example, if the insurer treats the insured/applicant as if he or she had neutral credit information). Assembly Bill 4754 also requires insurers to re-underwrite or re-rate a consumer within 30 days of receiving notice of any determination through the federal Fair Credit Reporting Act dispute resolution process that an insured's credit information was incomplete or inaccurate. The Bill also imposes on insurers various notice requirements, including having to provide initial notice to consumers if the insurer uses credit information in the personal insurance underwriting process and notice of any adverse action that is taken based on credit information. Credit scoring models and revisions thereto must be filed with the Superintendent of Insurance within specified time frames. *To view Assembly Bill 4754, visit* ***www.assembly.state.ny.us.***

WASHINGTON – Office of the Insurance Commissioner issues Memorandum regarding insurance broker duties and requirements

In response to recent investigations into alleged misconduct involving insurance producers and insurers, the Washington Office of the Insurance Commissioner issued Memorandum 10-21-2004 regarding the duties of Washington insurance brokers. The Memorandum reiterates the requirement that all compensation arrangements between an insurer and an insurance broker must be memorialized in a written agreement between the parties. Insurance brokers are required to disclose to an insured all compensation arrangements prior to any product decision. Such disclosure must be executed in a manner that is sufficiently complete and understandable to allow the insured to consider the incentives to its broker in placing the business and the costs of the coverage. Insurers, on the other hand, are reminded that they must consider all commissions and other compensation paid to agents and brokers when determining premium rates. Insurers are also required to maintain a record of all broker compensation arrangements, including an explanation of the basis for the compensation. The Memorandum also reminds insurers that they are required to routinely audit their records to confirm that all compensation paid to brokers complies with Washington laws and regulations. The Memorandum encourages insurers that identify any non-compliant arrangement to self-report such findings to the Office of the Insurance Commissioner. *To view Memorandum 10-21-2004, visit* ***www.insurance.wa.gov/oicfiles/techadvisories/T05-05.pdf.***

Casual Observations

Reality Check

If you hate reality shows as much as we do, you should know there's someone to blame: insurance companies. That's right, insurers are the ones responsible for removing the fear of litigation from *Fear Factor* and permitting *Survivor* to survive an onslaught of greedy trial lawyers. Without coverage for their off-the-wall stunts, these shows surely would have been killed off in development.

After all, there are but four essential elements to a reality show's success: (1) get the shows "creative team" to devise outrageous stunts like devouring worms or jumping off cliffs (having the mind of an eight-year old helps when concocting such stunts); (2) find participants dumb enough to risk life and limb for their 15 minutes of fame; (3) get these dummies to sign waivers absolving anyone associated with the show of responsibility; and (4) secure insurance coverage.

The waivers are an essential element of securing insurance coverage. Without them, insurers wouldn't touch these risks with a ten-foot pole. The waivers cover every possible contingency. For example, *American Idol's* release form says "I understand . . . other parties may reveal information about me that is of a personal, private, embarrassing or unfavorable nature, which information *may be factual and/or fictional*. (Italics added.) And at last count, *Survivor's* legal release was 92 pages long!

The release, of course, doesn't prevent a participant from filing suit, therefore insurance is still a must. The waivers do, however, help convince juries that anyone who would undergo such humiliation *and sign a release* doesn't deserve a dime's worth of damages. They also tend to dissuade these dumber-than-dirt contestants from suing in the first place.

We always imagined that pricing insurance for Betty Grable's legs would be tough: we can't imagine how one properly prices a policy for eating cow intestines mixed with Madagascar cockroaches. And such coverage isn't cheap. In fact, insurance costs for reality shows typically *start at* 3-5% of a show's total expenses, even though these shows employ the best risk management strategies imaginable.

But despite the waivers and the high-powered risk management techniques, lawsuits against these shows still manage to crop up. Many of the earliest suits focused on physical injuries, but lately mental anguish cases have surfaced.

We offer a modest proposal that would move these cases out of our courtrooms and help reduce insurance costs. What if both sides were to get their attorneys to compete in an earthworm-eating contest to determine fault? The contest would be aired on Court TV with profits going to the plaintiff should his attorney win. Hmmm, trial lawyers eating earthworms; now that's a reality show we'd watch. — *W.C.*

An IRES blessing: May you enjoy a healthy 2005

The 2005 IRES Career Development Seminar

JULY 31 - AUG. 2, 2005 TAMPA MARRIOTT WATERSIDE

Early Bird Registration Form

Fill out and mail to IRES: 12710 Pflumm Rd, Suite 200, Olathe, KS 66062

Yes! Sign me up for the 2005 IRES Career Development Seminar. My check payable to IRES is enclosed.

Name

Title First name for Badge

Insurance department or organization

Your mailing address Indicate: ☐ Home ☐ Business

City, State, ZIP

Area code and phone

$ Amount enclosed

Seminar Fees

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

Check box that applies

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

PAID Spouse/Guest name

If registering after June 29, add $40.00. No registration is guaranteed until payment is received by IRES.

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

Hotel Rooms: You must book your hotel room directly with the Tampa Marriott Waterside. The room rate for IRES attendees is $139 per night for single-double rooms. Call group reservations at 888-268-1616. The IRES convention rate is available until June 29, 2005 and on a space-available basis thereafter. Our room block often is sold out by early June, so guests are advised to call early to book rooms. See the hotel's web site at http://www.tampawaterside.com

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

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

CANCELLATIONS AND REFUNDS

Your registration fee minus a $25 cancellation fee can be refunded if we receive written notice before June 29, 2005. 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, 2005.

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

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

BULLETIN BOARD

√ All AIE and CIE holders are urged to check out the important Continuing Ed news developments on page 15 of this issue. If you aren't sure about the status of your continuing ed compliance, do NOT delay. Contact Susan Morrison right away at the IRES office, 913-768-4700

√ 2005 dues notices for regulators were mailed out just before Christmas. To avoid a late fee of $15, make sure your dues are received at the IRES office by Feb. 15.

√ Although we'll miss her regulatory expertise, we send congratulations to Oregon's Jann Goodpaster, a past IRES President, on her move to the private sector.

In the next REGULATOR:

Stopping health insurance scams in their tracks

Analyzing market analysis

√ **The Producer Dilemma**

The Regulator®

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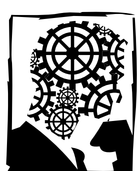

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