INSURANCE REGULATORY EXAMINERS SOCIETY

NAIC Model Producers Act

What hath Spitzer wrought?

by Scott Hoober
Special to *The Regulator*

As essential as the insurance industry may be to our nation's economic life, no one would be surprised to learn that it is unloved.

After all, the very act of buying insurance is a negative one, a reminder of mortality, of the inevitable rule of life: Bad things happen to good people.

So when someone, anyone, oh, say, the attorney general of a large state, says insurance agents are rigging bids, plenty of Americans will simply nod their heads and say "I thought so all along."

But what it doesn't mean is that all producers are acting to harm rather than help consumers, and that insurance regulators need to come down on all producers far more stringently than in the past.

Conflict of interest

There are certainly those who have accused New York Attorney General Eliot Spitzer of grandstanding. Yet his initial allegations, of specific misconduct by specific brokers at Marsh & McLennan, Aon and other firms, clearly involve serious offenses — as evidenced by the $850 million that Marsh recently agreed to pay to settle.

But even such a crusader as Spitzer could well be uncomfortable with the direction his probe has taken in the hands of others.

As Julie Rocheman of the American Insurance Association (AIA) says, the initial allegations involved a few individuals. "But Spitzer's broader statements impugn the work of tens of thousands of agents and brokers and other people in this industry.

"If you find specific instances of wrongdoing, deal with those," she said.

Trouble is, in our litigious society, with partisan talk show hosts screaming at their guests and doomsayers seeing evil at every turn, people like Rocheman sound like apologists. We all know the first rule of criminal investigation: Where there's smoke, there's fire.

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ERISA & MEWAs: Where states fit in?

by Luke S. Brown

Editor's Note: *Many health insurance plans claim that state insurance departments lack authority over them due to ERISA preemptions. Luke Brown explains why such claims, in most cases, are false, particularly when it comes to plans that are* bona fide *MEWAs. Although the author makes references to Florida statutes, the article is geared to regulators in all 50 states.*

Unlicensed insurance transactions pervade all lines of insurance and other risk-bearing activity,[1] however, some of the most pernicious activity is in the health insurance arena. This activity has intensified in recent years as a result of the hard health insurance market. Perpetrators have also become more sophisticated and the schemes themselves have become more complex. Nevertheless, common denominators transcend these frauds which regulators need to recognize and understand.

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From the President

Insurmountable Obstacles?

I frequently hear concerns from regulators who look at the challenges facing state regulation as insurmountable obstacles. Every day we confront new criticisms of our work and we hear the ways we have regulated the insurance industry are now considered outmoded and inadequate for the times. Then we see further cuts in state budgets and learn, once again, we must do more with less. I see the frustration in my own staff as they attempt to prioritize important projects, knowing that whatever is moved to the back burner will likely boil over in the not-too-distant future.

We're all on a treadmill, but sometimes we need to step off and look more closely at where we are. The states have made incredible progress related to uniformity of processes; especially, producer licensing, market conduct examinations and market analysis. Most states are making the shift to market analysis-based regulation as the first Level I and Level II reviews are being completed.

However, when I talk with the front-line staff in state insurance departments as well as other departments, I often hear: "How do I fit into the new processes?" I find several key traits common to those staff members who excel in today's regulatory environment. First, there is great opportunity for recognition and growth for those willing to look at current practices and say: "You know, we could do things this way and solve more problems," rather than, "Gee, we've always done it this way." In the past, some managers did not want to hear suggestions for different ways of doing projects, now the same managers are looking to staff for advice on improving operations.

Secondly, if you find your job routine and boring, it's time to reassess your situation. Regulatory work is most likely to be dull when performed in a vacuum. If you are an examiner doing routine exams, it is more likely that the work will be less than challenging if you're doing only technical reviews, *i.e.*, verifying the "i's" are dotted and the "t's " crossed. Market conduct work becomes exciting when it is problem based and when examiners are looking at company procedures and practices to determine why consumers are dissatisfied and then researching the bigger issues that really hit the consumers in the pocketbook.

Likewise, for complaint analysts, it is much more exciting to look for patterns and practices of wrongdoing, rather than working one file at a time, stack by stack. For rate and form analysts, it's so much more interesting to begin looking at rating practices of a company, considering market issues and financial considerations, rather than focusing on technical requirements.

Third, now is the time for anyone who is interested in the workings of other sections and other agencies to begin broadening and sharing knowledge. For too long regulatory work has consisted of many different processes and each staff member performing his or her own task in an assembly-line process. Now the future of regulation falls to the regulator who not only performs his or her job well, but also understands how they fit with the rest of the regulatory environment.

Successful regulators in the current environment are those who see patterns and trends by company and by industry group. They know when to refer an issue for examination or investigation. They know to make recommendations for changes in laws and to address new concerns. They work as teams, one day with complaint staff and another day with financial regulators. And most of all, they share their knowledge.

I have met regulators who felt that "knowledge is power" and that somehow the sharing of knowledge with peers would make them less important. Today, being a resource is power. Those who will be promoted and valued as top staff are those regulators who will share knowledge and exchange ideas for the betterment of the agency and the regulatory process.

Sound familiar? Again, I end at the same conclusion. Become involved in your education and the development of the staff around you. Share ideas, become a team, and enjoy the new challenges and broadening horizons. There are many ways for this to happen, but as an IRES member you are already aware of one of the best. Join, be active, grow and share your lifelong knowledge. What could be a greater opportunity?

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Agents and brokers on the hot seat

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But sometimes there's only smoke. And frankly, that seems to be the case here.

NAIC response

Though the NAIC's Broker Activity Task Force added an amendment to the Producer Licensing Model Act in response to Spitzer's investigation, there's a serious question whether it needed to.

The biggest problem with broad-brush accusations is that they lump together agents, brokers and others who sell insurance products.

Spitzer's most telling accusations have been against large brokers, the people who sell large, sophisticated products to large, sophisticated commercial customers, and who charge a fee for doing so. To extrapolate from those cases, as Robert Hunter of the Consumer Federation of America (CFA) and others have done, seems a stretch. Even if every single commercial broker was a crook, how does that imply that local insurance agents' compensation structure reduces competition and raises costs for consumers seeking auto or homeowners coverage?

> ***"Consumers have a right to expect that when they seek help, they get what they need, not what some agent is rewarded for by this company vs. that one."***

Yet the accusation is that all agents behave as some large commercial brokers have, saying they represent their customers' best interests when they actually represent insurers' interests.

It all boils down to who pays the producer.

Consumers have a right to expect that when they seek help, they get what they need, not what some agent is rewarded for by this company vs. that one. The reality, though, is that most consumers probably don't even think about how "their" agent is compensated — though if you asked them to think about it, they'd no doubt assume the guy is paid, and wouldn't be surprised to learn that it's via a percentage of premium.

Yet if the agent you choose to go to is in the Allstate office in the strip mall down the street, don't you expect he'll offer you an Allstate product — and hence be rewarded for selling you an Allstate product?

And realistically, even the most thorough of independent agents represent only a small portion of the hundreds of available insurers — and his or her compensation ultimately comes, directly or indirectly, from the insurer too, just like the captive agent. How am I, as a consumer, harmed?

CFA and other consumer-oriented groups allege that agent-broker compensation can reduce competition and raise premiums. Even Hunter's group would likely agree, though, that captive agents don't receive contingent fees — yet as the AIA points out, CFA admits in its own report, *Contingent Insurance Commissions: Implications for Consumers*, that 60% of auto and homeowners insurance is written by captive agents and direct writers.

Critics have nitpicked the way CFA selected which insurers to highlight in its report, yet a sizable number of the personal-lines writers CFA focused on don't use contingent fees.

Besides, says the Insurance Information Institute (I.I.I.), an association of property-casualty companies, contingent fees are too small to influence most agents — about 1% of all premiums written and just 0.14% in auto — and in any case, the competitive insurance marketplace would punish anyone who got out of line.

Fully two-thirds of P&C insurance companies pay contingent fees, says I.I.I. "If the payment of contingent commissions led to consistently higher prices for insurance," adds the institute's recent *Analysis of the Consumer Federation of America Report on Contingent Commissions,* "companies that pay those commissions would be driven from the market because their products would not be price competitive."

The model act

Sharon Emek, a New York City agent who serves as secretary-treasurer of the Independent Insurance

Agents and Brokers of New York, would agree that competitive pressures keep her and her peers honest.

"I've got 15 agents who would love to steal my clients," says Emek. "All I have to do is make one mistake, and they're knocking on the door, if somebody feels that they're not getting good service or the best price."

She's in Spitzer's backyard and has listened carefully to his testimony and other public utterances, and she doesn't think the New York AG ever meant his accusations to be spread equally among commercial brokers and personal-lines agents.

"I think NAIC is going overboard," Emek said. "It's an overreaction. I mean, independent agents don't operate the same way as brokers. And the profit-sharing on the back end [by which companies compensate independent agents] isn't even tied to any one account. . . . A broker can charge anything that a risk manager or a corporation is willing to pay. An independent agent can't charge anything."

"I think NAIC is going overboard. It's an overreaction."
— Sharon Emek

Some critics and regulators have said that a broad-brush approach is the only way to go, since it's sometimes hard to distinguish an agent from a broker. Emek disagrees with that contention too.

"It's very clear," she said. "There are two kinds of brokers. There are the national brokers who charge a fee for everything, and they don't take any commission from the carriers. And then there are agents and brokers, who are at the lower level, who basically take commissions whether they're acting as an agent or a broker."

And there's a big difference between commercial and personal lines, as well as the large and significant difference between independent agents and captive agents and direct writers.

"The worst thing they could ever do is try to disclose on personal lines," Emek added. "It would be a nightmare, it would be awful."

Within the industry, plenty has been written on this issue. The NAIC site alone contains a plethora of verbiage, including commentary from associations and individuals *(**www.naic.org/committee_activities/executive/brokers_tf.htm**)*.

The core of the dispute is the surprisingly brief Subsection B of the amendment to the Producer Licensing Model Act , which states, in its entirety:

B. An insurance producer must disclose the following, if applicable, to a customer, prior to the purchase of insurance:

(1) That the producer will receive compensation from an insurer or other third party for the sale;

(2) That the compensation received by the producer may differ depending upon the product and insurer(s); and

(3) That the producer may receive additional compensation from an insurer or other third party based upon other factors, such as premium volume placed with a particular insurer and loss or claims experience.

Sounds simple enough. And that may be the problem.

Every industry group that's expressed an opinion agrees that Subsection B is too vague and broad. Even the *Center for Economic Justice* says that "generic disclosures are worse than no disclosure at all."

NAIC critics add that specificity would avoid tarring all in order to catch the few, and that current statutes and regulations are quite enough to accomplish these goals.

The Independent Insurance Agents & Brokers of America (The Big "I") has written that the proposed legislation is "burdened by its overly broad scope, imprecise nature and a lack of clarity."

The National Association of Professional Insurance Agents (PIA) says: "Any model act imposing a single, inflexible statutory fiduciary responsibility on producers, agents or brokers . . . will interfere with what insurance common law has set out[:] a series of clear, relatively uniform fiduciary obligations for insurance

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What hath Spitzer wrought?

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producers to heed. . . . That insurance common law flexibility serves the consumers best."

The good news, if you can call it that, is that relatively few consumers — or legislators — seem to be paying attention to the dispute.

"The incoming president of the Big I was with us a few weeks ago at a meeting, and he said that when he travels across the country, most states don't even know what we're talking about," Emek said. "Most consumers have no idea. The majority of them don't have any idea what is going on with Spitzer. They don't even know who Marsh or Aon are."

Overreacting

How did we come to the point of writing model acts that regulate things that don't seem to be happening?

To begin with, Spitzer's other probes into stock manipulation and the like have given the man a great deal of credibility. Both the AG and his counterpart in insurance regulation, New York's former Superintendent Greg Serio, have done some back-pedaling in recent weeks and months, discouraging excessive or overly broad reaction to the Marsh-Aon findings.

Serio, speaking as part of a panel of the Property/Casualty Insurance Joint Industry Forum, cautioned against "overreaction."

"People ask if there is any possible situation, any fact set, under which it would be appropriate for a broker to accept compensation from both an insured and an insurer, and I think the answer is yes," he said.

"The underlying problem arises when what was materially driving the business shifted from serving the client to maximizing compensation by any means necessary."

Sometimes we have to face the facts: More regulation isn't always better regulation.

At the same conference, Brian Sullivan, editor of Risk Information, cautioned that seemingly simple disclosure would end up too cumbersome to do anyone any good.

"By the time the lawyers get through with it, you'll have what we got in the life industry after all the fuss of the early '90s, where every policy is accompanied by 27 pages of illustration nonsense," he was quoted by *BestWire*. "Once you start chronicling every possible machination, every twist and turn and potential bonus, what is meant to be more disclosure becomes, in practical effect, less. "

Though many people expect the NAIC to back down, it doesn't seem to getting set to do so.

The association's president, Pennsylvania's M. Diane Koken, agrees that "it's very difficult to come up with a bright-line distinction between brokers and agents. [But] my question would be, 'Why is more disclosure bad?'"

Not only does the commissioner's association seem to have gone a bit overboard, some observers have noted another irony. A few states' AGs, seeing Spitzer's success, have been proposing their own legislation — bypassing both the local commissioner and NAIC. It's not a big trend, but it does make you wonder whether championing an issue with less than universal support is, long-term, a wise move.

We're going to go out on a limb here and predict that NAIC, for all its proud words, will soon come to its senses and issue a producer licensing model act that imposes few if any additional disclosure rules, at least not on all producers.

Insurance regulation is a vital function, but sometimes we have to face the facts: More regulation isn't always better regulation. ■

MEWAs

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For many years, devious promoters have used *de facto* Multiple Employer Welfare Arrangements (MEWAs) as mechanisms by which to market illegal health insurance plans to employers for their employees. These arrangements have sometimes been referred to as "multiple employer trusts" or "METs". Despite the utilization of the term "trust" in the phrase, no *bona fide* fiduciary relationship exists with some of these plans, at least as far as the perpetrators of the schemes are concerned. The term is simply used to create an aura of legitimacy. This is not to say that there are no legitimate MEWAs. Most jurisdictions provide for the licensure of MEWAs under governing insurance statutes, and those that do become licensed can operate lawfully.[2]

Promoters typically represent to employers, agents, and insurance regulators that the plans are "employee benefit plans" within the meaning of the Employee Retirement Income Security Act (ERISA)[3] and therefore exempt from insurance regulation under broad principles of federal preemption. (In fact, they often deny their plans are MEWAS.) Those representations underlie many of the issues surrounding these illicit insurance products.

Such plans are marketed as an alternative to higher cost — and frequently less available — traditional indemnity health insurance products. Promoters claim the plans are "not insurance" and therefore not subject to state insurance reserve, contribution, participation, and other requirements.

ERISA

ERISA is a complex body of federal statutory law that governs employer-sponsored health and welfare benefit plans. Enacted in 1974, ERISA gave the U.S. Department of Labor enforcement responsibility. The law covers only those plans, funds or arrangements that constitute an "employee welfare benefit plan" or an "employee pension benefit plan." In other words, the law deals with matters relating to employer-sponsored health insurance-like plans and with retirement (pension) plans. Since a MEWA provides only health insurance benefits (not pension benefits), it is the primary insurance concept emanating from ERISA.

ERISA defines an "employee welfare benefit plan," in part, to be:

> *". . .any plan, fund, or program which was heretofore or is hereafter established or maintained* ***by an employer or by an employee organization,*** *or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,* ***(A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death*** *or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . ." (emphasis added)*[4]

Analysis

Several steps are involved in determining whether a health plan is within the scope of ERISA pre-emption from state insurance regulation.

First, one must determine whether a plan falls within the ERISA definition of "employee welfare benefit plan." In practice, the provision of virtually any kind of health, medical, sickness, or disability benefit will bring the plan within this definition, regardless of whether there is a written, formal program for providing such benefits and regardless of whether the benefits are funded (through an insurance policy or a trust) or unfunded (such as paid from the general assets of the employer—*i.e.*, "self-insured").

Next, if the plan meets the above criteria, it must be determined whether the plan was "established or maintained by an employer or by an employee organization," or both. ERISA defines "employer" as:

> *". . . any person acting directly as an employer, or indirectly in the interest of any employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."*[5]

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ERISA & MEWAs: Where states fit in?

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Accordingly, an employee welfare benefit plan can be established by a single employer or by a group of employers that have joined together for the purpose of providing employee benefits.

Although it is generally easy to determine whether a single person or entity qualifies as an "employer," the status as "employer" can become murky when benefits are provided through an association of unrelated employers. In making this determination, the following factors must be considered:

i) how are members solicited?
ii) who is entitled to participate in the association, and who actually does participate?
iii) how was the association formed?
iv) why was the association formed?
v) what were the prior relationships of the members of the association?
vi) what powers, rights, and privileges do the employer-members have?
vii) who actually controls the day-to-day activities and operation of the benefit program?[6]

As noted above, ERISA also recognizes plans established or maintained by "employee organizations." That term is defined by statute, and contemplates two types of organizations. The main type is a labor union. In order for a union to come within the ambit of ERISA coverage, employees must participate in it as voting members, and the organization must, at least in part, exist for the purpose of *bona fide* collective bargaining over terms and conditions of employment.

Every unlicensed health insurance plan that purports to fall under ERISA claims it is exempt from state insurance regulation. But in how many cases is this true? The claim of preemption offered by many unlicensed health insurance plans is rooted in Section 29 USC ss.1144(a) (*i.e.*, Section 514(a) of the ERISA Law), which states that ERISA

> "*. . . supersede[s] any and all State laws insofar as they...relate to any employee benefit plan. . . .*"

However, the scope of "preemption" is far narrower than the purveyors of unlicensed health insurance represent. This is due to the "Savings Clause" (29 USC ss.(b)(2)(A)) within ERISA that limits the sweep of 29 USC ss.1144(a). The Savings Clause provides that nothing in ERISA

> "*. . . shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.*"

To further clarify the intended scope of ERISA in regulating an employer-based plan, the "Deemer Clause" was included (29 USC ss.1144(b)(2)(B)). It provides, in part, that no employee benefit plan or trust

> "*. . . shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . .*"

Stated differently, the fact that ERISA preserves state regulatory authority over insurance should not be interpreted to mean that a legitimate ERISA plan providing health benefits can be "deemed" to be insurance. Despite the similarity of benefits afforded by the plan and by a health insurer, *a genuine single-employer ERISA plan is not subject to direct state insurance regulation*.

The net effect of the statutory provisions is that while ERISA may govern an employee benefit plan, its jurisdiction is not exclusive. For example, the state insurance regulator still has jurisdiction over the insurer that is financially responsible for the payment of claims in an insured ERISA plan and over the forms used by that insurer to provide the coverage.

MEWA Dilemma

MEWAs are risk-bearing entities regulated by the insurance laws in most states. In general, these insurance laws define MEWAs to be employee welfare benefit plans or other arrangements established or maintained to provide one or more insurance benefits (including health insurance) to the *employees of two or more employers*. Therefore, a MEWA *cannot* be a single-employer plan so as to exempt it from state

insurance regulation because it provides benefits to the employees of multiple, not merely one, employer.

ERISA also defines and recognizes MEWAs and in general provides that it applies to certain kinds of them (29 U.S.C. ss.1002(40)(A)). Therefore, there is concurrent state and federal regulatory authority over most employee welfare benefit plans that are also MEWAs.

Exceptions to MEWA definition

"Union Plans" can be an exception to the MEWA definition (that is, not constitute a MEWA) and therefore, also an exception to the general rule of concurrent state and federal regulatory authority. However, for the exception to apply, the U.S. Department of Labor must make an *express finding* that the collective bargaining agreements between that union and the employers are *bona fide*. Absent such an express finding, the plan remains subject to state regulation as a MEWA.

In general, association-based health plans are not currently exempt from state insurance regulation for at least two reasons: (a) there is no employer-employee relationship; and (b) by statute in many states, they must be fully insured (therefore, at a minimum, the insurer is subject to regulation).

It should be noted, however, that federal legislation approved by the House of Representatives, but not yet by the Senate, may change that. If enacted, the legislation would remove association health plans from the ambit of state insurance regulation, and permit them in states where they are now prohibited. Ostensibly to be regulated by the federal government, the plans could be either self-funded or fully insured.

"Professional Employer Organizations" (PEOs), also sometimes called "Employee Leasing Companies," present special issues, and have been targeted by purveyors of illicit insurance. Although there is purported to be a "co-employer" relationship established between the employer and the PEO, in reality, the PEO handles purely administrative tasks, whereas the original employer continues to direct job functions and retains the right to hire and discharge staff. A PEO-sponsored health plan is not exempt from state insurance regulation under ERISA because there is no true employer/employee relationship between the employee and the PEO. Some states, including Florida, statutorily prohibit PEOs from sponsoring self-insured health plans. [7]

Summary & Conclusions

A fully self-insured, single-employer health plan that qualifies under ERISA is ordinarily not subject to direct state insurance oversight. However, if there exists risk-bearing activity, including financial responsibility for the payment of claims of the employees and/or their dependents of two or more unrelated employers, the plan is likely either a MEWA or an insurer, and is subject to state insurance licensure and regulation. In addition, if there is commingling of funds of multiple, unrelated employers *at any level*, including by the purchase of a single stop-loss policy to cover more than one employer's plan, state insurance regulation is triggered. ■

Endnotes

[1]The reference to "other risk bearing activity" pertains to the increased prevalence of unlicensed activity in areas that, while often subject to State insurance regulation, are often not considered to be "insurance" in the customary sense. Among these include operations such as Service Warranty Organizations.

[2]See, for example, Sections 624.437, *et seq.,* Florida Statutes

[3] 29 U.S.C. 1001, *et seq.*

[4] 29 USC ss.1002(1)

[5] 29 USC ss.1002(5)

[6] U.S. Department of Labor, *Multiple Employer Welfare Arrangements under ERISA: A Guide to Federal and State Regulation*, pp 12-13

[7] Sec. 468.529(1), *Fla. Stat.*

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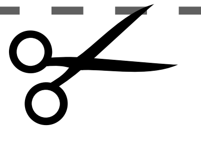

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FL	Kevin McCarty	Appointed	850-413-5914
GA	John Oxendine	Elected	404-656-2056
GU[a]	Artemio B. Ilagan	Appointed	671-475-1843
HI	J.P. Schmidt	Appointed	808-586-2790
IA	Susan Voss	Appointed	515-281-5705
ID	Gary L. Smith	Appointed	208-334-4250
IL	Deirdre Manna	Appointed	312-814-2427
IN	Jim Atterholt[b]	Appointed	317-232-2385
KS	Sandy Praeger	Elected	785-296-3071
KY	Martin J. Koetters	Appointed	502-564-6027
LA	J. Robert Wooley	Elected	225-342-5423
MA	Julie Bowler	Appointed	617-521-7794
MD	Alfred W. Redmer Jr.	Appointed	410-468-2090
ME	Alessandro Iuppa	Appointed	207-624-8401
MI	Linda Watters	Appointed	517-373-0220
MN	Glenn Wilson	Appointed	651-296-5769
MO	Doug Ommen	Appointed	573-751-4126
MS	George Dale	Elected	601-359-3569
MT	John Morrison	Elected	406-444-2040

for more information: contact Insurance Regulatory Examiners Society, ireshq@swbell.net

NC	Jim Long	Elected	919-733-3058
ND	Jim Poolman	Elected	701-328-2440
NE	Tim Wagner	Appointed	402-471-2201
NH	Roger A. Sevigny	Appointed	603-271-2261
NJ	Donald Bryan	Appointed	609-292-5360
NM	Eric P. Serna	Appointed	505-827-4601
NV	Alice Molasky-Arman	Appointed	775-687-4270
NY	Howard D. Mills[b]	Appointed	518-474-4567
OH	Ann Womer Benjamin	Appointed	614-644-2658
OK	Kim Holland[c]	Elected	405-521-2668
OR	Joel Ario	Appointed	503-947-7980
PA	Diane Koken	Appointed	717-783-0442
PR[a]	Dorelisse Jurabe Jimenez	Appointed	787-722-8686
RI	Joseph Torti III	Appointed	401-222-5466
SC	Eleanor Kitzman	Appointed	803-737-6212
SD	Gary L. Steuck	Appointed	605-773-4104
TN	Paula Flowers	Appointed	615-741-6007
TX	Jose Montemayor	Appointed	512-463-6464
UT	Kent Michie	Appointed	801-538-3800
VA	Alfred W. Gross	Appointed	804-371-9694
VI[a]	Vargrave A. Richards	Appointed	340-774-7166
VT	John Crowley	Appointed	802-828-3301
WA	Mike Kreidler	Elected	360-725-7100
WI	Jorge Gomez	Appointed	608-267-1233
WV	Jane L. Cline	Appointed	304-558-3354
WY	Ken Vines	Appointed	307-777-7401

[a] AS: American Samoa; GU: Guam; PR: Puerto Rico; VI: Virgin Islands
[b] At press time, these individuals were serving as Acting Superintendents.
[c] Appointed following the resignation of elected Director Carroll Fisher.
Source: National Association of Insurance Commissioners. Index is current as of February 1, 2005.
Individual state Web site addresses available via www.naic.org. Prepared by Kathleen McQueen.

Market Analysis – An Examiner's Perspective

by Craig L. Leonard

Examiners work hard. Having spent 13 years as an examiner for both a state insurance department and a professional services contractor, I am aware of the pressures and demands associated with the job. As an examiner, I wanted to be sure that when I was conducting an examination, I was looking at the right documents for the right reasons. While one can argue that examiners can always find a violation, good examiners know which findings are most important from a consumer perspective.

Tightening state budgets require examiners to do more with less. To expect examiners to be the sole monitors of the insurance market is both overwhelming and unrealistic. Many examiners have had to focus on fixing a problem rather than preventing its occurrence in the first place.

Additionally, examiners sometimes feel their hard work is not as beneficial as it could be due to system deficiencies. For example, some states routinely bury their market conduct examination reports without alerting other states of important findings. Even worse, some examiners are told to look the other way because a violation does not appear to affect consumers in their state.

Market Analysis (MA) is not just a precursor to doing a market conduct examination. It was developed based on the realization that states have very limited resources and must focus their efforts where they can be most efficient and effective. Instead of looking at an examination as a "first step," examiners should consider what other options might be appropriate before initiating an examination.

Market Analysis should be an appealing notion to examiners. It is a system whereby examiners can be assured their hard work and professional expertise is producing the intended results. Proper Market Analysis will ensure that if a company was selected for an examination, it was for the right reasons. Examiners work hard—and Market Analysis will ensure such hard work is paying off.

Craig Leonard, CIE, CPCU, FLMI, is the NAIC's Market Analysis Manager and a former Missouri state insurance department regulator. As Market Analysis Manager, Mr. Leonard oversees market analysis activities and maintains responsibility for all aspects of the NAIC market analysis process.

Defining MA

Market Analysis is a system of collecting and analyzing data and other information that enables a regulator to identify general market disruptions and important market conduct problems as early as possible to eliminate or limit harm to consumers. A primary goal of Market Analysis is to assist states in being proactive in their efforts to protect consumers.

Regulators can conduct Market Analysis at a variety of levels with a variety of techniques. For example, a regulator can apply rigorous statistical modeling to large amounts of data, or can have an informal discussion about an issue with co-workers over coffee. Market Analysis consists of all of the tools used to identify companies for further analysis. And while many Market Analysis tools are quantitative (data driven), one should not overlook qualitative (event-driven) tools.

Market Analysis is not new — but having a uniform nationwide Market Analysis process is. The current emphasis is on formalizing many of the tools previously used by states in identifying companies for further analysis and creating new tools to even better refine the process.

Who Supports MA?

In the summer of 2003, NAIC members developed the Regulatory Modernization Action Plan that set a broad general goal of implementing Market Analysis in all 50 states. Later in 2003, the General Accounting Office (GAO) issued a report also recommending a routine and systematic Market Analysis process to increase both efficiency and effectiveness of state regulation.

Shortly thereafter, the National Conference of Insurance Legislators (NCOIL) released a report calling for a fundamentally new state insurance market-conduct surveillance system that included the groundwork for Market Analysis. NCOIL and the NAIC jointly

developed a model act based on the NAIC's Market Analysis Handbook.

Consumer groups such as the Texas-based Center for Economic Justice and Housing Opportunities Made Equal have also promoted Market Analysis as a means of increasing effectiveness, while the insurance industry has embraced the concept due to its desire for increased efficiencies.

MAWG

NAIC membership recognized the importance of Market Analysis several years ago and created the Market Analysis Working Group (MAWG) as a forum for coordinating state Market Analysis programs; evaluating effectiveness of programs; and identifying and addressing multi-state concerns through the Collaborative Actions Subgroup. The Subgroup reviews and coordinates state market activities related to companies exhibiting characteristics that may have an adverse impact on multiple jurisdictions.

Market analysis consists of all of the tools used to identify companies for further analysis.

2004 Checklist

MAWG published the first NAIC Market Analysis Handbook in early 2004 to provide states with information about Market Analysis. The first edition provided examples from several states and information on financial and complaint data.

To provide a plan of action, the Market Analyst's Checklist was adopted as part of the handbook to provide a "to do" list for state analysts. The Checklist included such activities as designating a Market Analysis chief; establishing an interdivisional communication program; identifying key lines of business; identifying companies with significant market activity; performing further analysis on priority companies; and reporting significant findings to MAWG. One of the primary objectives of the Checklist was to begin testing an approach for uniform nationwide Market Analysis.

Forty-nine jurisdictions (48 states and the District of Columbia) successfully completed the requirements of the Market Analyst's Checklist as adopted in the NAIC Market Analysis Handbook. State market analysts and NAIC staff completed 1,865 Level 1 Analysis reviews on companies that represent approximately 85% of the market for private passenger automobile, homeowners, individual accident and life, and group health insurance lines. Their efforts resulted in 45 companies being referred to the Market Analysis Working Group's Collaborative Actions Subgroup for further action.

During the process, new reports were generated that revealed previously unrecognized trends and findings. For example, Market Analysis Company Listings have provided a new way to look at the data in the NAIC databases. Analysts discovered 330 private passenger automobile companies (comprising 10% of the market) that were never subject to an examination. They also found that 408 examinations (20% of all examinations) had been conducted on companies that made up only 1% of the market.

MA Tools

The NAIC has developed several I-SITE tools beneficial to state analysts. These tools include Market Analysis Profile Reports, which include five years of state- specific premiums, complaint indices, regulatory actions, special activities, and information on past examinations. Several I-SITE tools combine traditional financial information with market-related information. And while the intent is not to require market analysts to become expert financial analysts, good market regulators understand the correlation between market and financial data.

Proper Market Analysis requires states to systematically perform a high-level uniform review of all companies to identify those that should be targeted for further analysis. To ensure a minimum and uniform amount of further analysis, and to document an analyst's input, conclusions and recommended next steps, NAIC staff developed Level 1 Analysis. It was designed to be completed using available information

continued on next page

Market Analysis – An Examiner's Perspective

continued from previous page

without contacting the company and to identify companies that might require further review.

It does not necessarily indicate the company under review will be subject to a formal regulatory response, such as an examination. When finished with the Level 1 Analysis, the analyst will determine if the company requires additional analysis, needs to be immediately submitted to MAWG's Collaborative Actions Subgroup, or requires no further analysis.

Another important Market Analysis tool that will be in use by 17 states starting next year is the Market Conduct Annual Statement. Similar to the financial statement, the market conduct annual statement includes market-related information about a company such as underwriting, policyholder service, and claims-handling information.

The Continuum

The Continuum of Potential Regulatory Responses refers to the variety of options available to regulators once they discover a problem or potential problem with a company. Responses will vary depending on the depth of the problem and the impact on the company and marketplace. The Responses can be divided into several areas, *e.g.,* education, office-based information gathering, on-site options, or new regulations.

Success Stories

Some success stories have already surfaced. For example, one recent collaborative effort resulted in a settlement requiring a major insurer to change its claims practices and to reassess claims going back several years. All 50 states and the District of Columbia participated in the effort.

Another example is one nationally significant company that entered into a multi-million dollar settlement with one state to correct problems uncovered during the analysis process. This was done without an on-site examination and resulted in the development of a plan to address systemic problems that transcend state borders. Although the plan has just been initiated, it is important to note that a multi-state market conduct examination or several individual market conduct examinations would have been required had not a Market Analysis plan been activated.

One final example includes a company that was identified by several Market Conduct Annual Statement states as a company of interest. After discussions with a state that had already scheduled a periodic financial examination, the domestic state agreed to initiate additional requests and was able to identify that the company had not been reporting accurately. The company subsequently reported accurate data in its next Annual Statement filing, without the need for an additional examination.

What's next?

Over the course of 2005, NAIC members will define Level 2 Analysis, which will be used for the next level of review. It will "drill down" on some of the issues identified for further analysis in the Level 1 Analysis.

Additionally, the Continuum of Potential Regulatory Responses will also be refined with the goal that all significant communication with a specific company be documented by all states. Any analyst will be able to review the actions being taken by any other state regarding a specific company.

And while the attempt to create a uniform and collaborative Market Analysis process has not been without some setbacks, almost everyone agrees: now is the time for Market Analysis. ■

Quote of the Month

"Spitzer's specialty is moralistically stabbing the soft underbellies of industries in which smart lawyers have masticated the rules into mushy grayness."

— Jack Willougby, Barron's

IRES State Chapter News

LOUISIANA — Our last chapter meeting was held January 25. **Ron Musser**, Assistant Commissioner of Financial Solvency, spoke about NAIC initiatives and provided an overview of the NAIC Committee structure. He also discussed the SMART Act and the Compensatory Disclosure Amendment to the Producer Licensing Model Act. **Denise Cassano**, Assistant Commissioner of the Office of Health, spoke about the Regulatory Framework Task Force, the Senior Issues Task Force and health discount plans.
— Larry Hawkins; lhawkins@ldi.state.la.us

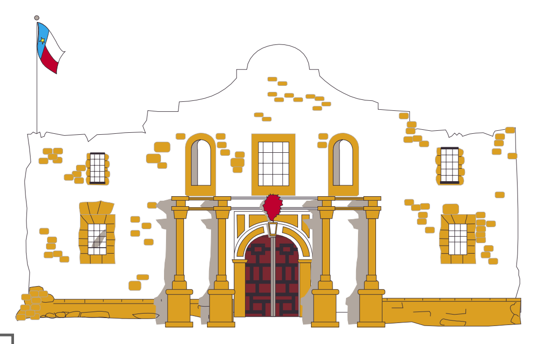
MASSACHUSETTS — **Lilla Frederick**, former IRES State Chairperson and 37-year employee of the Massachusetts Division of Insurance, recently passed away at 67. In addition to her full time position as a Senior Insurance Examiner with the Massachusetts Division of Insurance, Lilla was involved in many community activities including Project RIGHT (Rebuild and Improve Grove Hall Together). Lilla helped found and served as the President and Chair of Project RIGHT, a coalition of 40 groups focusing on quality-of-life issues in the Grove Hall section of Boston. Boston Mayor **Thomas Menino** said that Lilla "was one of the anchors of the community who made the city better for all of us." Lilla leaves a son and her mother.
— Matthew Regan; Matthew.C.Regan@state.ma.us

OREGON — Oregon Insurance Division Administrator **Joel Ario** discussed current NAIC issues at our December Chapter meeting. We also announced the 2005 IRES officers. They are: **Gary Stephenson**, Chairperson; **Rolfe Junge**, Co-Chairperson; and **Kathleen Kaulk**, Secretary. In January, we heard from **Dale Gesner** and **Gordon Compton** of the National Insurance Crime Bureau (NICB) who discussed recent auto insurance fraud developments.
— Gary Holliday; Gary.R.Holliday@state.or.us

VIRGINIA — We held our quarterly IRES meeting in December to elect officers for 2005. Weldon Hazlewood presided over the meeting. The new officers are: **Julie Roper**, AIE, President; **Sheryl Hines**, Vice President & Secretary; and **Carly B. Daniel**, Vice President & Treasurer. A series of informative educational programs is being planned for the remaining 2005 quarterly meetings.
— Sheryl Hines; Shines@scc.state.va.us

The National Insurance School on Market Regulation

for insurance industry professionals working in regulatory compliance



May 1-3, 2005

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email: info@ires-foundation.org

Regulatory Roundup

by
Stroock & Stroock & Lavan LLP

U.S. Court of Appeals dismisses class action lawsuit for lack of subject matter jurisdiction under the McCarran-Ferguson Act

In *Gilchrist v. State Farm Mut. Auto. Ins. Co.,* 390 F.3d 1327 (2d Cir. Nov. 18, 2004), the U.S. Court of Appeals for the Eleventh Circuit directed the U.S. District Court for the Northern District of Florida to dismiss a class action lawsuit for lack of subject matter jurisdiction in accordance with the federal McCarran-Ferguson Act. The McCarran-Ferguson Act reaffirms the power of the states to regulate the business of insurance and exempts insurer activities from the provisions of the federal Sherman Act under specified circumstances. Prior to the appeal, the District Court had certified a national class of approximately 70 million automobile insurance policyholders who charged that defendant had "conspired in violation of federal antitrust laws to limit insurance coverage for certain external auto body repairs to the cost of less expensive parts not made by an original equipment manufacturer (OEM)." The Eleventh Circuit ruled that it had no jurisdiction over the matter and, therefore, dismissed the appeal and remanded the case to the District Court with instructions to dismiss. The Eleventh Circuit concluded that plaintiffs' claims involved activities that were not within the reach of the Sherman Act. Among other factors supporting this conclusion, the Court stated that plaintiffs' claims, at the core, were that defendants had failed to perform their "obligation under the insurance policies to provide repair parts of 'like kind and quality'." This claim, according to the Court, is fundamentally an attack on defendants' performance of their contractual obligations to policyholders. As such, the underlying activities constituted the business of insurance, which falls outside the reach of the *Sherman Act* pursuant to the *McCarran-Ferguson Act*. To view the *Gilchrist* decision, visit **http://caselaw.findlaw.com/data2/circs/11th/0310799p.pdf.**

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 Todd Zornik, an associate in the group, and Robert Fettman, a law clerk in the group. This column is intended for informational purposes only and does not constitute legal advice.

DELAWARE – Department of Insurance to publish proposed regulations requiring disclosure of losses not covered by homeowners insurance

The Delaware Department of Insurance is expected shortly to issue proposed Regulation 702, which is intended to ensure that homeowners insurance policyholders are aware that they are not insured for certain types of risks or claims, to the extent that they do not have such coverage. According to a draft of the proposed regulation, which at press time had not yet been released for public comment, insurers, upon initial delivery of a homeowners policy, and not less than once annually after delivery, would be required to provide a disclosure form to the policyholder entitled "Important Information About Your Homeowners Insurance." The disclosure form must indicate that the homeowners policy does not cover damage caused by flooding, and in addition must include (i) a disclosure that the policy does not cover the full cost of replacement without depreciation of the property in the event of destruction of the property, and (ii) a disclosure of any limitations in the policy regarding reimbursement for items stolen from the property, including jewelry, furs and similar items. The disclosure form must also list claim activities that are likely to cause nonrenewal of a policy. Proposed Regulation 702 is scheduled to be published in the March 1, 2005 Delaware Register of Regulations for public comment. Proposed Delaware regulations are available on www.delregs.state.de.us/index.html. To view a Delaware DOI press release on proposed Regulation 702, visit **ww w.state.de.us/inscom/departments/news/012005-Press-Homeowners.shtml.**

OKLAHOMA – Insurance Department issues arbitration guidelines for property/ casualty insurers

On January 21, the Oklahoma Insurance Department issued Bulletin No. 2004-02 (Amended), which suggests new standards for arbitration clauses contained in property/ casualty insurance policies. The Insurance Department issued the arbitration standards in an effort to protect Oklahoma insurance consumers with respect

to contracts of adhesion containing binding arbitration provisions. Those provisions generally preclude the parties from seeking appellate review of arbitration decisions. Citing provisions of the Oklahoma Uninsured Motorist Law, the Bulletin recommends an arbitration clause that provides that the parties to the contract shall, upon demand of either party, submit their differences to arbitration; provided that, if agreement by arbitration is not reached within three months from the date of demand, the insured may sue the tortfeasor. Binding arbitration clauses between insurers are not included in these guidelines due to a presumption of sophistication between the parties. To view Bulletin 2004-2 (Amended), visit **www.oid.state.ok.us.**

VIRGINIA – Bureau of Insurance provides guidance on unfair discrimination and rebating requirements applicable to title insurance

On November 5, the Virginia Bureau of Insurance issued Administrative Letter 2004-7, which provides, in a Q&A format, specific guidance concerning unfair discrimination and rebating requirements applicable to title insurance. The Letter states that unfair discrimination in title insurance occurs where a different rate is applied to two risks that do not present any difference in terms of hazards and expense elements. In response to the question regarding the basis upon which the Bureau will reach a determination that unfair discrimination or rebating has occurred, the Letter states that the Bureau will rely on an insurer's price schedules which effectively become published upon use of the prices. The Letter also addresses the question of what documentation or evidence an insurer must rely on to demonstrate the differences between classes of risks. The Letter addresses this question, in part, with reference to the example of reissued coverage in which title insurers often charge lower premiums in respect to transactions involving a mortgage refinance and an insured with an existing title insurance policy on the property. The Letter advises that a title insurer under this example would "need to establish and document a reduced level of exposure to loss or a reduced level of expense associated with the underwriting of such risks" to justify the lower reissue rate. To view Administrative Letter 2004-7, visit **www.scc.virginia.gov/division/boi/webpages/adminlets/04-07.doc**

C.E. News

National IRES Continuing Education

The mandatory continuing ed program for AIE and CIE designees

What is a "retired" designation?

IRES will continue to maintain the registration of your designation as honorary and you will not be required to do the mandatory continuing education. You MUST notify the IRES CE Office by using the "permanent retirement status form." (Just changing your dues level on your membership renewal form does not automatically change your designation status.)

Permanent retirement is considered FINAL. It should not be elected by those below retirement age or by anyone who expects to someday re-enter the insurance industry for monetary gain.

The IRES CDS is July 31-August 2 in Tampa, FL, and is a great way to earn the required 15 CE hours for compliance year 9/1/04-05. CDS advance brochures will be mailed in March or see the registration form in this newsletter. Please keep in mind that CDS is not the only way to earn CE hours. Any course or seminar that is more than 50% insurance related, for which your attendance can be documented, can be used for continuing ed.

Lastly, we're working on improvements to our computer software that will make it easier and faster for us to keep your submitted C.E. credits up to date on the IRES web site.

Casual Observations

Smoking out Big Brother

How would you like to receive a "Healthy Lifestyles Rebate"? Sounds good, right? After all, you already exercise and watch your calories. Why not get paid for it? But under Florida's new, first-in-the-nation plan to compel health insurers to pay employers for their employees who lose weight or quit smoking, you won't be the one cashing in. It's more likely to be that amorphous blob in the adjoining cubicle. You know the one, the guy dusting his keyboard each morning with doughnut crumbs before waddling out for a smoke.

Although details haven't been worked out yet, it seems under Florida's Rebate plan, a health insurer or HMO would be required to credit, say, 50 bucks, to an employer who could document one of his workers lost weight or kicked the smoking habit. The employer could then, *at its discretion,* pass that $50 along to the employee. To us, it seems like an awful lot of paperwork and documentation for $50. And as we mentioned, employees who are already fit and trim apparently get bubkes.

One of Florida's Deputy Commissioners recently emphasized to the media that the overall incentive of the Rebate plan is to reduce the cost of health care. But, how much savings will really ensue if insurers and HMOs must hire more administrators and review more paperwork in order to credit those thousands of employer accounts? Isn't the high cost of health insurance a sufficient incentive for employers to encourage their employees to live healthier lifestyles?

The answer to that question is a resounding yes, at least in the eyes of one Okemos, Michigan employer who did take the bull by the horns. We felt an Orwellian chill when we first heard that employees at Weyco, Inc., a medical benefits administrator, were no longer permitted to smoke on *or off the job.* "We're not saying you can't smoke in your home. We just say you can't smoke and work here," explained Weyco's CFO Gary Climes.

The goal is clearly to reduce health insurance claims, but at what cost? Civil libertarians are up in arms. What's next, they ask, banning employees from McDonald's or the local pub?

And how will Weyco monitor its employees to ensure they're not crouching behind garages sneaking smokes? Periodic testing, no doubt. If it's good enough for Major League Baseball, it's good enough for Weyco, although last time we checked tobacco was still a legal substance in the United States.

Most Weyco employees did abide by the new policy, although four who refused to (or couldn't) quit found themselves out of a job as of January 1, 2005 when the new policy took effect. We couldn't help but think that in a different era had Weyco employed Dwight Eisenhower, Winston Churchill or Franklin Roosevelt, they, too, would be out pounding the Michigan pavement beneath a haze of smoke.

—W.C.

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

√ The person who recruits the most new IRES members between now and July 1 will get a free registration (travel not included) to the annual CDS in Tampa. For information, send an email to ireshq@swbell.net.

√ Former IRES President Gary Meyer has retired from the Missouri Department of Insurance after more than 30 years as a regulator. Gary is among the original founding fathers of the Society and served on numerous committees and task forces.

√ We were saddened to learn of the passing of Lilla Frederick, former IRES State Chairperson and 37-year employee of the Massachusetts Division of Insurance. She was 67.

√ If you haven't paid your 2005 IRES membership dues by now — or aren't sure if you have — contact Susan Morrison immediately at the IRES office, 913-7687-4700. Late notices have gone out and those who have not renewed run the risk of losing their AIE-CIE accreditation, plus other valuable benefits of IRES membership.

√ Don't wait to book a room for the CDS in Tampa! Rooms go fast. See registration form on page 19.

√ The IRES Website Committee is looking for additional volunteers to help with the IRES website. To find out more or to volunteer, please contact Jo LeDuc at **jo.leduc@oci.** state.wi.us.

In the next REGULATOR:

√ **How auto insurers are getting smarter**

√ **Global warming and insurance**

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What hath Spitzer wrought?
See story, PAGE 1

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