The Regulator®

INSURANCE REGULATORY EXAMINERS SOCIETY

Empowering the consumer

Will consumer-directed initiatives heal an ailing health care system?

by Erika Rosenfield

Just about the time the acronym HMO became firmly embedded in the national vocabulary — you'll find it on page 858 of the 1996 edition of The American Heritage Dictionary — along came another batch of alphabet soup: CDHP, HSA, HRA, FSA, MSA, and a few others.

While these are still gibberish to most of us, they are the rapidly advancing future of health care coverage. (Of the many definitions and glossaries available, among the clearest and least partisan is that provided by the Deloitte Center for Health Solutions, part of Deloitte & Touche USA.) They refer to plans, or elements of and variations on plans, aimed at meeting four goals articulated by President Bush in his Jan. 31, 2006 State of the Union address:

- Increasing the portability of health insurance;
- Making health insurance more affordable;
- Broadening the use of electronic health care records; and
- Addressing escalating medical costs.

The fundamental syllogism that underlies the Consumer-Driven Health Plan is not new: if employees pay more and employers less of the cost of health care, business will greatly benefit; if consumers pay more of the share of their health care costs, they will demand less health care service and choose more wisely; that, in turn, will create competitive pressure on the health care market and thus lower the cost.

What is new is the accelerating rate of adoption of these plans and, not surprisingly, the questions and criticism of both their fairness and efficacy.

Adoption of CDHPs

CDHPs were created as part of the 2003 legislative overhaul of Medicare, though they did not become available to many until the fall of 2005. In the simplest terms — and arguably given the complexity of the issues, simplistically — the various kinds of accounts (heath savings,

continued on page 4

The whitecoats are coming!

Health care revolution in Massachusetts

by Scott Hoober
Special to The Regulator

Back in the early days of the Clinton administration, the First Lady spearheaded an unsuccessful drive to establish a national health-care system.

The effort is remembered as over-reaching by a too-activist spouse. But perhaps Hillary was influenced by Census data indicating that around that time, in the early '90s, fully 15.2% of Americans had no health insurance. Congress in its wisdom decided the nation's health-care system was just fine without federal meddling.

A decade later, the proportion of Americans without health insurance has risen still higher.

Since lack of insurance leads to delayed treatment, which in turn

continued on page 10

JULY 2006

Bye, from President King..... 2
The Cost of Compliance 8
IRES Foundation School..... 15
C.E. News 16
IRES Chapter News 17
Casual Observations..... 18

The Regulator®

Wayne Cotter, CIE, Editor
quepasa1@optonline.net
Kathleen McQueen, Associate Editor

IRES PUBLICATION COMMITTEE
Kirk R. Yeager, CIE, unaffiliated, CHAIR
Polly Y. Chan, CIE, California • Janet Glover, CIE, retired (NY)
Wayne Cotter, CIE, NAIC • Bruce Ramge, CIE, Nebraska
Kathleen McQueen, New York • Kashyap Saraiya, AIE, New York
Christel L. Szczesniak, CIE, retired (CO) • Linda Yarber, California

THE REGULATOR is published every other month by the

INSURANCE REGULATORY EXAMINERS SOCIETY

12710 S. Pflumm Rd., Suite 200 Olathe, KS 66062
913-768-4700 FAX 913-768-4900
IRES Continuing Education Line: 913-768-NICE

David V. Chartrand, executive secretary
Susan Morrison, office manager and continuing ed coordinator

www.go-ires.org
e-mail: ireshq@swbell.net

From the President

Thankful and Humbled

As the 2006 CDS approaches, Wayne Cotter informs me that this is my last column, or as he put it, "the last column you'll ever have to write." To be absolutely candid, I can't say I'll miss writing the column, however, as IRES President (soon to be past president), I will miss the individuals who I have had the distinct pleasure to work with on a regular basis over the past year. So, I will use "my final space" to show my appreciation, by saying thank you to those who have made this year an enjoyable one for me and a very successful one for the organization.

As organizations go, success is oftentimes dependent on how well one delegates responsibility. I believe it is important to allow the thoughts and ideas of the members, those who have volunteered to be an active part of the "team," to drive the processes and develop the programs. Then, one must check the progress through regular follow-ups.

The Executive Committee, which consisted of Doug Freeman, Jo LeDuc, Kirk Yeager, Polly Chan, Katie Johnson and Karen Dyke, have raised the bar, in terms of expectations and accomplishments. Each of these committee chairs were involved in the process, committed to meeting deadlines and focused on accomplishing committee goals. Thank you for the many long hours, hard work and support.

Last year at the CDS I challenged the membership to get involved, with words similar to – "if you like what you see, join us and make it better – if you don't like what you see – join us and be a part of fixing the problem and improving this organization." Well, it was gratifying and humbling to see the number of volunteers that truly wanted to be involved in our organization. Thank you for your time and your contributions to the committees and sub-committees this past year. You folks truly make a difference.

For many years David Chartrand and his staff have been recognized at the CDS for their hard work. I know from personal experience that David, Susan, Joy, Scott and Elaine (Art, too) have always done what is necessary to help make IRES the

professional organization it is today. So, I am not surprised by the support I have received this year. You folks are the "rock" of IRES. Thank you for your help.

Last but not least, I give special thanks to Wayne Cotter, our editor of The Regulator who is responsible for dressing up my column, but more importantly, for his exceptional work on this professional publication.

Doug Freeman will take over as President in August. During this past year I have had the opportunity to get to know Doug better. Based on his superb organizational skills, his desire to succeed and his love of this organization, Doug will undoubtedly have a positive impact as President of IRES. I wish him the best.

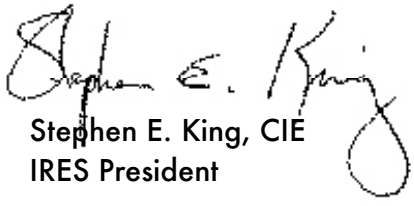
IRES made significant progress this year:

- We have implemented a number of new procedures that will help IRES maintain a more consistent approach in dealing with both CDS and Membership issues.
- Due in large part to the efforts of Gary Domer and a host of volunteers, the MC+ program should soon become reality.
- With a grant from the IRES Foundation, IRES has launched a new "CDS scholarship program" for new AIE-CIE designees.
- We are addressing the needs of IRES members as we upgrade our Web site.
- We have begun discussing opportunities for the coordination of efforts with the Association of Insurance Compliance Professionals (AICP), and hope to do likewise with SOFE in the future.

As we have seen, the regulatory landscape is ever-changing and will continue to provide challenges to this organization that we must be prepared to answer. With a little bit of luck and a lot of hard work and preparation, I believe the IRES membership will continue to look at the challenges as nothing more than opportunities for state regulators to excel.

I am thankful for and humbled by the opportunity you have given me to be the President of IRES and I look forward to seeing you in Chicago at the CDS.

Take care and may God Bless.



Stephen E. King, CIE
IRES President

Teacher Man

LONG BEACH, CA — Dudley B. Ewen, AIE, was honored here May 1 as the 2006 recipient of the Paul L. DeAngelo Memorial Teaching Award from the IRES Foundation.

The award was presented during the annual National Insurance School on Market Regulation (see photos, p. 15). Foundation board member John Mancini noted that Ewen, chief market conduct examiner of the Maryland Insurance Administration, has worked nearly 30 years as a regulator and given countless hours of service as a member of the School's faculty.

Ewen, Mancini noted, "is known to all as a regulator who is fair and thorough, who is contemplative and thoughtful in expressing views and opinions. When you think of all the NAIC market conduct initiatives that have been introduced over the past 15 years, this person has been actively involved in every one."

Dudley, with Foundation board members Carol Newman and John Mancini

Consumer-driven health care initiatives

continued from page 1

health reimbursement, flexible spending, medical savings) are different mechanisms for accomplishing the goals of the CDHPs, all of which call for a low premium and high deductibles. The decision about what specific medical treatments and services are covered is typically left to the employer.

Though the numbers vary somewhat, possibly owing to a lack of consistent clarity about the distinction between CDHPs and HSAs in the reporting, more than two million people have signed up for CDHPs so far, according to a January 2006 *New York Times* article. The article further notes that, while this is still a very small percent of the 180 million Americans who have health insurance, many believe that the numbers "show a very fast adoption rate for what is a complicated new consumer program." Moreover, many analysts expect the adoption of CDHPs to grow rapidly. Using the acceptance of HMOs in the 1980s as a benchmark, experts like Forrester Research, a market research firm, predict that by the beginning of 2008, nearly 22 million people will be enrolled in CDHPs, which would represent about 12 percent of the insured.

Other reports cut the numbers in slightly different ways. Bearing Point, consultants in management and technology, issued a February 2006 white paper in which they assert that the "pace of adoption" of CDHPs is "faster than the early days of IRAs and HMOs." At the present rate, by 2012 "some 70 million Americans are expected to be participating in at least one of three financial plans — HSAs, FSAs, or HRAs — for a total of 40 million established accounts."

UnitedHealth Group, which is the largest provider of HSAs, insures 24 million people under one or another of its policies. Of these, a total of only 1.5 million, or about 6.45%, are enrolled in CDHPs, 650,000 with HSAs, another 846,000 with HRAs, the funds which revert to the employer if and when a worker leaves. Not surprisingly, opinion surveys, as opposed to numerical data, tend to interpret their results somewhat more glowingly. A survey of employers released by the Deloitte Center for Health Solutions in January 2006 quoted Tommy G. Thompson, the center's chairman, as saying, "Employers are increasingly turning to consumer-driven health plans to reduce costs and help workers and their families make better heatlh care decisions."

According to the survey, 40 percent of employers believe that CDHPS provide "the most effective approach for managing costs and maintaining quality care." Moreover, the center found that the cost of CDHPs grew at a significantly lower rate in 2005 than did other kinds of plans.

Health Savings Accounts

In part because of the emphasis placed on Health Savings Accounts this year by the Bush Administration, which is seeking to increase the ceiling on contributions, the HSAs are drawing considerable, and equally laudatory and critical attention. Once again, the data are fairly consistent, but the interpretations vary according to the analyst's perspective.

HSAs allow workers to set aside pre-tax income to pay for certain health care expenses: deductibles, diagnostic services not covered by the plan, premiums, some nursing care, and the like. The deductibles are high and vary according to the plan; *The New York Times* puts them at a minimum of $1,050 per year for individuals and $2,100 for families.

Once the deductible has been expended, medical costs are covered under the "catastrophic" insurance policy whose purchase is a requirement for participation in the HSA. Premiums are correspondingly low: James A. Swick, founder and president of California Health Insurance Plans, estimates that a 19- to 29-year-old with an HSA might expect a monthly premium of just $77, but a deductible of up to $3,500. That same individual is permitted to contribute up to $2,700 annually to an HSA — $5,450 for a family.

Employers may, if they wish, make contributions to their employees' HSAs, though thus far the evidence suggests that most do not. It has been widely suggested that, because of the HSAs' portability, many employers may fear that their money will "walk out the door" if an employee leaves. Others have noted that employer contributions may prove significant in recruiting and retaining well-qualified employees. But even without the direct tax benefits of their own contributions, employers stand to benefit from the CDHP/HSA arrangement.

The cost of CDHPs rose at a "significantly slower rate in 2005" than that of other, traditional kinds of plans, according to a Deloitte Center for Health Solutions report released in January 2006 — just an average of 2.8 percent for CDHPs, as opposed to 8 percent in total premiums for HMOs and 8.5 percent for POS plans. The Kaiser Family Foundation has found that a typical employer pays $3,284 for a single employee in a traditional health plan, while the same employee in a CDHP would cost just $2,850. Moreover, employers who offer HSAs benefit from lower payroll taxes, according to *The Wall Street Journal,* which notes that, under certain HSA arrangements, employers are not subject to payroll tax on employee HSA contributions. Those savings are estimated to be as much as 10 percent, or enough at least to cover administrative costs.

Others are also poised to benefit from HSAs, among them financial institutions, for which such accounts are seen as a potential windfall. Bearing Point sees enormous opportunity for the financial services sector to capitalize on what it describes as a "burgeoning $2.6 billion market."

continued on next page

Some Essential Definitions

• **Consumer Driven Health Plan** (CDHP):* A health plan model designed to allow employees to take more responsibility for their health care. CDHPs usually pair a high-deductible catastrophic plan with a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). The belief is that because employees have more control of the savings fund, they'll be more aware of the actual costs and, thus, more selective in seeking care.

• **Flexible Spending Account** (FSA): A spending arrangement that allows employers and employees to us pre-tax dollars to pay for certain health care or dependent care expenses not otherwise covered by insurance. Health care FSAs can be used to finance health care expenses, including deductibles and copayments.

• **Health Reimbursement Account** (HRA): Employer sponsored plans that permit companies to reimburse employees for a wide range of medical expenses. They are tax-free and work well with high-deductible insurance policies. As opposed to HSAs (see below), they are funded only by employer dollars. Because only employer money is used to fund these plans, employers are granted considerable leeway in how they define the medical claims that will be reimbursed. The HRA can specify that only certain types and amounts of expenses will be eligible for payment.

• **Health Savings Account** (HSA): A tax-advantaged cash account that can be tapped to pay for a wide range of medical expenses not covered by insurance. Contributions to savings accounts can come from employees, employers, or both. Employer contributions must be comparable for similar persons (e.g., single vs. family coverage). Interest earnings are tax-free, as are withdrawals, before or after retirement, when used to pay for a wide range of medical expenses. Employees own the accounts from the outset; there are no "vesting" rules for employer contributions. When an employee leaves, the money goes with him or her. The accounts can roll over from year to year without limit.

• **Medical Savings Account** (MSA): Also called Medical IRAs and Medisave Accounts, MSAs are a health care financing arrangement proposed by the federal government to augment major medical coverage by allowing individuals and their employers to make regular, pre-tax deposits to personal medical accounts that can be used to pay for medical expenditures or health insurance premiums.

— Deloitte Center for Health Solutions, "Glossary of Health Care Terms," 2006

*It is worth noting that, while Deloitte uses "Consumer Driven," others refer to these plans as "Consumer-Directed." And at least one advocacy group is pushing for a name-change to "Consumer Choice," arguing, not unreasonably, that "choice" is the best — perhaps also the most American — connotation.

Consumer-driven health care initiatives

continued from previous page

The picture is somewhat less clear for the insurance industry. Patricia O'Brien, MD, who heads up the health care industry practice for management consultants DiamondCluster International, said that HSAs and the like "create challenges and opportunities that insurers ignore at their own risk." Among the problems she foresees arising from the Bush Administration's proposals are the requirement that insurers continue to provide coverage regardless of the health status of the insured; higher administrative costs resulting from the portability of CDHPs and HSAs; and the need for a significant investment in the new technology.

She also suggested that, since consumers will be allowed to purchase insurance outside their home state that "likely would encourage a flurry of industry consolidation among insurers," in order to eliminate price-based competition and to create economies of scale.

She explained, "[T]he barriers to competition that regional health insurers have enjoyed will fall as standardization emerges."

What's in it for the employee?

The message sounds good. If an employee enrolls in an HSA and contributes to it, he or she saves money on taxes, has the funds needed to pay health care costs not covered by the underlying insurance plan, and can make "good"choices. So far, it's not clear that the argument is really working.

For one thing, the availability alone of an HSA is clearly not sufficient to effect real change in consumer behavior. According to the Kaiser Family Foundation, as of early February 2006, more than 70 percent of the adults it surveyed had never heard the term "Health Savings Account." Even many of those who obviously have, as evidenced by their having enrolled, cannot be considered true participants: the nonpartisan Foundation for Taxpayer and Consumer Rights reported in February 2006 that "[m]ore than half of those already enrolled in these plans have no money in their Health Savings Accounts."

The New York Times article concurs: writing on January 26, 2006, Milt Freudenheim reports that many people have signed up for CDHPs and HSAs "not because they are eager to direct their own medical spending, but because the plan looked cheap or they had no other insurance option." Freudenheim points out, further, that "there will be no money building up for the next year's out-of-pocket expenses — a big selling point for these health plans."

The fact that money contributed to HSAs is pre-tax has also been touted as a significant benefit to employees. According to the U.S. Treasury Department, a married couple with two children and an income of $40,000 in 2005 could have saved $630 in federal income taxes — some, though not all, states also offer a break on income taxes — if they made a contribution of $5,000 to an HSA.

It is reasonable to ask, however, whether such a family has $5,000 to spare. Without question, HSAs are very appealing to the young, single, healthy, and well-employed and, equally, to those with substantial incomes. On the other hand, critics almost universally decry HSAs as harmful to low-income and middle-class people, some going so far as to claim that HSAs are essentially a tax-shelter for the wealthy. Two Stanford University health policy experts — the health economist Victor Fuchs and Laurence Baker, associate professor of health research and policy — have said that "HSAs are skewed toward healthy, high-income individuals. A well-off 35-year-old who visits the doctor once or twice a year stands to gain a nice sized savings account." The same, they add, cannot be said for the 59-year-old low-income individual with hypertension and emphysema.

There are other concerns as well. Many, including physicians like Dr. Jack Lewin, CEO of the California Medical Association, and California Insurance Commissioner John Garamendi are concerned that, as Lewin puts it, "middle- and low-income families won't spend the money in their HSAs to treat chronic diseases because they want to save the money." That would likely necessitate more costly care at a later date. Other patients may fail to save enough to cover future medical costs. And some will not save at all.

Even enthusiasts of HSAs express reservations, especially concerning the complexity of the plans and the nature of their advantages. The American Academy of Actuaries, in a January 2004 monograph on "The Impact of Consumer-Driven Health Plans on Health

Care Costs," cautions that putting so much decision-making in the hands of lay people "can be quite confusing to the employee and must be supplemented by an effective communication and education plan."

Focusing similarly on the decision-making process, Bearing Point notes that the premise behind CDHPs and HSAs is that "patients will shop for health care and make rational decisions based on price and quality." The problem, their white paper explains, is that while usually price information is the easiest to obtain, this is not true of health care. The price for health care services is "determined by a complex mix of treatment codes that can vary from one plan to another. Because of this, providers often are unable to tell patients at the point of care what their charges will be."

Writing in *The Wall Street Journal Online* on February 2, 2006, Sarah Rubenstein responds to the more typical questions readers might have about the appropriateness of HSAs for themselves. She acknowledges that just managing one's HSA "can be a hassle." Not only have many consumers had difficulty understanding how the accounts work, but they have been frustrated by glitches and what they perceive as a lack of expertise on the part of the insurers and banks that run the coverage and the accounts.

Does "Consumerism" work?

Bearing Point puts it bluntly: " . . . if employers and employees are going to embrace plans that put choice in employee hands, they will need standard, reliable, and understandable information on provider quality and prices. Without it, consumers will have to struggle through a bewildering mix of new and traditional health plans from both new and familiar vendors." Such issues can be resolved and no doubt will be, as all the parties involved become more familiar with CDHPs and HSAs and more accustomed to engaging in decision-making. Insurers, financial institutions, and providers will eventually develop the standards necessary for effective and efficient interface; consumers will learn the new vocabulary, as they have with HMOs, 401(k)s, even computers and the Internet.

The larger questions remains: will "inserting consumerism into health benefit programs," as Deloitte Consulting puts it, eventually, if not sooner, resolve the acknowledged crisis in the country's health care system? On that score, the jury is still out — way out.

Deloitte Consulting's 2005 survey report notes that "[a]s consumer-driven plans move into the mainstream, employers are optimistic, though not yet completely convinced, that consumerism in health care is the long-term solution for rapidly increasing costs."

The American Academy of Actuaries grants that the key question concerning CDHPs remains whether they will really "help stem the tide of double-digit premium increases."

Many critics believe that medical costs are rising so fast that no consumer-driven plan will be able to keep up. The Foundation for Taxpayer and Consumer Rights notes that health care costs will reach 20 perecent of the GDP by 2015, well beyond the means of the most effective HSA to control.

Others say bluntly that CDHPs and HSAs are nothing more than cost-shifting. Among those are Pat Schoeni, executive director of the National Coalition on Health Care, and Richard R. Evans, a health care analyst with Sanford C. Bernstein, who is quoted in the February 3, 2006 edition of *The Wall Street Journal* as saying, "The risk is being transferred [from employer to employee] without the consumer really realizing it."

Forecasting is as tempting as it is perilous. Reacting to the President's State of the Union address, Dr. O'Brien says, "No one can accurately predict what lies ahead or just how much progress we will make in improving the quality and affordability of healthcare," though she believes firmly that "very few, if any, insurers . . . are prepared to compete in that new frontier."

Quite apart from the difficulty of predicting the future of health care, its attendant costs, and the responses of the insurance and financial services industries, there is the absolute impossibility of predicting human behavior. CDHPs, as the American Academy of Actuaries explains, "aim to slow the growth in medical costs by providing participants with educational resources, decision-making tools, and financial incentives that will lead them to make more efficient health care decisions."

The key word, of course, is "lead." In one respect, at least, consumers are like horses; you can lead them to water, but you cannot make them drink. ■

This article, reprinted with permission of the Insurance Advocate, originally appeared in the March 27, 2006, edition. Questions should be directed to **editor@insuranceadvocate.com**

The cost of regulatory compliance

by Joseph F. Bieniek

While many insurance companies are focused on measuring return on investment, they often struggle with how to accurately quantify the costs related to compliance, where expenses tend to have an impact far beyond the compliance department.

Regulatory compliance-related expenses include direct costs that are most commonly associated with compliance, but they also include indirect and opportunity costs that often get overlooked when figuring expenses related to compliance products and services.

The total cost of compliance for a company cannot be measured with an exact dollar figure, but a company can control its overall compliance-related expenses and evaluate the value of maintaining compliance to the point where it can come relatively close to knowing the true overall cost associated with compliance.

Not only does this have the potential to help a company save money by letting the compliance department make more informed decisions when selecting vendors and services, it can also help put it in the best possible position to compete effectively.

When determining the total cost of compliance, a company should consider the sum total of its direct compliance costs, indirect compliance costs and opportunity compliance costs. It's important to note that both the costs of compliance *and noncompliance* should be evaluated.

Direct Costs

Direct costs are the items that are specific and easily identifiable as the cost of compliance *or the cost of noncompliance*. These include:

- *Fines and Penalties* — paid to regulatory bodies for being noncompliant;
- *Legal Fees* —necessary for settling any disputes when there are fines and penalties. Even a large company with its own legal staff will sometimes use outside counsel and incur legal fees;
- *Premium Refunds* —to insureds from the polices not correctly processed;
- *Increased Claim Payments* — the additional payments sent to claimants when claims were not previously processed properly;
- *Examination and Examiner Costs* — expenses that a company pays to the state for the review of their records;
- *Products Purchased* — products or services purchased to help the company comply with state requirements;
- *Examination Coordinator* —time spent by an individual assigned to ensure exam runs smoothly and who responds to all examiner requests; and
- *Staff Devoted to Compliance* — including any individuals assigned to helping the company be compliant, either part-time or full-time.

Indirect Costs

Indirect costs include money spent elsewhere, yet still related to compliance. Since these expenses can't always be quantified, an estimate often has to suffice. Examples of indirect compliance costs are:

- *Adverse Publicity* — negative publicity and the damaged reputation that can stem from an enforcement action;
- *Review and Defense of Class Action Lawsuits* — research time and expense involved in allegations against the company due to published examination results;
- *Time Spent on Remedial Actions* — particularly when a further review of a company's book of business has been ordered by an insurance department;
- *Premium Under-Charges* — the additional costs incurred when initial premium amounts are misrated;
- *Claim Overpayments* — overpayments that are not retrievable from the policyholder;
- *Internal Staff Devoted Elsewhere* — the time noncompliance staff devotes to compliance issues or supplying information related to compliance needs;
- *Processes & Procedures in Handling Insureds & Claimants* — all aspects related to compliance

activities, including training, travel and communication; and
- *Storage Costs* — costs to store documents, either in hard copy or electronically, related to an examination.

Opportunity Costs

Opportunity costs occur when there is missed revenue or investment because resources were deployed for alternative purposes. Opportunity costs are the most difficult to assign a dollar value to. These items include:

- *Lack of Proper Rate Due to Disciplinary Action*— premium rates generally include expenses/costs plus a profit margin, but companies are not allowed to include fines or penalties in their ratemaking cost allocations;
- *Reduction in Investment Assets/Returns*— investment returns can decline — and net income deteriorate — when funds are re-directed to compliance efforts;
- *Stock Price/Dividend/Company Value* — potential lowered stock price or company value that occurs when a noncompliant company does not manage its top and bottom lines effectively nor compete at the best of its abilities;
- *Staff Time Spent Elsewhere* — additional costs that accrue when production staff spend time on tasks not associated with their normal business routines; and
- *Possible Suspension or Revocation of a License or Certificate of Authority* — although suspensions or revocations occur rarely, the possibility should not be overlooked.

Compliance Costs With No Fines/Penalties

A company that successfully comes through an examination without a fine or penalty has avoided at least 8 of the 21 potential costs outlined above. These are: Fines and Penalties; Legal Fees; Adverse Publicity; Review and Defense of Class Action Lawsuits; Lack of Proper Rate Due to a Disciplinary Action; Reduction in Investment Assets/Returns; Possible Suspension or Revocation of License or Certificate of Authority; and Stock Price/Dividend/Company Value.

A company operating in this area is in a much better position to control its cost of compliance.

Compliance Costs When There Are Zero Errors

A company found to have no errors in its examination further reduces its compliance costs. The costs avoided include the eight listed above plus: Premium Refunds; Increased Claim Payment; Time Spent on Remedial Actions; Premium Under-Charges; and Claim Overpayments.

This is significant. The number of cost items is now narrowed down to:

Direct Costs

- Exam and Examiner Costs
- Products Purchased
- Exam Coordinator
- Staff Devoted to Compliance

Indirect Costs

- Internal Staff Devoted Elsewhere
- Processes & Procedures in Handling Insureds & Claimants
- Storage Costs

Opportunity Costs

- Staff Time Spent Elsewhere

A company that is totally compliant realizes some significant benefits. Almost all of its cost items fit into the "direct costs" category, which are usually identified with a specific dollar amount assigned to them. This means the company can manage its cost more effectively and allocate its resources more efficiently.

When costs associated with noncompliance are eliminated, a company can better determine its premium rate. When proper rates are established, the company can more accurately gauge its profit loading and enhance its competitive position.

Knowing where your costs are can help insurers manage their operation more effectively and stay compliant – it all comes full circle. ■

Joseph Bieniek, CPCU, ACP, CIC, ARC, AIS, AU, is Manager of Regulatory Compliance for CCH INSURANCE SERVICES, a part of Wolters Kluwer Financial Services. Before joining CCH INSURANCE SERVICES, Joe spent over two decades with the nation's largest personal lines stock company.

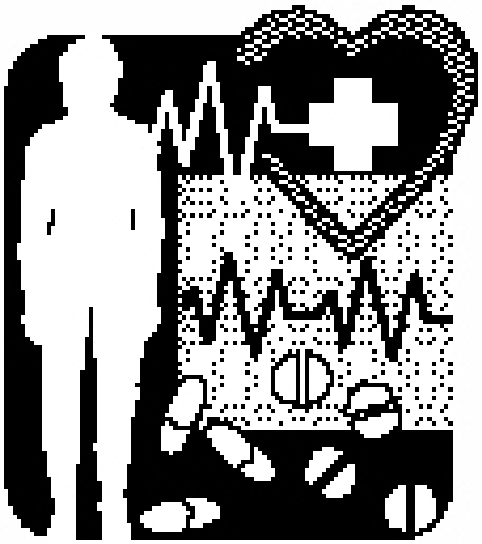
Revolution begins in health care

continued from page 1

leads to higher long-run medical costs, such statistics help explain why our nation pays one and a half times as much in per-capita health costs as any other nation (and about 30% higher than anyone else in relation to overall GDP) — and yet by several measures, Americans' overall health isn't the better for it.

By any measure, the nation's health system, including its health insurance system, is in trouble. But there has been one big change over the past decade or so: The federal government is no longer seen as the solution.

Today the action is in the states.



The bulk of the publicity has gone to Massachusetts, which has passed the most far-reaching solution to issues of access and cost, but a number of other states have enacted, or are thinking of enacting, reform measures of their own.

The gut issues that any reform plan must address are access (how to get people who don't work for large corporations into the health insurance system), cost (how to pay for the new care, and how to wring costs out of the entire system) and quality (how to do all of the above without providing worse care than before).

The Massachusetts plan

The compromise plan that Governor Mitt Romney, a conservative Republican, was able to get past the Democratic leadership of the Massachusetts Legislature creates a new kind of health insurance market in which workers, not employers, select and own the policies, picking and choosing from a variety of plans, including health savings accounts (HSAs), that pay the premiums tax-free out of flexible spending accounts (see HSA article, p. 1).

Indeed, in one key feature, the plan requires everyone to buy health insurance.

The idea is to make it easier for workers in nontraditional jobs — including part-time and seasonal employees, as well as contractors, sole proprietors and individuals with more than one job — to get and keep coverage. (And there are financial incentives for employers to pay a portion of their employees' premiums.)

By some estimates, carriers will be able to reduce average individual premiums by 20-50%.

It's just beginning to go into effect, with full implementation a couple of years away, but already it sounds amazing.

"I brought up [the Massachusetts plan] at a meeting of the American Association of Insurance Compliance Professionals," said Kevin Beagan, deputy commissioner of the Massachusetts Division of Insurance," and I've never seen so many people with their mouths hanging open.

"They could not believe that Massachusetts was implementing this. But they're not aware of how our market currently operates, and how what we are doing could work here."

"Here," meaning in his state, but probably not anywhere else. That's because the Massachusetts market for health insurance — and for that matter, its market for health care itself — is very different from just about anywhere else in the nation.

"We're dominated by four major nonprofit HMOs that probably have 75% if not more of the market," explained Beagan, who also serves as director of the State Rating Bureau.

"They realize that to compete they had to have every doctor — and the four large HMOs in our market do have just about every doctor in their own individual systems," he added.

"We usually refer to them as HMOs in drag. But they are HMOs, they are located here, they are nonprofit, and they're not going to leave. So it's almost as if whatever laws our Legislature throws at them, they're stuck and they've got to live with them.

"In addition, we've got a very compact state with a very large number of hospitals, and again, most of them are nonprofit — there are maybe two at most that are for-profit. And again, the hospitals are not going

anywhere, and they have in many cases accepted the fact that what our Legislature throws at them, they need to accommodate."

On top of that, since the early '90s, Massachusetts has had a guaranteed-issue health law.

Beagan explains: "Any company that is offering small-group coverage in our state not only has to offer it to every small employer between 1 and 50 eligible employees, but also, as a condition of being in our small-group market, they have to offer a guaranteed-issue product to any individual who wants to buy it — no questions asked.

"No health screening, no medical underwriting, and it's a Cadillac plan: soup to nuts, including unlimited drugs." There's a six-month pre-existing condition limitation, but the plan is available at any time with no annual open-enrollment period.

But wait, there's more.

The local HMOs can charge rates that are not subject to hearings. Plus there's a mechanism that allows the plans to rid themselves of any untoward risks, though they're not as a rule taking advantage of it. In general, though, all these factors would seem to be tailor-made to generate really expensive health coverage.

"Our prices as a whole in Massachusetts are exorbitantly high compared to the rest of the country," Beagan said, "because the cost of health-care delivery is so high here."

That's why most of the national health insurers have made it clear that they have no interest in moving into the Massachusetts market.

"Costs are 10-15% higher, just for hospital stays," Beagan said. "A lot of this is driven by the large teaching hospitals in Boston and because every HMO has every teaching hospital — and every other hospital — in its network."

"Our governor recognized that the time was ripe to really look for a different way of making sure that individuals had coverage," Beagan said.

The hard part

If health insurance is already expensive in Massachusetts, how are the unemployed and underemployed supposed to come up with the premiums?

One feature of the new program is subsidies, in the form of vouchers, for individuals below a certain income level. Plus there will be something called the connector that's designed to make it easy to locate coverage and find out which policy might be appropriate, rather than sort out competing claims —improving choice and portability.

The connector has been likened to a stock exchange: a single market organizing the sale and purchase of a number of similar products. It's also similar to the Federal Employee Health Benefit Program (FEHBP), which allows federal employees to choose from a variety of competing, private health insurance plans, and to keep the plan of their choice if they change jobs within the federal government.

Once the connector goes into effect, premium payments and the value of the benefits from the plan are tax-free, both to individuals and to businesses.

Tax-exemption is a classic carrot that states use to encourage behavior, but be assured that the Massachusetts plan uses some sticks too.

What would happen, for instance, if a small business ignored the employer mandate when it went into effect? They'd be liable for a fee of up to $295 per year per employee, with the cash earmarked to help subsidize the low-income.

Well, what would happen if a self-employed individual ignored the mandate and decided to go bare?

Boy, are we glad you asked. For the plan calls for the Department of Revenue (DOR) to either bill that individual for the coverage he or she should have bought — or take it out of an income tax refund.

That sounds somewhat like what most states do with auto insurance: require motorists to show proof of insurance when registering each year. Of course, those who don't want to pay for coverage often cancel the policy the day after they pick up their new plates, and even those states with active programs to catch cancellations can encounter gaps. What's to prevent that from happening in health insurance?

The Massachusetts plan calls for DOR to track coverage monthly, not annually, to prevent even small gaps in coverage.

This part of the plan, which doesn't go into effect until '08 (a year after the individual mandate), has become one of its most controversial elements.

continued on next page

Revolution begins in health care

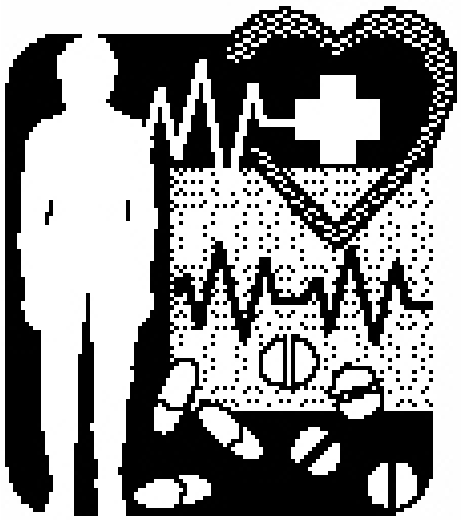
continued from previous page

That's because the department has demanded that health carriers use Social Security numbers to identify their customers. That way, they can more easily verify which taxpayer has or doesn't have coverage this month.

"Most of the insurance companies have made us well aware that they don't store Social Security numbers any more," said Beagan.

"Our Department of Revenue has made it absolutely clear that they need it. If they don't get a Social Security number, they have no way of actually lining it up with someone's taxes, and then dinging them on their taxes.

"It's become a major, major issue, to try to make sure that we're able to construct a database that's reliable," he said.



Remember that the dollars involved are substantial. We're not talking about low-cost major-medical plans here — indeed, it's illegal to sell such products in the state of Massachusetts (though somewhat modestly priced high-deductible plans will continue to be available).

Though Gov. Romney was able to incorporate some deregulation into the final compromise bill, his state remains one of the most highly regulated health insurance markets in the U.S., with an array of underwriting rules, rating restrictions and coverage mandates.

The reality is that, even in Massachusetts, the plan is controversial. And for the most part, it's not really in effect yet.

As Beagan put it, "The euphoria of passing this a few months ago is slowly being replaced with all of the hard questions about who's going to be doing what when.

"I hope that six months from now I'm able to tell you that the pieces are all coming into place," he added. "If we can get through this summer, I think we'll have good headway on how to get this thing implemented."

But, he added, "based on what I'm aware of, in other markets it would be very difficult to do at this time."

Other states

We haven't heard of any other state with as thorough-going a revision of health insurance as Massachusetts, though a number of them have made substantial moves to improve coverage and costs.

One big impetus is what's known as the Wal-Mart effect: the consequences of Wal-Mart's efforts to keep prices down — including holding down wages and benefits.

With 1.7 million employees, the retailer is larger than any other private employer. Despite the fact that, overall, its benefit policies aren't worse than other retailers, Wal-Mart's size makes it vulnerable.

Last January, Maryland passed a law requiring any company with more than 10,000 workers — surprise! Wal-Mart is the only outfit that meets the definition —to spend at least 8% of its payroll on health care. Fully 30 other states are considering enacting similar legislation.

In a revealing interview with *Atlantic Monthly,* Andy Stern, president of the Service Employees International Union and one of Wal-Mart's main antagonists, revealed that his aim isn't to organize the retailer for his union. He intends to make an example of them, forcing change in employees' access to health insurance across the nation.

As Stern said in that article, "If Wal-Mart's CEO, Lee Scott, were to come out and say, 'We need a national health-care system that works for everyone,' then it's a whole new ball game."

On the assumption that his strategy will fail, and Wal-Mart will neither reform its own employee health system nor force the federal government to change its stripes, the action seems likely to remain at the state level.

One excellent example of what's going on is in Maine, where the new Dirigo Health Reform had

enrolled 9,743 at last report in DirigoChoice, a product administered by Anthem Blue Cross Blue Shield.

The policies offer comprehensive coverage to small groups, sole proprietors and individuals. Mainers with household incomes under 300% of the federal poverty level can receive subsidies on their premiums, as well as on deductibles.

The program is funded by an assessment based on anticipated savings in the health-care system.

The state's Superintendent of Insurance estimated last year that Dirigo-related savings to the health-care system would come to $43.7 million, and insurers and third-party administrators have been assessed this amount (though they've appealed the legitimacy of the ruling both in court and in the Legislature).

In addition, bad debts and the cost of charity care are expected to decrease as more people are insured. Plus the state's hospitals, providers and insurers have agreed to voluntary revenue caps, and regulatory changes have been made to the existing Certificate of Need process for reviewing proposed hospital projects.

Interestingly, the Maine plan includes specific measures to improve the quality of care, including establishment of a Maine Quality Forum to promote safe practices among hospitals through a certification program that rates hospitals against national standards.

The new agency has already begun providing information on the quality of care at some of the state's hospitals on its Web site and is developing a statewide project that will allow any provider to access the patient's complete medical records (with, of course, the patient's consent).

Down the road from Maine, in Vermont, the 2006 Health Care Affordability Act established Catamount Health (what is it with these names?), a voluntary plan aimed at the uninsured.

Something like 25,000 of the state's 60,000 uninsured are expected to sign up in the initial phase of the new program. The ultimate goal is to enroll 96% of eligible Vermonters, and if that goal isn't met by 2010, the legislation calls for making Catamount mandatory.

Besides premium income, Catamount will be funded by assessments on employers who don't offer group coverage, or who for some reason don't enroll all workers, as well as increased tobacco taxes (the per-pack tax tripled to $1.79 this month and will rise another twenty cents in July 2008). The employer assessment comes to $365 per full-time employee, remarkably close to the Massachusetts figure, and just as prone to raise one question: Since that's less than the employer cost of insuring an employee, why not just pay it?

In Pennsylvania, a bill has been introduced that would use a 10% payroll tax and a 3% personal income tax assessment to fund universal care. The bill, which calls for bypassing traditional insurers in order to cut administrative costs, is seen as unlikely to pass.

Similarly, a controversial bill introduced this session in the New York Legislature by the labor-backed Working Families Party is promoting discussion but is unlikely to be enacted into law — if only because it involves a tax hike, estimated by the state's small business lobby as $8.4 billion.

Next steps

No matter who takes or retains control of Congress this fall, no matter who wins the White House in '08, a single-payer system or other nationwide solution to the puzzle of health care is not likely any time soon.

Controversial or not, costly or not, the health-insurance ball is going to stay in the states' court.

In the end, assuming the Massachusetts bill turns out to be a success story, perhaps that's the system to emulate.

Beagan isn't so sure his state's experience can be exported to other venues.

"They would have to do it in steps," he said.

"I really think each state would have to get the carriers involved in its market used to the guarantee-issue world, where you cannot automatically underwrite or health-screen. And that in itself was a big step when we implemented that in 1996.

"That was 10 years ago, and we had a mass exodus from our market," Beagan added. "We were just fortunate that the four or five big companies that dominate our market are local and decided to stay.

"For those companies that may have for-profit national affiliates, like the Humanas, they may decide that's something they just don't want to be part of." ■

IRES Membership Drive

The IRES Membership & Benefits Committee announces its 2nd annual membership drive. For this year's membership drive, the Membership & Benefits Committee is challenging each and every IRES member to recruit one new general member.

Every member that meets the challenge and recruits at least one new general member will receive a token of appreciation from IRES.

It's as easy as 1, 2, 3.

1. Identify potential new members.
2. Initiate contact.
3. Follow up!

So take the Membership Challenge! Complete details and everything you need to promote IRES are available online at **www.go-ires.org**. For additional information about this year's membership drive, contact Jo A. LeDuc, Membership & Benefits Chair at jo.leduc@oci.state.wi.us or (608) 267-9708.

"Quotes of the Month"

"[The McCarran-Ferguson Act's] repeal would not improve the affordability, reliability or availability of insurance to consumers, but rather inject uncertainty, reduce stability and predictability, deter capital infusions, and ultimately harm competition and raise costs."

— Illinois Director of Insurance Michael McRaith, representing the NAIC, testifying at a U.S. Senate Judiciary Committee hearing on the implications of repealing the McCarran-Ferguson Act

"McCarran-Ferguson is one example of an exemption that has no apparent business justification and that impedes free and open competition in a major sector of the U.S. economy."

— New York State Assistant Attorney General Elinor R. Hoffmann in testimony before the same hearing

Clockwise from Left: **Sam Binnun, Florida Insurance Department • Susan Voss, Iowa Insurance Commissioner • School Chairperson Lew Melahn, aboard the Queen Mary with Teri Hernandez**

The 2006 Market Regulation School

More than 270 industry compliance professionals and insurance regulators attended the 13th annual National Insurance School on Market Regulation at the Hyatt Regency in Long Beach, Calif., April 30 to May 2.

Attendees furthered their study of market analysis regulation, the future of market conduct exams, "suitability" and various other insurance regulatory issues.

The Foundation's 2007 School will be April 15-17 at the Westin Hotel in Hilton Head, S.C.

Left: Joel Laucher of California (back to camera) meets privately with industry compliance personnel • *Lower Right:* Anne Marie Narcini explains regulation in New Jersey • *Lower Left:* Stephen King, IRES President, and Carol Newman, chair of the IRES Foundation

Welcome, new members

Scott P. Borchert, MN
Ronald P. Broussard, Jr., LA
Patrick D. Campbell, CA
Kimberly A. Coward Mullins, CIE, VA
Roy A. Foster, NC
Walter D. Guller, MO
David J. Isaacs, KS
John I. Morgan, NC
Candace B. Reese, DE
Lee I. Shimmin, CA
Robert F. Sloper, AK
Charles Swanson, WV

C.E. News

Coming to the CDS in Chicago to get your IRES continuing ed credits?

Then be careful with your travel arrangements.

The only way to obtain a full 15 credit hours from CDS is to stay until the bitter end and pick up your attendance certificate. The certificate handout room will open at 3 pm Tuesday — and no sooner.

There are no exceptions for travel or work schedules. The only way to obtain all 15 hours is to stay until the certificates are handed out on Tuesday.

It goes quickly, however, so don't be alarmed by the long line that materializes outside the certificate room at 3 pm. Once the doors are open, virtually all certificates are distributed within 15 minutes.

Those who leave the CDS early may apply for C.E. afterward, but the maximum granted will be 12 hours.

N · I · C · E
National IRES Continuing Education
The mandatory continuing ed program for AIE and CIE designees

Compliance Professionals to gather in Orlando

The Association of Insurance Compliance Professionals (AICP) will host its 19th Annual Conference in Orlando, Florida from Oct. 8 through Oct. 11, 2006, at the Orlando Peabody Hotel.

More than 700 insurance professionals, regulators, members of trade associations and vendors are expected to participate in this year's conference.

The program will offer a variety of educational sessions and workshops that address professional development as well as current topics geared to compliance professionals of every experience level, from beginner to advanced. In addition, a variety of regulatory sessions, workshops and roundtables will be presented by regulators from more than 30 states and representatives from the NAIC, FEMA and Canada.

The AICP is a non-profit, non-lobbying membership corporation founded in 1985 as the Society of State Filers. In 1998, the name was changed to Association of Insurance Compliance Professionals (AICP) to reflect the diverse membership and activities of the organization. For more information, visit: **www.aicp.net**.

IRES State Chapter News

CALIFORNIA — California State Chair **Polly Chan**, CIE, has reactivated the California State Chapter to promote IRES and to offer enhanced training, collaborative and networking opportunities for regulators. Interim officers include **David Langenbacher**, CIE, president; **Woody Girion**, CIE, vice president; **Russell Meals**, vice president; **Nicholas Adam Gammell**, vice president; **George Yen**, CIE, treasurer; and **Craig Dixon**, secretary.
At the May 31 meeting, **Deputy Commissioner Woody Girion**, CIE, expressed the need for greater participation in the IRES organization.
— Polly Chan, CIE; chanp@insurance.ca.gov

LOUISIANA — **Lieutenant Alan Carpenter** of the Louisiana State Police Insurance Fraud Unit addressed the Louisiana Chapter meeting on May 4. Lt. Carpenter discussed how the State Police Insurance Fraud Task Force operates and the various types of insurance fraud they encounter. He also discussed the various fraud issues that arose after Hurricanes Katrina and Rita, including false insurance claims.
— Larry Hawkins; lhawkins@ldi.state.la.us

NEBRASKA — **Jack Herstein**, Assistant Director Securities Bureau, with the Department of Banking and Finance and **Jane Francis**, the Department of Insurance's Consumer Affairs Division Administrator, spoke at the Chapter's April meeting. Jack explained the functions of his division and discussed the use of seminars for selling investments. Jane discussed the Nebraska Senior Protection in Annuity Transactions Act and complaints regarding suitability issues.
Two Nebraska IRES members have recently received their AIE designations. They are **Reva Vandevoorde**, Market Conduct Supervisor, and **Scott Zager**, Consumer Affairs Division Complaint Investigator. Congratulations to both!
Details of upcoming Nebraska chapter meetings can be found on the IRES Web site.
— Karen Dyke; kdyke@doi.state.ne.us

OREGON — At our April meeting, we heard from **Pat Allen** of the Director's office for the Department of Consumer and Business Services. He discussed efforts by Oregon state government to streamline regulatory processes, and also discussed the process of developing policy proposals for the Oregon legislature.
In May, the group's guest speaker was **Jan Margosian**, the Consumer Information Coordinator from the state Department of Justice. She discussed the Department's efforts to provide protection for consumers from illegal business practices and financial fraud. We also discussed ways in which the Insurance Division could work cooperatively with the Department of Justice to better assist consumers in our state.
— Cliff Nolen; Cliff.Nolen@state.or.us

VIRGINIA — Our quarterly IRES Chapter meeting was held in conjunction with the Richmond Society of Financial Service Professionals (RSFSP) on April 25 with 27 regulators in attendance. Presentations regarding Virginia's current life and health laws and regulations were given by the following Bureau employees: **Andy Delbridge** on company licensing, **Al Battle** on policy forms and rates, **Preston Winn** on agent licensing, **Jackie Waters** on consumer services, **Raymond Anderson** on agent investigations, **James Young** on market conduct, **Julie Roper** on market analysis, **Tom Bridenstine** on ombudsman services, and **Jackie Cunningham**, Deputy Commissioner for Life and Health Market Regulation, provided an overview of new Virginia insurance statutes.
— Carly Daniel; carly.daniel@scc.viriginia.gov

Casual Observations

Keeping Your Foul-Ups in Perspective

When we first got wind that up to 26.5 million personal files* were pilfered from a Department of Veterans Affairs (VA) analyst's Maryland home, our hearts — like everyone else's — went out to all those men and women whose names, birth dates and social security numbers were compromised. The theft was apparently the biggest data loss ever suffered by a federal agency.

The more we thought about it, however, the more we also empathized with the unnamed civil servant who actually brought those files home to complete his assignment. We're sure he wasn't the first VA employee to work on unencrypted data from his home, nor the first whose bosses — and we're guessing here —turned a blind eye to it.

We've all been there. "Get it done by Tuesday — or else." Implicit in that directive is: "We don't care how you do it, just do it." After all, would anyone really *want* to toil over 26 million files at home. (*"Honey, can you hold dinner? I just have to crosscheck 6.7 million more names."*)

Ever since we heard the news, we've been thinking about how this beleaguered civil servant broke the news to his boss. How do you tell someone you just lost 26 million files? We envision a conversation something like this:

Analyst: You know those files you wanted completed by today?
Boss: Of course, where are they?
A: Well, I took them home last night to complete the project.
B: Good thinking! Did you finish?
A: Well, some files were . . . how should I put this . . . compromised.
B: Compromised?
A: Well, stolen.
B: Stolen?!
A: Yes
B: How many files were taken? A dozen? A hundred?
A: 26 million
B: 26 million!!
A: Yes, give or take a few . . . million.

About one in nine adult Americans is now a potential identity theft victim thanks to this fellow. As one veteran put it, those that once helped protect America now feel they can't trust it to protect their private information. Imagine making a blunder that enraged millions of constituents, besmirched your agency for decades, and cost tens of millions to mitigate. That's one royal screw-up!

A few years ago, a co-worker gave us a plaque with a photo of a sinking ship inscribed: "*It could be the purpose of your life is only to serve as a warning to others*." If that analyst's name should ever be revealed, we'll be glad to send him the plaque. We'll also express our thanks for helping us to keep all our foul-ups in perspective.

* At press time, the FBI had announced it had recovered the analyst's stolen laptop with the files intact. The agency said that its "preliminary review" indicated that none of the data had been accessed. Prior to the FBI announcement, the VA said it had reduced its estimate of potentially affected persons from 26.5 million to 17.5 million.

— W.C.

Chicago — your kind of town

by Mike Hessler, CIE, AIRC

Chicago is a business center with a diverse, powerhouse economy. It is also a tourism center, with world-renowned shopping, dining, museums, architecture, music and more. It's definitely your kind of town.

Chicago is known as the Windy City and some say it's because of the strong winter winds off Lake Michigan, while others believe the moniker stems from all the hot air emanating from City Hall. In any event, we think you'll fall in love with Chicago and its distinctive diversity.

Chicago's free trolleys are a great way to see some of Chicago's most popular attractions. The trolleys run seven days a week from 10:00 a.m. to 6:00 p.m. and serve popular visitor, cultural and shopping destinations.

For those of you who like to shop, Michigan Avenue, also known as the "Magnificent Mile," offers 460 stores within eight city blocks. Marshall Fields, Lord & Taylor, Saks Fifth Avenue, Nordstrom, Bloomingdale's and Nike Town are just a few of the stores located there.

Chicago is a very diverse city as evidenced by its many ethnic neighborhoods. Some noteworthy places to visit are Printer's Row, Wrigleyville, River North, Streeterville, Old Town, The Loop, Maxwell St., Chinatown and Greektown.

If you are into the more cultural side of Chicago then you might want to visit some of these great attractions; the Field Museum, the Art Institute, Millennium Park, the Museum of Science & Industry, the Museum of Contemporary Art, the Adler Planetarium, Shedd Aquarium, John Hancock Observatory, Sears Tower, Brookfield Zoo, and the Lincoln Park Zoo. Of course no trip to Chicago would be complete without a trip to Navy Pier, 50 acres of parks, restaurants, shops and attractions. Free fireworks light up the lakeshore skyline every Saturday night.

And what better way to cap off a full day of sightseeing and shopping than a great meal at any one of the many world-class restaurants Chicago has to offer? There are the usual chain restaurants: Ruth's Chris, Morton's and the ESPN Zone. While there are a lot of spectacular restaurants, some of the more popular ones include the Kinzie Chop House for steaks & chops, Boston Blackie's for burgers, Andy's Jazz Club for great jazz, Nick's Fish market for seafood, Bin 36 for both steak and seafood, the Weber Grill where food is actually cooked on a Weber Grill and the ever-popular Harry Caray's (Holy Cow!).

If you like sports, Chicago is home to the Cubbies, Da Bears, the Bulls and the World Champion White Sox. Only the White Sox will be playing at home during the CDS; the ballpark is a short cab ride down the Dan Ryan Expressway.

So you say you want more? Well try the North Halstead Market Days on August 5-6. This event is the largest two-day street fair in the Midwest and spans six city blocks and typically offers over 400 food, arts and crafts vendors. Still not enough? How about the Royal George Theatre with its Rat Pack tribute to Frank, Sammy, Joey & Dean? You're guaranteed to be transported to a balmy night in 1960 when four show business icons converged at the Sands Hotel in Las Vegas to regale audiences with their freewheeling, no-holds-barred show.

See you in Chicago.

New York's Richard Nebb, CIE, also contributed to this piece.

BULLETIN BOARD

√ There's still time to register to attend next month's Career Development Seminar in Chicago. But don't wait! If you haven't registered, contact the IRES office right away at 913-768-400. Ask someone to email or fax you a registration form. Fees, hotel information and everything else you need to know is at **www.go-ires.org**

√ Correction: In the May issue, Marsh & McLellan was misspelled in Karl LaFong's front-page article. In the "2006 Commissioner Guide" on pp. 8-9, Missouri Commissioner Dale Finke's surname was misspelled.

√ Due to space constraints, REGULATORY ROUNDUP does not appear in this issue. The feature will return in the September issue.

In the next REGULATOR:

Highlights and photographs from the Chicago Career Development Seminar

BULLETIN BOARD items must be no more than 75 words, and must be accompanied by the sender's name, e-mail address and phone contact information. Submit plain, unformatted text without special font stylings, underlined hyperlinks or special margins and headings. A submission will be posted in the next edition of *The Regulator* as well as on the IRES Web site.

The Regulator®

Published by the
Insurance Regulatory Examiners Society
12710 S. Pflumm Rd., Suite 200, Olathe, Kansas 66062

e-mail: ireshq@swbell.net
www.go-ires.org

What state regulator received the 2006 DeAngelo Teaching Award? p. 3

AUTO
First Class Mail
U.S. Postage Paid
Kansas City, MO
Permit No. 1794