INSURANCE REGULATORY EXAMINERS SOCIETY

Addressing violations of law and regulations in market conduct exams

by Douglas A. Freeman, CIE

This is another in a series of articles in The Regulator *summarizing some of the chapters in the Insurance Regulatory Examiners Society's Market Conduct Certification Plus (MC+) textbook. The MC+ textbook, classes, and case studies are geared to providing practical educational training and certification to regulators, examiners, independent contractors, insurance industry personnel, and attorneys about how to run effective targeted market conduct examinations, as warranted by market analysis.*

Freeman

This article explains how to address various violations of law and regulations during a market conduct examination. As a prerequisite, one should be aware of the various types of violations that may occur during an audit and how to distinguish an alleged violation from other types of errors.

When reviewing records for compliance, an examiner should perform **three tests**:

- **Determine if a violation of law or regulation has taken place.** A violation can take several forms, i.e., a company may have violated a state statute; a company may not have complied with a specific regulation; or, a company may not have followed an Insurance Department advisory bulletin correctly. Another possibility is that a court in the pertinent jurisdiction may have recently ruled on a case similar to the fact pattern at issue in a review.
- **Determine if a violation of company procedures and/or policies occurred.** These violations differ from violations of law. While a company may not have violated a specific insurance law, it does have a contractual duty to provide the services that it promised to perform when issuing an insurance policy. Furthermore, even if a company did provide a contracted service (according to a policy provision) and did follow the state's insurance laws, the company can still be criticized for not following its own written procedures on how to handle a claim, underwrite a file, etc.

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Policies are contracts — *unless no one enforces them*

by Scott Hoober
Special to *The Regulator*

We know an economist who likes to say that the entire banking system is a giant con game. He means it in a good way: The system depends on the public having confidence in bankers and banking regulators to keep things on an even keel.

Insurance is a lot like that. As long as insurance companies act in good faith, regulators keep an eye on them and most consumers don't try to defraud the companies, claims get paid. The companies do OK too, earning a decent profit on both underwriting and investing.

Yet some people have begun to say that, when it comes to insurance, since the 90s this mutually beneficial system has been breaking down.

A number of large companies, they allege, have been putting the almighty dollar ahead of the once-almighty customer, shortchanging policyholders and earning greater-than-ever profits.

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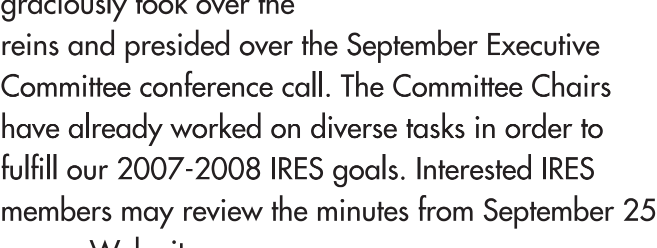
From the President

Gaining higher ground

I recently returned from a strenuous but fascinating trip to the mountainous area of China, near Mongolia. On my trip, I found the higher I climbed, the more spectacular the views. It reminded me of the progress we've made at IRES. Our organization has overcome frequent hurdles and climbed several mountains. As a result, we have gained the higher ground of success.



During my absence, our President-Elect, Jo LeDuc, graciously took over the reins and presided over the September Executive Committee conference call. The Committee Chairs have already worked on diverse tasks in order to fulfill our 2007-2008 IRES goals. Interested IRES members may review the minutes from September 25 on our Web site.

I am delighted to share the good news that IRES has achieved one of its global goals. The Market Conduct Plus (MC+) Certification program is to be launched in November. The MC+ Program will provide practical training and certification on how to run effective and efficient market conduct examinations.

I would like to express my appreciation to Gary Domer and the MC+ Subcommittee for their tremendous effort to develop the MC+ textbook,

class, and case studies. Also, on behalf of IRES, I would like to extend our gratitude to the IRES Foundation, the independent contractors groups, and law firms that provided generous and continuous support.

As to the other learning opportunities, IRES Immediate Past President, Doug Freeman, will continue to be the external IRES representative working with the Association of Insurance Compliance Professionals (AICP). Joe Bieniek, our newly elected IRES Board member and A&E Committee member, will serve as IRES' internal point person to implement the tasks suggested in the AICP/IRES Strategic Alliance Project plan. IRES and AICP will collaborate in areas of common interest. Joe is looking forward to working with the respective IRES Committee chairs and members. Therefore, IRES members, please stay tuned!

Many of you are aware that Doug Freeman recently left the regulatory ranks to join Sonnenschein Nath & Rosenthal LLP as an insurance regulatory consultant. Since he is no longer a regulator as defined by IRES bylaws, Doug has resigned from the IRES Executive Committee. We'll miss Doug as an IRES Executive Committee and Board member, but Doug has assured us that he will remain active on various other IRES committees.

With Thanksgiving just around the corner, I would like to take the opportunity to thank the IRES staff, the Executive Committee members, and all the unsung heroes who have labored to climb with IRES to the higher ground. Finally, I wish all of you and your families a VERY HAPPY THANKSGIVING HOLIDAY!

God Bless,

Polly Chan

Polly Chan, CIE
IRES President

Chapter News

NEBRASKA — **John Dohmen**, Vice President and Treasurer of the Insurance Marketplace Standards Association (IMSA) spoke at our September meeting. John provided a detailed explanation of IMSA, including its history and purpose. He also discussed variable, fixed and indexed products, supervision standards, trend analysis and more. Details of upcoming meetings can be found on the IRES Web site as they are scheduled.
—*Karen Dyke; kdyke@doi.state.ne.us*

VIRGINIA — We held our quarterly IRES meeting on September 12 with 22 regulators in attendance. **Rusty Shropshire**, P&C insurance market analyst, and **Bill Benson**, L&H insurance market examiner, summarized some of the key sessions from the recent CDS in Pittsburgh. The session was highly informative.
—*andrea.baytop@scc.virginia.gov*

"Quote of the Month"

"The NAIC and its members welcome Congressional interest in insurance supervision. But even well intended and seemingly benign federal legislation can have a substantial adverse impact on existing state protections for insurance consumers. Modernize, don't federalize."

— NAIC President and Alabama Insurance Commissioner Walter Bell, in testimony on October 3 before the U.S. House Subcommittee on Capital Markets, Insurance and Government-Sponsored Enterprises

Finding violations during market conduct exams

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- **Use professional skepticism (i.e., the "smell" test) in instances when the facts do not seem to add up to some logical conclusion.** Even if a company has followed the law and all of its policies and procedures, the possibility exists that a situation may still be suspicious due to the specific nature of the circumstances. An examiner should not go on a "witch hunt" or attempt to "throw the kitchen sink" at a company. However, an examiner's instincts should be followed in those instances when something just does not add up or make sense (i.e., it fails the "smell" test).

I. Best Course of Action

An examiner should address each of the above three tests in a specific manner, as outlined below. At times, the examiner can address these issues simultaneously. What is important to keep in mind while reviewing the relevant files is that the standards and procedures for these three tests differ from each other, and the best course of action for each will vary, depending on the situation.

A. Documenting Violations of Laws and Regulations

For instance, in order to allege a violation of a law or regulation, an examiner must have specific proof and documentation of an error. This first requires obtaining the pertinent facts and a list of relevant state statutes, regulations, Department advisory bulletins, and case law for each line of business under examination. Other chapters of the IRES MC+ textbook cover how to obtain the pertinent facts and sample data for review. Presented here is how to acquire the relevant pool of insurance law within which to test the company under review.

Nobody should expect an examiner to know all the insurance laws of all the states off the top of his head. Yet, it is prudent for an examiner to research, summarize, and organize the basic insurance laws into a format that an examiner can easily access.

While state employee examiners, contract examiners, and independent examiners may have several assignments pending for various projects or clients simultaneously, an examiner usually is working on one examination at a time for one state (or several states, if it is a multi-state examination). Therefore, it is reasonable for the examiner to follow some version of the best courses of action indicated below.

- **Compiling Statutes, Regulations, etc.** Whether compiling state statutes, regulations, Department bulletins, or case law, the examiner should get a listing of all pertinent laws associated with the lines of business (individual and/or group life, accident and health, property and casualty, annuities, managed care insurance, etc.) for the market conduct examination in effect for the jurisdiction (i.e., state) and time period of the records under review.

  Fortunately, for those examiners who travel to the insurer's site to perform examinations, the Internet has simplified the task of obtaining these listings of laws. The NAIC has links to all state Insurance Departments, many of which have links to state insurance statutes, regulations, and Department bulletins. (State insurance laws are also available through on-line subscription services, such as the National Insurance Laws Service (NILS).) *Be careful, though, to use the law in effect during the time period under review. Some Internet sources contain only the current law and not the laws in effect years ago. Even though the chances are small that a law you're reviewing has been changed, it does occur more often than one may realize, and an oversight in this area does not reflect well on the final work product.*

  Obtaining an accurate list and interpretation of pertinent case law is a little bit more difficult. It is recommended that the examiner contact appropriate Department legal counsel in order to retrieve the correct case briefs, rulings, and Department legal interpretations of court rulings in effect for the jurisdiction during the time period of the examination.

- **Recording Data & Legal Research.** After obtaining this pool of insurance laws, regulations, Department bulletins, and case law relevant to the lines of business and

jurisdiction under review, the examiner should develop Excel spreadsheets (or similar type of worksheets) to serve as a checklist and record of the examiner's work. The format and content of these spreadsheets vary tremendously. Basically, they should contain the company listing of the data from the sample or census of the line of business under review along with pertinent data, dates, amounts, etc., that the examiner has selected through computer generated programs like ACL (Audit Command Language). The examiner usually adds more columns to the spreadsheet to note important dates, company actions taken or not taken, and formulas to count the number of calendar and/or work days taken to acknowledge, investigate, and/or pay or deny a claim, underwrite a file, reply to complaints, file advertising, calculate any interest due, etc.

In addition, many examiners add columns to these worksheets with notes and legal citations summarizing their research about the pertinent state laws for the line of business under review. These checklists are handy, quick references to remind the examiners what to look for during the review and to record their work appropriately.

B. Documenting Violations

At this point, one should have completed the research on the pertinent laws, obtained the data to be reviewed, and organized the information in a spreadsheet in order to begin the market conduct review.

Other chapters of the IRES MC+ textbook discuss how to collect company data and sample in a statistically valid and fair manner. In addition, examiners may need other supplementary material in order to continue with the review. This includes selecting policies from all relevant jurisdictions to review for legal compliance, gathering rate and form filings from each relevant Insurance Department, and obtaining other materials pertinent to the line of business and jurisdiction(s) under examination. Appropriate market conduct and legal staff in each Department office can assist the state employee, independent or contract examiner, etc., with the collection of this material.

- **Gathering Company Policies.** When an examiner selects or is provided with policies from all relevant jurisdictions to review for legal compliance, it is important to note and verify the following:

  First, obtain a list of all the company policies. While it may be helpful to have the template for all versions of these policies, for legal compliance, the examiner really needs the actual policy forms, amendments, riders, etc., for the specific file(s) in the sample under review. Many policies look similar but have important differences. Templates are not detailed enough to check for legal compliance when auditing specific files. Additionally, the template may only reflect current language and not correspond to the language in use for the examination period. A company should be able to reconstruct the actual, complete policy.

  Further, some companies market policies in other languages to serve particular markets. Do not assume that the foreign language version of a policy, application, or marketing piece is exactly the same as the English version. If a member of the examination team is not fluent in the other language, it is helpful to have policies, applications, and marketing materials translated by a competent person. Often, it is not necessary to have the entire document translated, but sections concerning eligibility, benefits, limitations, and exclusions should be scrutinized carefully. Foreign language applications should also be translated to assure that the questions asked comply with each state's laws and regulations.

- **Obtaining Rate and Form Filings.** Likewise, an examiner needs to gather – or be provided with – rate and form filings from each relevant Insurance Department for the lines of business under review. Some Departments may have this information online, but again, be careful to use the appropriate version when auditing files from years ago. Obtaining an accurate list of forms and filings and the Department form approval sheets is vital for a thorough compliance review.

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C. Documenting "Smell" Test Concerns

An examiner's instincts and experience are important tools for reviewing files for compliance, as explained more fully later in this article. However, documenting one's instincts and experience requires drawing a distinction between one's personal concerns and the facts. The examiner should document concerns in an internal Department Management Report for possible legislative and NAIC Model Law consideration and tracking or reference to other regulatory authorities (other states or federal government entities) with jurisdiction in those other areas.

II. Performing the Compliance Review

Now the examiner is ready to review the material for legal compliance and apply the three tests described above.

A. Testing for Law Violations

In order to test for violations of the law, remember the following basics:

- Statutes supersede regulations, which, in turn, supersede Department advisory bulletins. All are subject to interpretation by courts and administrative hearings in the pertinent jurisdictions. If a specific law applies, use that law instead of a general law. In many instances, a statute authorizes the issuance of regulations. Sometimes an examiner needs to cite both the statute and the regulation. The Department issues advisory bulletins to clarify regulations even further. Court rulings and administrative hearings apply to specific cases, but the ruling may have broader implications for similarly situated circumstances. The examiner should consult with Department legal counsel to clarify the interpretation of a law in effect during the time period of the records under review.
- Laws are not necessarily clear or specific. For example, many "prompt pay laws" are not as clear as they may seem. Moreover, many insurance laws – particularly in the health arena – are subject to significant interpretation.

  Yet, examiners are fact-finders, not courts of law. The role of an examiner is to record the facts and not act as a judge, jury, or attorney.

So, how does one lay out the facts in a way that demonstrates an alleged violation of law? While there is no one way to proceed with this task, the following recommendations may be helpful, especially with the more complicated laws:

- **Follow the wording of the law.** Whether an examiner likes, understands, agrees with, or disagrees with the law does not matter. Follow the wording of the law.
- **Do not paraphrase. When in doubt, quote the law, word for word.** State Legislatures pass laws for specific reasons, and Departments issue regulations for specific reasons as well. Each word and/or punctuation mark may be in the text of the law for a particular purpose. It is not the examiner's right or prerogative to paraphrase statutes, regulations, bulletins, or case law. When in doubt about the meaning or phraseology of a law, quote the law, word for word. *It is also a good idea to ask Department legal counsel for assistance.*
- **Break down complex laws into their component parts.** In more complex statutes and regulations, outline and break down the elements of the law into component parts. This facilitates the task of ascertaining whether each element of the law has been addressed.
- **Outline the gathered facts to follow the component parts of the law.** Especially with more complicated fact patterns (such as, but not limited to, disability claims) outline the facts in a way that mirrors the component elements of the law.
- **Lay out the facts in a manner that leads the reader to see that the component parts of the law were not followed.** Try to lay out the facts in a manner that matches the component elements of the law. When following this technique, an examiner is not drawing conclusions. Rather, the examiner is reporting the facts and demonstrating how the facts violate component parts of the law.

- **Do not draw any conclusions. Just lay out the facts.** Again, the examiner is a fact-finder, not an attorney, judge, or jury. Examiners should describe what the company actually did in response to the circumstances presented and explain how the action(s) failed to comply with the applicable statute(s) or regulation(s).
- **Document the alleged violations and submit to the company for response.** Insurance Departments submit inquiries to the company in varying formats. Regardless of what the documents are called (e.g., "Criticisms," "Requests," "Comments"), present the alleged violations in a format that asks for the company to review and comment on the specific instance(s) at hand.

B. Testing Procedure/Policy Violations

In order to test for a violation of a company procedure and/or policy, the following steps are suggested:

- Obtain access to the company's procedure manuals (either in hard copy or on-line). Also, as described above, acquire the pertinent and specific company policies (including policy forms, riders, amendments, etc.) that the company issued to the individuals and/or groups under review.
- Confirm with company personnel that the company procedures were the ones in place during the relevant time period.
- Examine the documents in the file to ensure the company followed its procedures and the provisions in its policies.
- Note differences between company procedures and the provisions in its policies, notably:
    - A company procedure is an internal procedure that employees should follow for various lines of business.
    - A provision in a company policy issued to an individual or group is a part of a contractual agreement between the company and its policyholders.
    - A violation of a company procedure is one matter. A violation of a provision in a company policy is a contractual, legal concern.
- Document any discrepancies and submit the allegations to the company for a response.

C. "Smell" Testing

The following recommendations should be kept in mind when applying the "smell" test:

- The examiner is a finder of fact, not a "witch hunter" or "kitchen sink thrower." Moreover, an examiner should not go on a "fishing expedition" seeking inappropriate company actions.
- The examiner should follow his/her instincts and not ignore an issue just because no laws, company procedures or policy provisions were violated.
- The examiner should consider whether an action taken by the insurer could potentially harm consumers.
- The examiner should thoroughly research if there are any applicable federal or state laws (e.g., anti-fraud laws), NAIC Model Laws, or other guidelines available concerning the particular issue or line of business under review.
- The examiner should document concerns in an internal Department Management Report for possible legislative and Model Law consideration as well as tracking to other relevant regulatory authorities.

III. Allegation Documents & Company Responses

Once the examiner drafts allegation documents,[1] the examiner should attach written proof that illustrates the alleged violation of law and/or company procedure and/or policy. The examiner should include documentation of the specific and relevant pages from the file, company procedure, policy, or any other material that substantiates the violation alleged in the Criticism or Inquiry.

Another chapter in the IRES MC+ textbook deals with confidentiality and work papers and the whole issue of chain of custody. The examiner should follow the guidelines in that chapter when preparing

[1] Called "Criticisms" or "Inquiries" by some Departments

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these documents and take measures to comply with state and federal Health Insurance Portability and Accountability Act (HIPAA), privacy, and other legal and confidentiality requirements.

For items that may not pass the "smell" test, the examiner should submit "Formal Requests"[2] to ensure that the Department has all the documents and information necessary for the examiner to include in an internal Management Report to the Department.

A. Soliciting Insurer Response

Most Departments have laws regarding the necessity for companies under review to cooperate with market conduct examinations and regulators in order to promote timely, efficient, and effective audits. Most Departments also offer the company an opportunity to comment on the Criticisms/Inquiries/Formal Requests that the examiners submit. These company responses then become part of the exhibits and supporting material in the Market Conduct Examination Report.

B. Handling Documentation

Whether the Department allows the company to respond to each individual Criticism/Inquiry/Formal Request or just to the entire Market Conduct Report as a whole, the examiner should review the company responses completely and log them to keep track of how long it takes the company to respond to the examiner's inquiries. This documentation is important to substantiate the substance, length, and content of a market conduct examination.

It is recommended that, based on the company's response, the examiner compile some sort of internal memorandum to the Department explaining why an alleged violation should be included in or excluded from the Market Conduct Report.

It is not recommended that the examiner enter into a debate with the company about whether an item should be included in a report. It is the examiner's responsibility to document the facts and cite any alleged violations. *Engaging in a back and forth discussion or debate with company personnel serves no purpose.* So long as the company has provided all the requested material necessary to conduct the review, the examiner should focus on reporting the facts and documenting alleged violations and errors.

C. Pre- and Post-Examination Meetings

One method of informing companies about the market conduct process and the content of the report is to offer pre- and/or post-examination meetings. As discussed in other chapters of the IRES MC+ textbook, a pre-examination meeting is vital to inform the company about the scope, content, and process examiners will follow.

Similarly, an exit or post-examination meeting is a good way to allow both the company and the examiners an opportunity to ask each other questions and clarify any concerns. The exit interview/meeting is also a way to let the company know how the Department will handle the rest of the report process (including which personnel will handle this portion of the process), the timetable for implementation, and possible stipulation or final settlement procedures (including appeal opportunities for the company).

IV. Conclusion

Addressing violations of law, regulations, Department bulletins, and court cases can be a difficult matter if the examiner does not remember that he or she is a fact-finder. Even an examiner trained as an attorney should not be an advocate for either side. Rather, the market conduct examiner's role is to document the facts, provide a level playing field for all insurers, and protect consumers – all within the purview and scope of the state laws pertaining to the lines of business under review. ■

Doug Freeman is an IRES Past President (2006-2007). He recently joined the law firm of Sonnenschein Nath and Rosenthal as an insurance regulatory consultant. The views expressed are those of Mr. Freeman and do not constitute legal advice or necessarily reflect the opinions of IRES, the NAIC, the Missouri Department of Insurance, Financial Institutions and Professional Registration, or Sonnenschein Nath & Rosenthal. In addition, Mr. Freeman's statements may not necessarily apply to an examiner's specific circumstances and readers are therefore advised to consult counsel prior to taking action. The author can be contacted at **dafreeman@sonnenschein.com**.

[2] This document is known by different names by various Insurance Departments.

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The McKinsey effect

As alleged in an article in the September 2007 issue of *Bloomberg Markets,*[1] a host of insurers — Allstate, State Farm, Farmers, USAA, Fireman's Fund and Liberty Mutual among them — refused to pay policy limits, even following the total devastation of a hurricane or tornado. The script, they say, largely comes from the New York-based consulting firm of McKinsey & Co.

According to information from lawsuits and complaints, insurers in some cases seem to be paying 30-60% of the cost of rebuilding a damaged home, then resisting fiercely if the policyholder complains or sues.

What do the companies get out of it, aside from tons of ire from their customers? Well, consider this: Over the past 12 years, they've seen profits soar, even in '05, when Katrina hit Louisiana and Mississippi.

Insurance companies traditionally have made much of their profits by investing premiums until the money was needed to pay claims. Now they're paying back to policyholders less of the premium money they collect, according to data from A. M. Best.

P&C insurers reported profits of $73 billion last year, a record high, according to Highline Data LLC, a Cambridge, Mass.-based firm that compiles insurance industry data.

McKinsey's core advice, according to Bloomberg, was: (1) make low offers, (2) fight back if claimants resist, and (3) delay payments as long as possible.

"I hope Allstate didn't pay too much for this advice," said one long-time regulator, "because anyone with a modicum of insurance knowledge would know that doing these things would help lower claims cost, though at the very real expense of customer goodwill.

"The [Bloomberg] article makes it sound like this was a revelation for companies, but it's really Insurance 101 stuff as far as I can tell."

If the allegations are true, however, the companies' actions go way beyond anything taught in Insurance 101.

Robert Hunter, director of insurance for the Consumer Federation of America, grew up with insurance. His father was an adjuster, and after a stint with the feds, he himself served as insurance commissioner in Texas.

"When my father started in the business, when I started in the business, it was still run by insurance people," Hunter said. "I don't think it's run by insurance people any more.

"They don't need to cheat customers to make money. Yet that seems to be happening. From talking to executives and reading some of the stuff they send out and say on their conference calls with stock analysts, they sure seem more focused on making the stock market and the rating agencies happy."

As Bloomberg tells the tale, it was in the 1990s that the industry began systematically looking for ways to increase profits by streamlining claims handling.

"Hurricane Hugo was a major catalyst," the article says. "The 1989 storm, which battered North and South Carolina, left the industry reeling from $4.2 billion in claims."

In September of that year, court records show, Allstate hired McKinsey & Co., which has advised many of the world's biggest corporations, to help the company achieve greater efficiencies. State Farm and Farmers later also hired the consulting firm.

McKinsey produced thousands of pages of documents for Allstate, including PowerPoint slides, laying out recommendations to help the company become more profitable by paying out less in claims, according to videotaped evidence presented in Fayette Circuit Court in Lexington, Ky., in a civil case involving a 1997 car accident. (Despite the prosecutor's use of the McKinsey slides, however, the jury only took about an hour to rule in Allstate's favor last month.)

"Property insurers systematically deny and reduce their policyholders' claims, according to court records in California, Florida, Illinois, Mississippi, New Hampshire and Tennessee," Bloomberg said.

"The insurance companies routinely refuse to pay market prices for homes and replacement contents, they use computer programs to cut payouts, they change

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[1] www.bloomberg.com/news/marketsmag/mm_0907_story1.html

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policy coverage with no clear explanation, they ignore or alter engineering reports, and they sometimes ask their adjusters to lie to customers, court records and interviews with former employees and state regulators show.

"As Mississippi Republican U.S. Senator Trent Lott and thousands of other homeowners have found, insurers make low offers — or refuse to pay at all — and then dare people to fight back."

Boxing gloves

Aside from allegations by engineers and adjusters, most of the data backing up these accusations have come from the discovery part of any number of lawsuits.

Since material made available in court is as a rule protected by confidentiality agreements, background on company behavior and McKinsey recommendations has been made public only when it's been presented in open court.

Until 2000. In December of that year, a Santa Fe attorney named David Berardinelli filed a routine bad-faith lawsuit against Allstate. The trial judge ordered Allstate to turn over McKinsey's PowerPoint slides.

The company immediately appealed, arguing the slides were confidential and proprietary. So the judge instructed Berardinelli to treat the materials as if they were confidential in case Allstate won its appeal. After two years, when the appeal was denied, Berardinelli turned over the 12,500 pages to Allstate and demanded in return a clean copy, without the background printing declaring them to be confidential.

Allstate refused, leading the court to enter a default judgment, finding the company liable in the underlying bad-faith lawsuit. And Allstate continues to defy the judge's order, what it calls "respectful civil disobedience."

Unfortunately for Allstate and other insurers making use of the McKinsey slides, during the two years Berardinelli had the slides in hand, he made extensive notes.

Those notes are now available, primarily to fellow trial lawyers, in a book called *From Good Hands to Boxing Gloves,* named for the most notorious of the McKinsey slides. In it, the recommendation is to increase early settlements, settled for less than full value and without benefit of counsel. This, the slides purported, would affect 90% of claims, and those 90% would get the company's vaunted "good hands" treatment.

The remaining 10% get the boxing gloves, with payouts stretched out for four years or more.

Trial lawyers say they noticed the change right away: After about 1995, when the program known as CCPR (Claim Core Process Redesign) was rolled out, settlement offers from Allstate slowed and then stopped.

"You can get your claims resolved promptly or fairly," Berardinelli said in an interview with BusinessWeek, "but not both. In his book, he compares Allstate to a purveyor of canned peas. Documents from the Santa Fe case, Berardinelli said, "show how McKinsey . . . deliberately designed Allstate's claim factory to arbitrarily 'underfill' every can of Allstate insurance."

Allstate says the materials are proprietary. As for the 10% of "boxing glove" claims, that's about the percentage of claims that another McKinsey slide said stemmed from fraud.

Joseph Annotti, spokesman for the Property Casualty Insurers of America, told *The New York Times* that the billions of dollars paid out for the unexpected surge of hurricanes in recent years has pushed insurers for the first time to focus on how crowded the coastlines have become with expensive homes and businesses.

"From a business perspective," he said, "you look at the coastal markets and the catastrophic exposure and you say, 'That's a dangerous place to write policies. I need to charge more or limit what I'm writing.'"

Bob Hartwig, president of the Insurance Information Institute, added that insurers weren't insensitive or greedy, but that "an insurer that is financially weak or insolvent is no use to anybody."

In a letter to Ronald Henkoff, editor of Bloomberg Markets, seeking a face-to-face meeting, Hartwig wrote: "The data, research and even the originality of the . . . article are highly suspect. . . . You should be

seriously concerned that in a number of instances, your 'facts,' calculations, assertions, and consequently your conclusions, are entirely wrong."[2] Bloomberg was apparently not moved by Hartwig's argument and has issued only one factual correction.

As a trial lawyer, Berardinelli's motives may be considered suspect, but the slides are directly from Allstate's files. And other information that has come up from a variety of other sources show the same trend. Other lawsuits have turned up examples of altered engineering reports, for instance.

Rising complaints, reports of organized company behavior from a number of courtrooms, rising profits, reduced claims payouts — doesn't it sound as if these allegations, if true, would have been picked up by now by regulators?

Regulators' role

Here and there, individual regulators have taken action. In California, for instance, the department investigated Allied Property & Casualty Insurance Co., AMCO Insurance Co. and Allstate in connection with the 2003 San Diego fires, fining Allied and AMCO a total of $20,000 for misleading nine policyholders into believing they were insured for full value.

The regulators cited Allstate for six rule violations but didn't fine Allstate, which told the department it had done nothing wrong. In any case, considering the kind of money insurers know they can make by wearing boxing gloves, small, routine fines can easily be considered no more than a cost of doing business.

"The regulators have been in decline, in part because they're so afraid of a federal regulator," said Hunter.

"A lot of these market conduct examinations are pretty superficial," he added. "They come in and they get out the manual and they check some policies to make sure they were rated under the same rating system as the file. If they find some that are in error, they fine the company. They don't dig into a claims file.

"If they were a little more sophisticated, they would catch it."

Though companies don't typically disclose systems such as those spawned by McKinsey, either to regulators or to customers, they sometimes brag about them in annual reports and other filings.

Even so, says Hunter, "only a handful of regulators have actually even looked at these questions. And then, they've been lied to."

Needless to say, all regulators would not agree. Sure, these allegations constitute a new threat, but regulators face new threats all the time in the changing insurance marketplace.

"I've got a real bulldog as the head of my consumer division," said Kansas commissioner Sandy Praeger, "and he doesn't let anything get by.

"We can't monitor everything that's going on in the marketplace. We have to rely on consumers to call us, and if this is a covered benefit, I mean, these are contracts, they're legal documents.

"I will fess up — we have found some policies that slipped through our approval process that we've had to go back and rescind because they were not written in accordance with our state laws," said Praeger. "So sometimes things can be really subtle and hard to pick up."

She says the Kansas department aggressively pursues consumer complaints, and it would seem that financial regulators would be expected to catch some of these abuses — though perhaps not to notice patterns emerging.

"There's going to have to be a stated goal of looking for those kinds of things," Praeger said. "And then looking beneath the surface to see if that is the practice."

Plus, she said, "we know that in the two years since Katrina [a period when profitability would be expected to be slowly rebounding], companies' profits have increased, and their RBC [risk-based capital] has increased. So companies right now are in a very healthy situation.

"That's good news, but we certainly don't want them to be in a healthy situation if they're not paying claims."

Some of the recent high-profile lawsuits by state attorneys general have raised the question of why insurance regulators hadn't filed the suits themselves. The answer, at least in part, is that most departments have no authority to file lawsuits.

"In many states, the attorney general's office is the

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[2] www.statefarm.com/about/media/bloomberg_letter.asp

Policies are contracts — *unless no one enforces them*

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corporate lawyer, if you will, for the state, and for all state entities," Praeger explained.

"We do work closely with our attorney general's office. We can go into court to demand restitution for the consumer, or go into court to follow up on allegations of fraudulent behavior by agents, because our attorney general has given us special attorney general status, in our fraud division."

In some cases, the Kansas department will put together the case and then offer it to local officials.

"Sometimes they'd just as soon we take it," she said. "Oftentimes, the evidence we gather is so compelling that we just get pleas. There's no sense in fighting it — we've got them dead to rights. One nice thing about insurance and insurance fraud is that there is a paper trail — and a lack of a paper trail can be damning too."

Praeger has some lawyers formerly in the AG's office in her legal division, and the head of her consumer division is the former head of consumer fraud for the AG. It's since she's been in office that the Kansas Legislature has given the Commissioner special status with the AG's office. Also new on her watch: an anti-fraud division headed by a former Kansas Bureau of Investigation investigator.

In general, Praeger agrees that penalties for some offenses are too mild.

"There is some concern that the crimes may continue because the penalties aren't severe enough," the commissioner said.

"We've gone to our Legislature and asked for increases in penalties, and presumptive jail time for crimes that are above $25,000. We think it's wrong [that no one ever goes to jail]. Especially crimes against individuals — the poor widow who was relying on this money and then has a rogue agent essentially steal it from her.

"We didn't have presumptive jail time. Our securities commissioner did, and that was our argument: Look, give us the same penalties that you let securities have. We did get that passed in our last legislative session."

Praeger, who also serves as president-elect of NAIC, said this is an issue that clearly needs to be brought up at the next NAIC meeting. In the meantime, both financial surveillance and consumer affairs personnel need to start looking for patterns they haven't been looking for in the past.

State regulation

"This is where state regulation steps in," she added. "When we see patterns like that, we do have the ability to make the appropriate changes so that we can correct the action. I think this is something that we will want to look at and find the reasons behind it.

"Our ultimate responsibility is toward our consumers. And that means making sure we have companies that are playing by the rules. The good companies want us to be vigilant, because if others aren't and are out there making more money because they're not treating their customers fairly, it puts the good companies at a disadvantage.

"If the big guys are making it because of questionable practices, and we don't do something about it, we encourage others to move in that direction as well, thinking, 'Well, if it's not going to get regulated, I have to do it too to stay competitive.'"

If other states' commissioners are as flexible and responsive as Praeger, perhaps this issue will start fading away soon.

Considering how much money companies have made since putting on the boxing gloves, however, don't expect them to roll over quietly. ■

The CDS Commissioners' Interview — Part 2

The Consumer Comes First

Below is the second part of an interview conducted by Regulator *editor Wayne Cotter at last summer's Career Development Seminar (CDS).* ***Pennsylvania Commissioner Joel Ario****,* ***Missouri Director Douglas Ommen*** *and* ***Nebraska Director Tim Wagner*** *participated in this portion of the interview. Due to space limitations, some responses have been abbreviated.*

Regulator: *Commissioner Ario, you said at the Commissioners' Roundtable that insurers would like to get rid of market conduct exams. I assume they'd like to get rid of all exams, but I know the market conduct process has undergone some analysis with regard to the appropriateness of its function. What is the future of market conduct exams?*

Ario: [They are] an important tool in the toolbox. There are situations where the only real way to get to the bottom of a problem is to send examiners onsite to dig through information and get to the bottom of the problem. So they will always be part of the system. I think they're overused in the current system, but the companies that want to get rid of them before they put in place alternative regulatory mechanisms are making a mistake. The *first* priority for us is to put in place good forms of regulatory intervention and that to me starts with good data to tell us where the real problems are. That ought to be a priority.

Everybody wants to cooperate to get a data system on the market side that's similar to what we have on the financial side. We also should continue to hone our regulatory tools such as desk audits and target interrogatories. If we build those tools, *then* we can talk about limiting examinations.

Ommen of Missouri

Ommen: [Market conduct examinations] are one of the tools available to the regulator in protecting the citizens of the state. At the same time, if they become the focus of the enforcement efforts, they not only become less effective, but — because they are more expensive — they also become a point of disagreement with an industry that should be working with us in terms of a level playing field and a fair market.

Regulator: *What is the value of the principles-based approach to regulation? Isn't it alien to our regulatory culture?*

Wagner: We are moving toward a more risk-based approach and I believe we will gravitate towards a more principles-based process. You know, one of the things that I wrestle with — almost on a daily basis — is the statutory rules and the interpretations of these rules. Clearly there is room to interpret some transactions one way and some transactions another way, but what is the right interpretation when in fact it really doesn't make any difference? Because really what we're interested in is solvency and what we're doing is getting mired down in rules and in the process losing our vision in terms of what is that rule and what is its relationship to solvency. In other words, we want transparency and a uniform playing field *to an extent*, but it seems that a principles-based approach may be a better indicator of financial health than the way we're working today.

Ario: To my mind, if you can take a rule that's in dispute and get underneath the rule and say, "What is the purpose of this rule?" and derive a standard that is broader and more encompassing in terms of what it is trying to accomplish, [then] standards are better than rules in those sorts of situations. There are certain situations where you just want straight-out predictability — you just want everybody to do it the same way — then a rule is easier and more likely to be uniformly implemented. But generally with more difficult problems, trying to get behind the rules to the standards that drive the rules is going to get you to a better solution than trying to fight over rules that don't necessarily connect to your purpose anymore.

Regulator: *This morning at the Roundtable, Commissioner Wagner stressed that regulators should keep their eye on the "big picture." How do state insurance departments promote that? How do you get*

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Commissioners: The Consumer Comes First

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regulators not only to know the rules and the law, but also to think outside the box, to think creatively during a period when things are changing rapidly?

Ario: I'll throw two ideas out there. One is a customer service orientation that ought to apply first and foremost to the consumers who come to our departments, but also frankly to the companies that come to our departments. And it would also apply internally so when people raise questions, the first answer isn't "Well the rule is X." The first answer is "Let me try to understand what your real problem is" and "Let's see if we can problem solve together." I think that's a better starting point and gets you to the real issues.

And at the top, commissioners should be saying to all staff at all times: "Don't lose sight of the fact that consumer protection is our job." If the first question you ask is "What is good for the consumer?" you get better results across the board.

Wagner: I think there are a couple of things that foster vision. [Nebraska] puts a heavy emphasis on education. We've actually built that into our compensation system on the financial side. The reason for stressing education is so that you have a broad understanding of your role — where you're going and where you want to be.

The second thing we do is a lot of hands-on management and by that I mean I think every commissioner has got to express an interest in what every individual is doing, whatever process is going on in the department. I do that by walking around to every area. We only have 100 people. Everyday I ask, "What's going on?" "What are you seeing?" so people feel engaged in the process.

The third thing is to encourage decision-making at the lowest level you feel comfortable with because when you empower people to make decisions, they begin looking outside the box and you start building the vision necessary for the long term.

Ommen: Related to what Tim said, asking people to make decisions is a big part of what we can do to make improvements. One of the areas where I've had the most difficulty is the turnover at the higher levels of insurance regulation. I served under Director Finke for two years and I think before that the Director was there

Director Wagner and Pennsylvania's Ario

for a short period of time so it's really hard to get some continuity of vision from the top.

Regulator: *The average term of a commissioner used to be 18 months.*

Ario: It's probably about the same today. If you look at organizational theory these days, most of it is about asking the "why" questions, never accepting the answer, "Well, we do it that way because we've always done it that way." It should always be open for discussion. Is there a better way to do things? I think that philosophy is very important.

Regulator: *I think there's a real tendency for regulators — if they get into a situation where the turnover at the top is every 18-24 months — to say to themselves: "This is just the latest management theory of the day and if we wait this out, in another 18 months they'll be hitting us with something else." That can be bad for morale too.*

Ario: . . . If a commissioner comes [with the attitude] of "I'm the boss and I'm going to tell everybody what to do," the staff will take the attitude "We be here when you be gone" and you won't get anything done. You have to work with people and it has to be their vision that comes out of those discussions. Otherwise, nothing will last that you accomplish in your short tenure.

Regulator: *That's a good point to end it on. Thank you.*

Editor's Note: *The preceding interview was conducted in August. In October, Nebraska Director Tim Wagner — a long-time supporter of state-based insurance regulation and IRES — died following a brief illness.*

Lloyd's, Equitas and retroactive reinsurance

by Warren Buffett

Our tale begins around 1688, when Edward Lloyd opened a small coffee house in London. Though no Starbucks, his shop was destined to achieve worldwide fame because of the commercial activities of its clientele — shipowners, merchants and venturesome British capitalists. As these parties sipped Edward's brew, they began to write contracts transferring the risk of a disaster at sea from the owners of ships and their cargo to the capitalists, who wagered that a given voyage would be completed without incident. These capitalists eventually became known as "underwriters at Lloyd's."

Though many people believe Lloyd's to be an insurance company, that is not the case. It is instead a *place* where many member-insurers transact business, just as they did centuries ago.

Over time, the underwriters solicited passive investors to join in syndicates. Additionally, the business broadened beyond marine risks into every imaginable form of insurance, including exotic coverages that spread the fame of Lloyd's far and wide. The underwriters left the coffee house, found grander quarters and formalized some rules of association. And those persons who passively backed the underwriters became known as "names."

Eventually, the names came to include many thousands of people from around the world, who joined expecting to pick up some extra change without effort or serious risk. True, prospective names were always solemnly told that they would have unlimited and everlasting liability for the consequences of their syndicate's underwriting – "down to the last cufflink," as the quaint description went. But that warning came to be viewed as perfunctory. Three hundred years of retained cufflinks acted as a powerful sedative to the names poised to sign up.

Then came asbestos. When its prospective costs were added to the tidal wave of environmental and product claims that surfaced in the 1980s, Lloyd's began to implode. Policies written decades earlier — and largely forgotten about — were developing huge losses. No one could intelligently estimate their total, but it was certain to be many tens of billions of dollars. The specter of unending and unlimited losses terrified existing names and scared away prospects. Many names opted for bankruptcy; some even chose suicide.

From these shambles, there came a desperate effort to resuscitate Lloyd's. In 1996, the powers that be at the institution allotted £11.1 billion to a new company, Equitas, and made it responsible for paying all claims on policies written before 1993. In effect, this plan pooled the misery of the many syndicates in trouble. Of course, the money allotted could prove to be insufficient – and if that happened, the names remained liable for the shortfall.

But the new plan, by concentrating all of the liabilities in one place, had the advantage of eliminating much of the costly intramural squabbling that went on among syndicates. Moreover, the pooling allowed claims evaluation, negotiation and litigation to be handled more intelligently than had been the case previously. Equitas embraced Ben Franklin's thinking: "We must all hang together, or assuredly we shall hang separately."

From the start, many people predicted Equitas would eventually fail. But as Ajit (**Editor's Note:** Ajit Jain heads several reinsurance operations for Berkshire Hathaway) and I reviewed the facts in the spring of 2006 — 13 years after the last exposed policy had been written and after the payment of £11.3 billion in claims — we concluded that the patient was likely to survive. And so we decided to offer a huge reinsurance policy to Equitas.

Because plenty of imponderables continue to exist, Berkshire could not provide Equitas, and its 27,972 names, unlimited protection. But we said – and I'm simplifying – that if Equitas would give us $7.12 billion in cash and securities . . . we would pay all of its future claims and expenses up to $13.9 billion. That amount was $5.7 billion above what Equitas had recently guessed its ultimate liabilities to be. Thus the names received a huge — and almost certainly sufficient— amount of future protection against unpleasant surprises. Indeed the protection is so large that Equitas plans a cash payment to its thousands

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Buffett on retroactive reinsurance

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of names, an event few of them had ever dreamed possible.

And how will Berkshire fare? That depends on how much "known" claims will end up costing us, how many yet-to-be-presented claims will surface and what they will cost, how soon claim payments will be made and how much we earn on the cash we receive before it must be paid out. Ajit and I think the odds are in our favor. And should we be wrong, Berkshire can handle it.

Scott Moser, the CEO of Equitas, summarized the transaction neatly: "Names wanted to sleep easy at night, and we think we've just bought them the world's best mattress."

Debits & Credits

Warning: It's time to eat your broccoli — I am now going to talk about accounting matters. I owe this to those Berkshire shareholders who love reading about debits and credits. I hope both of you find this discussion helpful. All others can skip this section; there will be no quiz.

Berkshire has done many retroactive transactions – in both number and amount a multiple of such policies entered into by any other insurer. We are the reinsurer of choice for these coverages because the obligations that are transferred to us – for example, lifetime indemnity and medical payments to be made to injured workers – may not be fully satisfied for 50 years or more. No other company can offer the certainty that Berkshire can, in terms of guaranteeing the full and fair settlement of these obligations. This fact is important to the original insurer, policyholders and regulators.

The accounting procedure for retroactive transactions is neither well known nor intuitive. The best way for shareholders to understand it, therefore, is for us to simply lay out the debits and credits.

Charlie (**Editor's Note:** Charlie Munger, Berkshire's Vice-Chairman) and I would like to see this done more often. We sometimes encounter accounting footnotes about important transactions that leave us baffled, and we go away suspicious that the reporting company wished it that way. (For example, try comprehending transactions "described" in the old 10-Ks of Enron, even after you *know* how the movie ended.)

So let us summarize our accounting for the Equitas transaction. The major debits will be to Cash and Investments, Reinsurance Recoverable, and Deferred Charges for Reinsurance Assumed ("DCRA"). The major credit will be to Reserve for Losses and Loss Adjustment Expense. No profit or loss will be recorded at the inception of the transaction, but underwriting losses will thereafter be incurred annually as the DCRA asset is amortized downward. The amount of the annual amortization charge will be primarily determined by how our end-of-the-year estimates as to the timing and amount of future loss payments compare to the estimates made at the beginning of the year. Eventually, when the last claim has been paid, the DCRA account will be reduced to zero. That day is 50 years or more away.

What's important to remember is that retroactive insurance contracts always produce underwriting losses for us. Whether these losses are worth experiencing depends on whether the cash we have received produces investment income that exceeds the losses. Recently our DCRA charges have annually delivered $300 million or so of underwriting losses, which have been more than offset by the income we have realized through use of the cash we received as a premium. Absent new retroactive contracts, the amount of the annual charge would normally decline over time. After the Equitas transaction, however, the annual DCRA cost will initially increase to about $450 million a year. This means that our other insurance operations must generate at least that much underwriting gain for our overall float to be cost-free. That amount is quite a hurdle but one that I believe we will clear in many, if not most, years.

Aren't you glad that I promised you there would be no quiz? ■

© Warren Buffett is CEO and Chairman of the Board of Berkshire Hathaway. The article is excerpted from Mr. Buffett's most recent annual letter to Berkshire shareholders and is reprinted with permission.

Regulatory Roundup

by
Stroock & Stroock & Lavan LLP

New York – Insurers must rescind illegal non-renewal notices sent to coastal homeowners

On August 28, the New York State Insurance Department issued Circular Letter No. 11 (2007) after receiving complaints that insurers were refusing to renew homeowners insurance policies based on whether a policyholder has other business with them, such as an automobile or life insurance policy. The Circular Letter makes clear that the Department considers the non-renewal of homeowners insurance based on the insured not having another policy with the insurer an unlawful inducement in violation of Insurance Law Section 2324(a), which provides in part that no insurer may "give or offer to give any valuable consideration or inducement of any kind, directly or indirectly, which is not specified in such policy or contract," and any notice using that reason would be invalid. In addition, the Department determined that although an insurer may not explicitly tell those insureds whom it renewed that they were renewed because they in fact had supporting business, it is reasonable for these insureds to infer that they were renewed because they had supporting business, and that the insurer would again implement a supporting business condition the next time that the insurer could non-renew the policy. Moreover, since most insureds are not aware that the required policy period for a homeowners policy is three years, insureds might believe that the insurer will elect to non-renew their policies on the next annual renewal date if they do not maintain supporting business. The Circular Letter also finds insurers' claim that their non-renewal decisions are based on the overall hurricane exposure on the Atlantic coast unpersuasive, because if the reason for non-renewal is in fact catastrophic risk exposure, then there is no rationale for these insurers to non-renew those with the least overall exposure (i.e., those that only insure their homes with the insurer, as opposed to those that insure both their homes and automobiles). In a press release dated the same date, the Department noted that insurers have the right to reduce their exposure to risks, such as hurricanes, but they must follow statutory requirements when choosing not to renew policies. For example, they can only not renew a maximum of four percent of their homeowners policies statewide in any one year. To view Circular Letter No. 11 (2007), visit **www.ins.state.ny.us/circltr/2007/cl07_11.htm**.

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

California – Governor signs bill eliminating certain reserve requirement for workers' compensation

On October 10, Governor Schwarzenegger signed SB 316. The new law eliminates the requirement that workers' compensation insurers place 65% of written premium in reserve. According to legislative analysts, the 65% reserve requirement, on top of existing deposit and RBC requirements, forced carriers to over-reserve, thereby stifling new investment in the workers' compensation market and inflating rates. Analysts also concluded that the reserve requirement was most detrimental to smaller carriers writing policies for a narrow category of specialized occupations. The new law also directs the Commission on Health, Safety and Workers' Compensation to study why certain workers' compensation insurers became insolvent in the late 1990s and earlier this decade. The CHSWC is to publish its findings by July 1, 2009. To view SB 316, visit **www.sen.ca.gov**.

Washington – Voters to decide fate of treble damages in bad faith suits

On November 6, 2007, voters in the State of Washington will decide (Referendum 67) the fate of Engrossed Substitute Senate Bill 5726 (ESSB 5726). ESSB 5726, signed into law May 15, 2007, would make it unlawful for insurers to "unreasonably" deny

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Regulatory Roundup

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a claim for coverage or payment of benefits to any first party claimant or to violate insurance fair practices regulation. With court approval, successful claimants would be entitled to actual damages plus costs and reasonable attorney fees, and in some cases up to triple damages. The law does not apply to a health plan offered by a health carrier. Opponents of ESSB 5726 predict that insurance rates will increase by $650 million a year — $205 per household. Supporters contend the legislation will encourage auto and property/casualty insurers to investigate and settle cases in a reasonable time frame and for reasonable amounts. The issue was certified on July 30, 2007 to appear as a referendum on Election Day ballots after a petition was submitted to the Secretary of State containing more than the required signatures of at least 112,440 registered voters. To view Referendum 67, visit **www.secstate.wa.gov/elections/initiatives/text/r067.pdf.**

Welcome, new members!

Earl C. Brown, AIE, NV
Mark Burdett, NV
Molly Champagne Seward, RI
John Chaskey, NY
Denise L. Cone, DE
James A. Dickson, NAIC
Mark J. Duffy, CT
Rosemarie W. Halle, IL
Maureen Hartsmith, NH
Nellya Kolpakov, NY
Anatol Monid, Canada
Nitza A. Pfaff, WI
Darrel G. Powell, UT
Debra L. Roadcap, PA
Nicoleta Smith, CA
Barry Wells, Unaffiliated

Nebraska's Commissioner Tim Wagner: A Friend to IRES

As many IRES members know, Nebraska Insurance Director Tim Wagner died in October as a result of a stroke. Wagner, 65, had headed the Nebraska Department since 1999 and was a long-time friend to IRES.

In fact, as recently as August, Director Wagner joined in a lively Commissioners' Roundtable to kick off this year's Pittsburgh CDS, participated in a Commissioners' interview that followed the session (see pp. 13-14), and then delivered the session's keynote address on global warming.

Alabama Commissioner and NAIC president Walter Bell said "Tim Wagner was everything a state insurance commissioner should be. Nebraska and the NAIC were equally blessed by his service. My heart goes out to his wife, Martie, the Wagner family and the Nebraska Department of Insurance."

Wagner frequently stressed that regulators should keep their eye on the "big picture." Insurance commissioners should, said Wagner, "encourage decision-making at the lowest level you feel comfortable with because when you empower people to make decisions, they begin looking outside the box and you start building the vision necessary for the long term."

Tim Wagner was an outstanding public servant and a true visionary. He will long be remembered for his efforts to enhance state insurance regulation.

Casual Observations

Coffee, Tea or R-67?

Perhaps you've heard. Trial lawyers and insurers in the State of Washington are battling over the right of policyholders to sue their insurers for treble damages when their claims have been unreasonably denied. Actually, policyholders gained that right earlier in the year when Senate Bill 5726 became law. It applies to all lines of insurance except certain health plans.

Insurers fought 5726 tooth and nail, but when the bill became law they refused to give up. Instead they collected over 150,000 signatures and forced a referendum onto this year's ballot. It's called Referendum 67 (R-67) and lots of bucks have been flowing into organizations supporting or opposing the measure. (Incidentally, a "yes" vote means you favor the new law.)

In fact, more than $8 million (mostly from out-of-state insurers) has poured into an organization called "Consumers Against Higher Insurance Rates" (also known as "Reject 67"). Reject 67 describes itself (**www.reject67.org**) as a "broad-based coalition of individual consumers and business groups." We're always suspicious of broad-based consumer and business groups that get most of their funding from insurers.

Meanwhile, another organization, Appove 67 (**www.approve67.org**) has attracted less funding — about $800,000 — mostly from trial lawyers.

Reject 67 claims these new rights come at a cost —more than $200 per policyholder — an estimate that Approve 67 vehemently disputes. We, too, find it hard to believe that premiums would rise significantly under the law.

The statute, as we read it, states that it's the court's job to determine whether an insurer acted *unreasonably* and, if so, award *up to* treble damages to the policyholder. If an insurer's attorneys can demonstrate that the firm acted in good faith, then the insurer should have nothing to fear from the new law. Insurers, however, counter that such a law would weaken their ability to challenge potentially fraudulent claims.

We also enjoyed Reject 67's argument that the new law is superfluous because the Washington Insurance Commissioner already has the power to punish wayward insurers. The problem with that line of reasoning is that current Commissioner Mike Kreidler disagrees. He's an ardent supporter of R-67 and readily acknowledges his office's limitations when it comes to dealing with recalcitrant insurers.

In fact, Kriedler recently said of R-67: "I know there absolutely won't be any impacts for companies that act in good faith."

R-67 has also generated some pretty entertaining commercials (most of which can be seen on YouTube). Our favorite is called "The Diner," a 30-second spot funded by Reject 67. The ad features a waitress named Linda serving coffee to one of her regulars, Craig.

We go to a lot of diners, but never have we overheard a conversation remotely like this:

Linda: Craig said he didn't give a hoot about trial lawyers suing insurance companies.
Craig: I didn't care until . . .
Linda: So I told him, frivolous lawsuits mean higher auto and homeowners rates for everyone.
Craig: (shrugging sheepishly): I hate it when she's right.

For all the money that's been floating around Washington State as a result of this referendum, it seems hard facts are few and far between. By the time you read this, Washington voters should have already passed judgment on R-67 and we'll all know if Linda and Craig got their wish.

— *W. C.*

√ Sonnenschein Nath & Rosenthal LLP is pleased to announce that IRES Immediate Past President Douglas A. Freeman, CIE, has joined the law firm as a consultant in the Insurance Regulatory Practice Group. Doug can be reached in the St. Louis Sonnenschein office at (314) 259-5839 and dafreeman@sonnenschein.com

√ We are pleased to announce that Vi Pinkerton of Colorado has replaced Doug on the Executive Committee and will serve as Publications Chair.

In the next REGULATOR:

The first Market Conduct-Plus class!

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.

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Happy holidays, from the writers and editors at *The Regulator.* See you next year.