A Commission Report

State Solvency Regulation of Property-Casualty and Life Insurance Companies

Advisory Commission on
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John Kincaid
Executive Director

Executive Summary

Since the late 18th century, states have exercised virtually exclusive regulation of the property-casualty and life insurance industries. A recent rash of insolvencies, however, has called into question the ability of state regulators to supervise insurers doing interstate business and the capacity of state guaranty funds to reimburse policyholders for losses resulting from insolvencies.

The purpose of this report is to inform policymakers of the options available for improving state solvency regulation of the property-casualty and life insurance industries. The report examines the entire range of issues in state solvency regulation, including regulatory accounting and finance, the role of reinsurance, multistate insurance holding companies, state liquidation proceedings, and state guaranty funds. The study identifies 18 areas in which state solvency regulation could be improved, describes state efforts to implement needed reforms, and examines several federal proposals for reform.

The number and size of insurer insolvencies have increased dramatically. For example, the number of property-casualty insurer insolvencies rose from four in 1980 to 25 in 1985, and, nationwide, the guaranty fund assessments rose from $19 million in 1980 to $292 million in 1985. Life/health guaranty fund assessments tripled from $154.8 million in 1990 to $469.7 million in 1991. Some estimates place the cost of the recent failure of Executive Life of California at $400 million per year over five years.

These figures have prompted calls for federal regulation of the insurance industries. Among the problems in state regulation of insurance noted by the Congress and the U.S. General Accounting Office are differences in quality due to disparities in resources and regulatory philosophy, inconsistent solvency laws and the failure of states to coordinate their efforts, the failure of state regulators to enforce their solvency laws in a timely fashion and to pursue wrongdoers, the failure or inability of states to oversee holding companies and foreign reinsurers, and insufficient capacity of state guaranty funds.

Congressional proponents of federal regulation propose various forms of intervention. For example, a bill introduced by Sen. Howard M. Metzenbaum in 1991 would create a federal insurance regulatory commission with authority to certify state insurance departments. Without federal certification, a state could not issue a license to insurance companies engaged in interstate commerce. In order to become certified, a state insurance department would have to adopt certain uniform minimum federal standards. The certification program would, in effect, transform state regulators into administrators of a federal program. A bill introduced by Rep. John D. Dingell in 1992 would establish an independent federal agency to regulate insurers that choose a federal license. According to the Dingell bill, federally licensed insurers would remain subject to certain state laws, including those regulating unfair trade and claims settlement practices. Yet, because the Dingell bill would give the federal agency broad authority to preempt all state laws, the ability of states to enforce their laws would be questionable.

States have countered the calls for federal regulation of insurance by pointing to recent efforts to tighten state regulation. Many states have passed laws that address areas of weakness. For example, recent investigations identified several factors, such as the use of unregulated managing general agents to underwrite insurance, that contributed to large property-casualty insurer failures. States responded by adopting laws to license managing general agents and to prohibit companies from delegating their underwriting function to such agents.

To the extent that some insurance problems spill over state lines, the National Association of Insurance Commissioners (NAIC) has established a program to accredit state insurance departments that have adopted certain uniform model laws to ensure solvency and have met certain standards for staffing. NAIC believes that this program will produce a nationwide insurance regulatory system. Other NAIC efforts to overcome the limited jurisdictional reach of state regulators include the establishment of a centralized working group to monitor the financial health of large multistate insurers. The National Conference of Insurance Legislators has drafted an interstate compact that would centralize and coordinate the administration of state liquidations and guaranty funds.

This study concludes that proposals for federal regulation of insurance are premature. The recent savings and loan crisis and continuing bank defaults serve as powerful reminders that federal supervision has not eliminated industry failures, whether those failures result from insufficient regulatory resources, lack of regulatory will, industry manipulation of the political process, or fraud. All of these problems were present in the recent crises in our depository institutions. Although there have been failures in state insurance regulation for similar reasons, all of the state regulatory lapses combined have not produced a taxpayer bill comparable to the federal bill (over $500 billion) for the savings and loan crisis. Given the present efforts of states, individually and collectively, to seek solutions to serious regulatory problems, the substitution of federal for state regulation appears unwarranted.

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Findings and Recommendations

FINDINGS

1. States have long demonstrated a commitment to effective and efficient regulation of insurance.

States have been virtually the sole regulators of the insurance industry since the establishment of the first state insurance department in 1851. The historical record demonstrates that, since the mid-19th century, states have experimented actively with various regulatory mechanisms, ranging from laws regulating rates, solvency, and liquidation to the establishment of guaranty funds to protect policyholders. Regulatory innovations by individual states, such as the establishment of risk-based capital standards, are now being refined for adoption by all states. Current regulatory innovations include the establishment of central working groups to identify and monitor nationally significant troubled companies.

2. Insolvencies among insurance companies have risen in recent years, The amount of money assessed by state guaranty funds to pay for insolvencies has increased as well.

Historically, life company failures and guaranty fund assessments have been low. For example, from 1975 to 1982, those assessments averaged **$6.2** million a year. Recently, however, life company failures have increased significantly. For example, life guaranty fund assessments tripled from $154.8 million in 1990 to $469.7 million in 1991. The problem of insolvency of life companies is not limited to small companies. In **April** 1991, the California Department of Insurance seized Executive Life Insurance Company of California. Assessments for Executive Life of California could reach $400 million per year over five years. Although it is difficult to find a trend in the number and size of property-casualty insolvencies, guaranty fund assessments have been significant in recent years. From 1986 through 1991, 106 property-casualty companies failed, and guaranty fund assessments totaled **$3.3** billion. Studies suggest that the insolvency of a large national property-casualty insurer could exceed the guaranty fund capacity of most states.

3. Although the history and current status of state regulation of insurance demonstrates a record of strength, some areas could be improved.

Some of the areas in which state regulation could be improved include:

a. Adoption of tighter regulatory controls on reinsurance, including
   - (i) limitations on the conditions under which a reinsurer may rescind its contract with insolvent insurers,
   - (ii) limitations on the conditions under which balances due from an insolvent insurer can be offset against the amount the reinsurer owes as reimbursement for the liabilities of the insolvent insurer, and
   - (iii) limitations on the use of cut-through clauses that grant some policyholders special treatment by allowing them to receive payments directly from the reinsurer without complying with state liquidation procedures;

b. Adoption of minimum capital and surplus requirements that are related to risk (risk-based capital requirements);

c. Adoption of methods to increase the efficiency of field examinations and decrease the delays in their completion;

d. Restrictions on the extent to which fronting can be used to circumvent state licensure and regulatory requirements;

e. Adoption of uniform liquidation and guaranty fund laws to
   - (i) mitigate disagreements among state guaranty funds as to which fund must pay a particular claim, and
   - (ii) decrease the ability of multistate policyholders to engage in forum shopping by bringing their claims to the state guaranty fund that offers the broadest coverage;

f. Adoption of more meaningful investment standards for life insurance companies.

g. Introduction of market discipline into state guaranty fund plans by limiting the guaranty fund cov-

erage that is provided to policyholders with net high worth and requiring that a portion of the plan's cash be based on prior assessments;

h. Adoption of laws requiring public disclosure of situations in which insurers recover their guaranty fund assessments by state tax offsets and/or policyholder surcharges and publicizing the effects of such recoveries on state revenues and/or the price of insurance, respectively;

i. Adoption of more effective regulations of transactions between insurers and their parent and among insurers and their affiliates; and

j. Adoption of measures to increase the capacity of state guaranty funds. To do so:
   (i) states could increase their assessment limits to at least 2 percent, or all states could increase their assessment limits beyond 2 percent,
   (ii) states could reduce guaranty fund coverage by, for example, restricting payments to all policyholders to 80 percent of state maximums, or excluding/limiting coverage for policyholders with high net worth,
   (iii) states could adopt a partially prefunded guaranty fund program, and/or
   (iv) state guaranty funds could jointly establish a reinsurance or excess insurance mechanism.

4. *To improve their ability to regulate the insurance industry, the states created the National Association of Insurance Commissioners (NAIC). As an instrument for coordinating state regulation of insurance, NAIC has both strengths and weaknesses.*

With the formation of the National Association of Insurance Commissioners in 1871, states began to coordinate their regulatory efforts by, for example, adopting uniform accounting standards, model laws, and regulations. Recently, NAIC established an accreditation program to strengthen state solvency regulation. To become accredited, a state must comply with NAIC's financial regulation standards. NAIC has identified 16 model laws/ regulations that a state must adopt before becoming accredited. An accreditation team tests compliance with the NAIC standards by reviewing a state insurance department's laws and regulations, past examination reports, organizational and personnel policies, and assessing the department's levels of reporting and supervisory review. If adopted by all states, this program will establish a nationwide system of consistent regulation.

As a voluntary organization, NAIC's principal weakness is its lack of enforcement powers. For example, as of August 1992, only 13 states had adopted the necessary laws and regulations for accreditation.

In addition, industry practices at NAIC's conferences tend to weaken public confidence in state regulation. These practices have included hosting of luncheons and dinners, establishment of hospitality suites, and distribution of gifts to commissioners by representatives of regulated industries. While some states prohibit commissioner acceptance of industry gifts or require full disclosure, other states have no policy. NAIC has established a fund to underwrite the travel expenses to NAIC conferences of consumer representatives, and NAIC members voted to have its conference dinners paid for by NAIC rather than by industry.

5. *Some state groups have proposed to increase the uniformity of state insurance regulation through the use of a legislative interstate compact.*

One area that may benefit from legislative coordination through an interstate compact is the administration of liquidation and guaranty fund proceedings. A legislature-based compact would be in a position to work with and exploit the experience gained by the states through NAIC.

Usually, interstate compacts have a greater chance for success if they (1) focus on two or three specific problem areas in which the states are individually ineffectual, (2) provide for accountability through an independent and publicly available audit of the compact's activities, and (3) contain incentives to encourage participation.

In addition to providing a mechanism to coordinate the activities of states, a compact could have another important benefit. During the 1970s and 1980s, the bright lines separating insurance from banking and from securities activities began to blur. The distinctions among these financial industries will continue to blur in the foreseeable future. A realistic assessment of state/federal relations suggests that federal regulators faced with regulating the interstate and international aspects of the financial industries will be strongly motivated to preempt state regulation of insurance, rather than deal with 51 regulatory systems. However, if states establish a structure for coordinated regulation of the interstate aspects of insurance, they have a greater ability to restrain federal preemption and to enter into a regulatory partnership with the federal government, if necessary.

6. *Two federal statutes, the Federal Priority Statute and the Federal Arbitration Statute, have been interpreted by some courts to preempt state laws regulating insurance. These interpretations appear to conflict with the* McCarran-Ferguson Act, *which provides that no Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance, "unless such act specifically relates to the business of insurance."*

The Federal Priority Statute provides that a claim of the federal government will be paid first when the debtor is insolvent. In contrast, many state priority statutes grant federal and state government claims lower priority than those of policyholders. The Federal Priority Statute does not relate specifically to the business of insurance. Yet, two federal circuit courts of appeal have interpreted the *McCarran-Ferguson Act* narrowly in connection with insurer insolvencies, finding that the liquidation of an insurance company is not the "business of insurance." The Federal Priority Statute reduces the size of the insolvent insurer's estate available for policyholders.

Most reinsurance agreements contain arbitration clauses. These clauses typically require the use of arbitration in the event there is any difference of opinion between the reinsurer and the primary company with respect to the interpretation of their agreement. Sometimes, reinsurers dispute the amount due upon the insolvency of the ceding insurer and invoke their right to settle their dispute in arbitration rather than before the state insurance liquidator.

Both of these federal statutes reduce the effectiveness of state regulation of insurance.

7. *Since the inception of state insurance regulation, some insurance companies have urged federal regulation. The Congress has not done so; however; congressional investigations into state regulation of insurance have often stimulated states to strengthen and coordinate their regulatory systems.*

As early as 1866, bills were introduced in Congress to create a national bureau of insurance. Although all of the bills introduced to preempt state powers have failed to become law, congressional debates have often stimulated states to strengthen regulation. For example, recent congressional investigations identified several factors, such as the use of unregulated managing general agents to underwrite insurance, that contributed to several large property-casualty insurer failures. States responded by adopting laws to license managing general agents and to prohibit companies from delegating their underwriting function to such agents. The history of state insurance regulation illustrates the beneficial effects of congressional investigations and reports.

8. *The justification and potential scope for federal intervention in the regulation of the insurance industry are very limited. Regulatory failures in connection with financial institutions have increased dramatically in recent years. The recent savings and loan crisis (at a cost to taxpayers of over $500 billion) and continuing bank failures serve as powerful reminders that federal supervision has not eliminated industry failures, whether those failures result from insufficient regulatory resources, lack of regulatory will, industry manipulation of the political process, or fraud. All were present in the recent crises in our depository institutions. Although there have also been failures in state insurance regulation for reasons similar to those present in federal supervision of depository institutions, all of the state regulatory lapses combined have not produced a taxpayer bill comparable to the federal bill.*

Many states have adopted laws that address the areas of weakness in current state regulation of insurance. NAIC, through its accreditation program, and the National Commission of Insurance Legislators, through its proposal for an interstate compact, are attempting to find solutions for those areas in which collective state action is needed. Given the willingness of states, individually and collectively, to seek solutions to serious regulatory problems, the substitution of federal for state regulation would appear to be premature and unwarranted.

RECOMMENDATIONS

Recommendation 1
Limit Federal Intervention in State Regulation of the Insurance Industry

There are problems in the **U.S.** insurance industry. Both the number of insolvencies and the resulting level of guaranty fund assessments are high compared to their pre-1981 levels. Several factors may have contributed to this situation. For example, the combination of product underpricing and significant unforeseen emergencies has contributed to difficulties for property-casualty companies. Alternatively, the lack of asset portfolio diversification, especially with respect to large holdings of junk bonds and real estate, has been among the major factors creating a crisis-like situation for life insurance companies.

Although problems in the insurance industry have increased significantly since 1981, these problems are not similar in scale to the problems in other industries, such as banking and savings and loans. In addition, problems in the insurance industry appear to be more isolated and sporadic among firms. Indeed, there is significant variation in the number of insolvencies and the level of guaranty fund assessments on a state-by-state basis.

Although some reforms in state regulation of insurance are necessary to reduce the likelihood of future problems and to improve the ability of states to implement appropriate responses to the current situation, the recent difficulties experienced in the regulation of the insurance industry, including both insolvencies and liquidation and guaranty fund proceedings, do not require federal government intervention. State governments have regulated insurance for nearly 200 years and have cooperated through the National Association of Insurance Commissioners for 121 years. State governments have also demonstrated a growing ability and willingness to seek innovative solutions in response to problems. Moreover, recent experiences with federal regulation of depository institutions, health care, and other industries suggest that the federal government is less well suited, relative to the states, to monitor this industry.

Therefore, the Commission recommends that (1) the federal government not preempt state government regulation of insurance; (2) the Congress pass laws to clarify that the Federal Priority Statute and the Federal Arbitration Statute do not take precedence over the McCarran-Ferguson Act, which gives states the sole authority to regulate the insurance industry; and (3) the federal presence be limited to an investigatory role, including, for example, conducting basic research and issuing reports on both the property-casualty and life insurance industries so as to help alert citizens to problems and assist states to strengthen and coordinate their regulation. The Congress should also (4) defer to the judgment of the states and move expeditiously to approve proposals for interstate compacts, where states demonstrate that these compacts represent the most appropriate tool for achieving desired uniformity of regulatory procedures among states.

Recommendation 2
Encourage States to Become Accredited under the NAIC Program

The National Association of Insurance Commissioners (NAIC) recently established an accreditation program

to strengthen state solvency regulation. NAIC has developed **16** model laws and/or regulations that reflect its financial standards; a state must adopt these model laws and/or regulations to become accredited by NAIC. A nationwide system of consistent state regulation would result if all states were accredited. As of August 1992, only **13** states had completed the steps necessary for accreditation. In **1994,** NAIC plans to ask accredited states to penalize those that do not become accredited.

The Commission strongly encourages all states to become accredited under the NAIC program.

Recommendation 3
States Should Consider Various Options to Increase the Capacity of Their Guaranty Funds

The number of property-casualty insurer insolvencies and the level of guaranty fund assessments nationwide increased significantly between **1980** and **1985.** Although the patterns have been less consistent since **1985,** neither the number of insolvencies nor the level of assessments has returned to the lows that prevailed prior to **1981.** Recent reports by the Illinois Department of Insurance and the **U.S.** General Accounting Office suggest that the insolvency of one or more large property-casualty insurers could exceed the guaranty fund capacity in a majority of states. With respect to life-health insurers, assessments have tripled from **$154.8** million in **1990** to **$469.7** million in **1991.**

Therefore, the Commission recommends that states consider various options to increase the capacity of their property-casualty and life guaranty funds.

Recommendation 4
NAIC and State Commissioners Should Avoid Appearances of Impropriety

Industry practices of providing meals, entertainment, and gifts to state insurance commissioners create appearances of impropriety that can weaken public confidence in state regulation of the insurance industry. Some states prohibit insurance commissioners from accepting any gifts or other services from regulated industries, and other states require full disclosure of any gifts or services, but still other states have no policy on these matters. Although NAIC recently voted to fund commissioners' conference dinners rather than to accept industry funding, only the states can regulate the conduct of their own insurance commissioners.

The Commission recommends, therefore, that NAIC take all steps necessary and possible to avoid appearances of impropriety at NAIC conferences and that states adopt policies to ensure that public confidence in the integrity of their insurance commissioners is not compromised by industry practices that can create appearances of impropriety.

Recommendation 5
States Should Consider Entering into Interstate Compacts to Ensure Uniform Application of liquidation and Guaranty Fund Proceedings

Problems in at least two areas are difficult to solve on an individual state basis, including (1) the liquidation of insolvent companies, and (2) guaranty fund assessments and disbursements. For example, the lack of uniformity among state liquidation proceedings can lead to costly conflicts among states. Similarly, the lack of uniform guaranty fund procedures can lead to disputes over the division of fund assets and gaps in coverage. These problems can best be addressed by increasing regulatory cooperation among states, rather than through federal intervention.

Therefore, the Commission recommends that states consider entering into interstate compacts to ensure uniform application of liquidation and guaranty fund proceedings,

Introduction

Property-casualty and life insurance companies are among the last of the regulated industries over which states exercise virtually exclusive regulatory control. Earlier in the history of the United States, state agencies were typically the sole regulators of such diverse industries as banks and telephone companies. Gradually, the Congress, convinced of the need for federal regulation of industries whose activities crossed state lines, passed legislation creating federal regulatory agencies. For some industries, federal regulation became the norm, displacing state regulation entirely. For others (e.g., banking), a dual system of federal and state regulation was formed. Insurance regulation did not follow either path—primarily because of an early decision by the U.S. Supreme Court that the business of insurance was not interstate commerce.

THE STATES AS REGULATORS

The continuing role of states as sole regulators of the property-casualty and life insurance industries is at a crossroads. Congressional investigations and **U.S.** General Accounting Office (GAO) studies into the recent rash of insurance company insolvencies have prompted many commentators to call for federal regulation of insurance. These commentators have concluded that state regulation of the insurance industry is an anachronism that the country can no longer afford. Among the problems noted are differences in the quality of state regulation due to disparities in available resources as well as variances in regulatory philosophy, inconsistent solvency laws and the failure of states to coordinate their efforts, the failure of state regulators to enforce their solvency laws in a timely fashion and to pursue wrongdoers, the failure or inability of states to oversee holding companies and foreign reinsurers, and insufficient capacity of state guaranty funds.

Proponents of federal regulation propose various forms of intervention, ranging from replacement of state regulation of insurance with a federal agency, to a dual regulatory scheme in which multistate insurance companies would have the option to choose a federal license and regulation by a federal agency, to federal preemption of state solvency laws that fall below federal minimums, and to disclosure requirements for foreign reinsurers without setting up a federal regulatory bureaucracy.

States have countered the calls for federal regulation of insurance by pointing to recent efforts to tighten state regulation as well as the failure of federal regulation in connection with the savings and loan industry. To the extent that some insurance problems spill over state lines, the National Association of Insurance Commissioners *(NAIC)* has established a program to accredit state insurance departments that have adopted certain uniform model solvency-related laws and have met certain standards for staffing. NAIC hopes that this program will produce a nationwide insurance regulatory system.

GAO has reported on the weaknesses in NAIC's program. According to GAO, although NAIC has established standards for insurers and regulators and has adopted model laws and regulations, it cannot compel states to implement those standards or adopt the model laws. States can legislatively cede some authority to NAIC through an interstate compact, but because they can also revoke that authority at any time, GAO argues that NAIC might be a weak regulator, serving at the pleasure of those it regulates. The problems created by regulators who serve the industry they regulate, sometimes at the expense of the public, **is** not, however, peculiar to states. On numerous occasions, GAO and others have reported on similar problems with federal regulation of banks and savings and loan associations.

THE REPORT

The purpose of this report is to examine the critical areas of state solvency regulation of property-casualty and life insurance and to describe and evaluate proposals for reform. The report concludes that states face a formidable task if they are to continue as sole regulators of the property-casualty and life insurance industries. States will have to implement a system that assures a new level of intra- and intergovernmental cooperation, requiring ongoing collaboration between state regulators and legislators in a state and across state lines. At least with regard to safety and soundness regulation, state "beggar-thy-neighbor" policies adopted in the name of economic development must be put to rest.

If, on the other hand, the federal government **is** to have a role in the regulation of property-casualty and life insurance companies in a dual regulatory scheme, it is essential that congressional legislation be drafted in a manner to ensure that states are genuine partners in such

a scheme. In some dual regulatory schemes, such as banking and telecommunications, federal agencies have used their power to preempt state laws, thereby undermining the statutory dual regulatory system.

Part I of this report reviews the history of property-casualty insurance regulation and describes issues in state solvency regulation of property-casualty insurance, focusing on the areas in which state regulation has been heavily criticized. Part II follows the same structure, focusing on state solvency regulation of life insurance. Finally, Part III summarizes the findings of Parts I and II and analyzes proposed solutions to the problems in the current regulatory system, including reform of the state system and federal legislative and/or regulatory involvement.

Part I

Property-Casualty Insurance

1

History of State Regulation of Property-Casualty Companies

Little is new in the rash of insurance company failures, consumer outcries against perceived price gouging by insurance companies, charges of industry collusion in fixing contract rates and terms, industry complaints about inconsistent and restrictive state laws, and calls for federal control of the business of insurance. The history of government regulation of property-casualty insurance illustrates the long history of these criticisms.

EARLY HISTORY OF PROPERTY INSURANCE

Maritime trade among foreign countries provided the impetus for creating marine insurance, the earliest form of property insurance.[1] Insurance in the modem sense, as a contract between risk takers and risk bearers, began in Genoa, Florence, and Pisa in northern Italy about 1300.[2] Early legislation (1435-1523) regulating marine insurance restricted the activities of insurance brokers, prescribed the content and form of policies, and created administrative agencies with insurance commissioners who were empowered to fix the rates of premiums.[3]

Until the late 1500s, most marine insurance policies, even those on foreign ships, were written in the cities of northern Italy.[4] By 1600, however, the English were writing their own sea risks. Shipowners, merchants, and brokers in goods often met at Edward Lloyd's coffeehouse to trade information on the nature and value of the cargo on ships preparing to set sail and to solicit participants in insuring the ships and their cargo. Participants would sign their names on a sheet of paper under a statement identifying a particular ship, its destination, and the ship's value including contents, indicating how much of the total value they would personally insure. In return, these "underwriters" received commissions in the form of cash advances from the owners of the ship or cargo. The safe return of the ship ended the transaction. If the voyage ended in disaster, the underwriters lost what they had pledged. Sometimes, these underwriters were not able to pay the amount they had pledged.[5]

During colonial times in America, these Lloyd's underwriters and other foreign insurers provided most of the marine insurance on ships carrying goods to and from the colonies. With the rise of the shipbuilding industry in Massachusetts, colonial merchants began to argue against "local merchants and traders paying London underwriters for a service which might be performed as well at home, . . . [keeping] the money . . . on this side of the water."[6] By 1760, two home-grown marine insurance offices, one in Philadelphia and one in New York, conducted a Lloyd's-type underwriting business.[7]

Philadelphia was also the home of the first successful fire insurance company, organized by Benjamin Franklin in 1750.[8] Named the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire: the company consisted of members who chipped in equal shares to build a fund that was used to indemnify members whose homes were destroyed by fire. For three decades, the Philadelphia Contributionship was the only fire insurance company in America. Two early practices of the Contributionship marked the beginning of modem risk rating. First, prior to insuring a home, the directors would inspect the property and require the owner to provide a safe access to the roof for fire fighters and to remove any hazards. Second, the Contributionship set rates individually in accordance with the quality of the risk insured.

Because an act of the English Parliament in 1719 prohibited the organization of stock insurance companies other than those existing on that date, colonial efforts to compete with English insurance were limited to underwriting by individuals and to the organization of two mutual insurance companies.[10] These early forms of colonial insurance were not regulated by government.

The Birth of State Regulation of Property Insurance

The rise of government regulation of insurance in the United States began after the adoption of the Constitution and coincided with the incorporation of stock insurance companies. In 1794, the Insurance Company of North America (INA) became the first stock insurance corporation." INA was created with capital stock of $600,000 by a special act of the Pennsylvania legislature, which required that (1) the company's funds be invested in certain stock, (2) all deposits of money be made in the Bank of Pennsylvania, (3) the company not hold real estate of a yearly value exceeding $10,000, and (4) ready money be reserved to pay losses.[12]

Soon after the creation of INA in Pennsylvania, the Massachusetts General Court (legislature) passed an act incorporating the Massachusetts Fire Insurance Company with capital stock of $300,000.[13] The Massachusetts law required the company to invest its stock in the debt of the United States or Massachusetts, or in the stock of the Bank of the United States or any incorporated Massachusetts bank, and provided for an assessment of $10 per share on the stockholders if losses exceeded capital.

Early state regulation served multiple purposes. For example, the Pennsylvania and Massachusetts provisions requiring conservative investments and safeguarding the company's solvency were enacted to protect the policyholders. States adopted other regulatory requirements to raise revenue. For example, some states required domestic companies to file reports of their financial condition, listing the total premium on which taxes were levied. Other states levied a license tax on insurance agents, and still others imposed a stamp tax on insurance policies.[14] Finally, some states passed legislation designed to protect local companies. Pennsylvania and South Carolina had statutes restricting the activities of alien insurers (insurance companies domiciled in ***another country***); and New York became the first state to enact a discriminatory tax, with a low rate on New York-based companies and a higher rate for ***foreign*** companies (insurance companies domiciled in ***another state***).[15]

By the early 19th century, over half of the states (most along the eastern seaboard) had one or more fire and marine insurance companies, and most of these states had adopted laws imposing general regulatory requirements on domestic companies. The requirements included minimum initial capitalization, investment restrictions, provision for reserves, and periodic public financial reports. Yet, because no state agency was charged with overseeing compliance with the law and examining the condition of the companies, these early systems of regulation were not very effective, and "unscrupulous sales propaganda, fictitious stocks, and phantom capital were the ready weapons employed in the bitter fight for insurance profits."[16] A Missouri insurance superintendent described the situation prior to the passage of that state's regulatory laws as follows:

> . . . there were no police regulations governing either home or foreign companies. Some kept but a few books of any kind, and these in so slovenly a manner that even the officers could tell nothing about the entries. The agents covered the State, wrote on specious and novel plans, and defrauded without fear of penalty. The mutuals were most productive of fraud and mischief. There was nothing to prevent their organization by any poverty-stricken adventurer. Any five or more persons could procure a license from the Secretary of State by merely filing the corporate name and number of directors. Parties by insuring for twelve months became members, and ignorantly gave liens on their property. Premium notes were obtained in that and other States from unwary parties on false pretenses, and assessed without stint, while losses would be fought off in the courts."

In 1851, New Hampshire established the first board of insurance commissioners.[18] The duties of the commissioners included examining the financial affairs of all insurance companies each year and reporting the results to the legislature. Massachusetts followed one year later with a board of insurance commissioners, which examined the annual reports of insurance companies and generally enforced the state's insurance laws. In the same year, Vermont created two boards with similar duties. Typically, the members of these insurance boards consisted of existing officers of the state, who fulfilled other duties as well as enforcing insurance legislation. In 1859, the New York legislature established an independent administrative agency headed by an insurance superintendent with licensing and inquisitorial powers. By 1919, 36 states had established similar independent administrative agencies to regulate insurance.[19]

EARLY HISTORY OF CASUALTY INSURANCE

Generally, casualty insurance covers accidental injury to persons and property. The term also includes liability insurance coverage for accidental injuries to third parties. Thus, casualty insurance provides protection against direct losses from an accident suffered by a policyholder and indirect losses arising from an accident that causes injury or loss to some other person but for which the policyholder is liable. Compared to marine and fire insurance, casualty insurance is a newcomer. Few casualty companies existed before 1900. The first mutual casualty company, called the Mutual Boiler Insurance Company of Boston, was formed in Massachusetts in 1877.[20] As its name suggests, the company insured all types of boilers and similar hazards, as well as property damaged as a result of accidents like boiler explosions. Other kinds of casualty coverage offered in the late 19th century included personal accident insurance (offered to travelers), health insurance, bank burglary, messenger robbery, and elevator in-

surance. Like that of fire insurance companies, the lifetime of the early casualty companies was frequently short. Most did not survive more than a few years.[21] Moreover, some casualty polices promised more than they delivered. One insurance historian noted that "the policy promised liberally on the initial page and on its reverse side reconsidered the generous impulse."[22]

Automobile Insurance and Workers' Compensation

The two most common modem forms of casualty insurance, automobile insurance and worker's compensation, had very different beginnings. The first automobile policy was a liability policy issued in 1898 to a physician in Buffalo, New York, who owned one of only 200 automobiles manufactured in the United States. Two years later, 12 American companies manufactured 4,000 vehicles.[23] As the number of automobiles increased, *so* did the number of casualty companies and the kinds of coverage offered. In addition to liability coverage, companies offered automobile fire-and-theft insurance.

Worker's compensation insurance had a less auspicious beginning in the late 19th century. The industrial revolution brought an increase in foreign trade and raised the national standard of living. The price paid for these benefits was high, including a phenomenal growth in industrial accidents. Although the common law gave an employee the right to sue an employer for negligence that resulted in job-related injuries, the employer had three defenses that made it virtually impossible for the employee to win such a lawsuit. The *fellow-servant* rule held that an employer was not liable for the injuries caused by the negligence or carelessness of fellow employees; the contributory negligence rule relieved the employer of liability if the employee contributed (even incidentally) to the cause of the accident, and the *assumption-of-the-risk* rule held that an employee had accepted all the customary risks of the occupation.

To correct the inequities in the common law, some states adopted so-called employer's liability laws. Alabama adopted such a law in 1886, and Massachusetts followed suit in 1887. Although these laws were designed to hold employers liable for injuries resulting from defective machinery, they did not provide injured employees with adequate compensation. For example, employers often resisted payment, claiming that the accident resulted from the worker's negligence, and the worker was forced to litigate the claim. Litigation delays of six or seven years were common, and stories abounded of lawyers fees of up to 50 percent of the judgment or settlement.[24]

Other states turned to worker's compensation legislation. Typically, these laws required employers to pay compensation to employees injured in the course of their employment according to a prescribed schedule without regard to fault. Employer payment was assured by various means, including premiums paid into a state insurance fund or to a private insurance company, or by the deposit of securities with the state. Maryland passed the first such law in 1902, and Montana and New York soon followed.

The New York Court of Appeals (the state's highest court) struck down the worker's compensation law, finding that in depriving employers of property without regard to fault the law violated the due process clause of the state constitution and the Fourteenth Amendment to the U.S. constitution." Thereafter, New York adopted a constitutional amendment, effective in 1914, declaring that nothing in the constitution "shall be construed to limit the power of the legislature to enact laws for the protection of the lives, health, or safety of employees; or for the payment . . .of compensation for injuries to employees or for death of employees resulting from such injuries without regard to fault as a cause thereof. . . ." In 1917, the U.S. Supreme Court upheld the New York law against a contention that it violated the due process clause of the Fourteenth Amendment.[26] The Court noted the deficiencies in the common law and concluded that compulsory compensation was within the police power of the state. The Supreme Court's decision paved the way for general acceptance of worker's compensation legislation.

LEGAL CHALLENGES TO STATE REGULATION

From the beginning, some insurance companies and agents opposed state attempts to regulate them.[27] Frequently, companies facing state regulatory restraints would threaten to leave the state. Big companies, at least, rarely followed through on these threats. Companies and agents also fought state regulation through lawsuits.

Is Insurance Commerce?

In one of the earliest lawsuits, Samuel Paul, an insurance agent for several New York companies, challenged a Virginia law that prohibited a foreign insurance company (a company incorporated in another state) from soliciting business in Virginia without depositing a bond with the state treasurer and receiving a license. When Paul refused to post the required bond, he was denied a license. Paul continued to solicit business on behalf of the New York companies and was fined $50. The Virginia Supreme Court affirmed Paul's conviction, and he appealed to the U.S. Supreme Court, where he maintained that the Virginia statute burdened interstate commerce in violation of the commerce clause. The Supreme Court disagreed, ruling in 1869 that insurance contracts

> are not articles of commerce in any proper meaning of the word. They are not subjects of trade and barter offered in the market as something having an existence and value independent of the parties to them. They are not commodities to be shipped or forwarded from one State to another, and then put up for sale. They are like other personal contracts between parties which are completed by their signature and the transfer for the consideration. Such contracts are not inter-state transactions, though the parties may be domiciled in different States. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions, and are governed by the local law. They do not constitute a part of the com-

merce between the States any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion.[28]

The decision of the Supreme Court in *Paul* v. *Virginia* not only cleared the way for states to regulate insurance but also thwarted federal regulation. Shortly after *Paul* v. *Virginia*, when it became clear that the states had exclusive authority to regulate insurance, the state insurance commissioners formed a national organization. Although it had no independent legal authority, the National Convention of Insurance Commissioners (now National Association of Insurance Commissioners or NAIC) provided a coordinating influence on regulation.

Rate-Making Bureaus and Anticompact Laws

The actions of fire-rating bureaus set the stage for two other landmark Supreme Court rulings upholding state insurance regulation.[29] The first ruling upheld state anticompact laws, which were passed in response to industry rate-making bureaus. The bureaus emerged out of the intense competition and unprecedented increase in the number of insurance companies that followed the Civil War.[30] Start-up companies, led by the promise of large profits, cut prices in order to attract the best risks away from their competitors. The low premiums, coupled with deficient reserves and capital and inadequate regulatory oversight, left many companies in a weakened condition. Two great fires proved disastrous to the underfunded companies. On the eve of the Chicago Fire of 1871, there were about 4,000 fire insurance companies. After the Boston fire of 1872, there were only 1,000 companies, and many claimants were unreimbursed because their insurers were bankrupt.

Having suffered enormous losses from these fires, companies turned to concerted rate making. National, regional, state, and even city boards were organized, "all directed to the restraint of anarchic competition."[31] The national board was soon joined by regional organizations, which set rates by compact. States enacted anticompact laws that made such rate fixing illegal. Alabama passed such a law in 1896, which prohibited rate fixing by company bureaus by providing that an insured who suffered a loss covered by a policy of insurance issued by a company that belonged to and set its rates in agreement with a rating bureau could recover the actual loss plus a penalty of an additional 25 percent. The German Alliance Insurance Company challenged the Alabama statute as depriving it of property in violation of the Fourteenth Amendment to the U.S. Constitution. The U.S. Supreme Court upheld the Alabama statute in 1911, ruling that:

> We can well understand that fire insurance companies, acting together, may have owners of property practically at their mercy in the matter of rates, and may have it in their power to deprive the public generally of the advantages following from competition between rival organizations engaged in the business of fire insurance. In order to meet the evils of such combinations or associations, the State is competent to adopt appropriate regulations that will tend to substitute competition in the place of combination or monopoly. . . . Regulations, having a real, substantial relation to that end, and which are not essentially arbitrary, cannot properly be characterized as a deprivation of property without due process of law.[32]

Another landmark Supreme Court case arose out of consumer complaints about the arbitrary rates set by the Clarkson rating bureau in Topeka, Kansas. After the Kansas legislature failed to pass an anticompact law, the state's populist governor, John W. Leedy, issued an order requiring the companies to cease using the bureau rates, which he deemed to violate the state's antitrust law.[33] Governor Leedy's order was upheld on appeal, and for a short time the cost of fire insurance protection in Kansas decreased. Yet, within two years, a new rating bureau was established, and the cycle of rate hikes and consumer outcry began again. A similar scenario, including rate hikes by rating bureaus, consumer complaints, and passage and enforcement of antitrust laws, was played out in Missouri, Texas, and New York.

When the Kansas antitrust legislation proved unsatisfactory, the state insurance commissioner drew up a rate-control proposal that required fire insurance firms to file rate schedules and gave the commissioner the power to pass on the rates and to decrease excessive ones or increase inadequate ones. The proposal became law in June 1909. Shortly thereafter, responding to complaints from small businesses, the Kansas commissioner ordered a flat 12 percent reduction in the rates on all business property. A lawsuit challenging the constitutionality of the statute followed.

The German Alliance Insurance Company claimed that the Kansas statute violated the Fourteenth Amendment to the Constitution because

> its business of fire insurance is a private business and, therefore, there is no constitutional power in a State to fix the rates and charges for services rendered by it. . . [the attempted] exercise of such right . . . is a taking of private property for a public use.[34]

The lower court upheld the Kansas statute and the company appealed its cause to the U.S. Supreme Court. The Supreme Court upheld the law, noting that under the Fourteenth Amendment, private property is not always constitutionally immune from state regulation. When private property has become "clothed with a public interest [because it is] used in a manner to make it of public consequence, and affect the community at large. . . [the owner] must submit it to be controlled by the public for the common good."[35] The Court acknowledged that it had ruled in *Paul* v. *Virginia* that a contract for fire insurance is personal, but it found that the personal character of insurance did not preclude regulation. To illustrate the public interest nature of insurance, the Court focused on its *effect*:

> The effect of insurance—indeed, it has been said to be its fundamental object—is to distribute the loss over as wide an area as possible. In other

words, the loss is spread over the country, the disaster to an individual is shared by many, the disaster to a community shared by other communities; great catastrophes are thereby lessened, and, it may be, repaired. . . . the companies have been said to be the mere machinery by which the inevitable losses by fire are distributed so as to fall as lightly as possible on the public at large, . . . not the companies. Their efficiency, therefore, and solvency are of great concern.[36]

Rate Regulation Experiments

With *Paul* v. *Virginia,* the Supreme Court affirmed the primary right of states to regulate insurance by removing congressional control under the commerce clause. With *German Alliance* v. *Kansas,* the Court cleared the way for states to experiment with various forms of rate regulation. State experiments proliferated. For example, a 1911 Missouri statute allowed companies to set charges through a fire rating association, but granted the superintendent of insurance the power to lower rates when they were deemed excessive.[37]

In New York, the legislature appointed the Merritt Commission to hold hearings during 1910-1911 on alleged industry abuses. The commission found numerous industry wrongdoings, including customer boycotts, exorbitant rates, unfair challenges of loss claims, and discriminatory rating practices.[38] Although the commission found the antitrust acts "utter failures," it did not recommend state rate-making. Instead, it favored allowing New York's regional rating association to continue to set rates, in return for certain public disclosures. Not until the 1920s did the New York legislature give the insurance superintendent power to fix rates. In 1917, the Wisconsin legislature passed a rate-making act, which allowed the state's insurance commissioner to fix a reasonable rate after establishing the inequity of any charge and to order the newly created statewide rating bureau to correct any discriminatory rates.

INDUSTRY CAMPAIGNS FOR FEDERAL REGULATION OF INSURANCE

Early advocates for federal regulation of insurance argued for congressional intervention in order to stem the "[c]haos [that] reigns through the land. . . [because] most states lack any type of regulatory bodies . . . and insurance statutes."[39] Yet, as states began to establish insurance regulation, proponents of congressional action changed their tune and argued for federal intervention to "nullify most, if not all, [of] the obnoxious laws on the statute books of the several states."[40]

Bills were introduced in the Congress in 1866 and 1868 to create a federal bureau of insurance, in 1869 to create the position of federal commissioner of insurance, and in 1897 to declare that insurance companies doing business outside their state of incorporation were engaged in interstate commerce.[41] None of the bills passed, and two were never reported out of committee. Congressional debate over federal regulation continued during the following years. In 1906, the judiciary committees of the House and the Senate concluded that the Congress did not have the constitutional power to regulate the business of marine, fire, and life insurance.[42] According to the House committee, "the question as to whether or not insurance is commerce has passed beyond the realm of argument, because the Supreme Court of the United States has said many times for a great number of years that insurance is not commerce."[43] In an attempt to overcome this constitutional bamer, resolutions were introduced in the House and the Senate in 1914-1915 proposing a constitutional amendment that would give the Congress power to regulate the business of insurance.[44] The resolutions were not reported out of the judiciary committees. A similar resolution was introduced in 1933, but this resolution also failed in committee.

This state of affairs changed dramatically in 1944 with the decision of the Supreme Court in *U.S.* v. *South-Eastern Underwriters Assn.*[45] The *South-Eastern Underwriters* case arose when Missouri Attorney General Roy McKittrick filed suit accusing more than 100 insurance companies of conspiring to fix prices and limit competition. In this suit, McKittrick sought assistance from U.S. Attorney General Nicholas Biddle. Biddle authorized grand jury proceedings to investigate criminal violations of federal antitrust law. The South-Eastern Underwriters Association (SEUA), which was considered one of the most flagrant monopolists, was chosen as the target.[46] In November 1942, a grand jury returned criminal indictments against SEUA. The indictment alleged that the members of SEUA (200 private-stock fire insurance companies and 27 individuals) conspired to restrain trade "by fixing and maintaining arbitrary and non-competitive premium rates on fire . . . insurance in Alabama, Florida, Georgia, North Carolina, South Carolina, and Virginia,"[47] and conspired to monopolize trade and commerce in fire insurance in the same states. SEUA argued that it was not subject to the *Sherman Antitrust Act* because the business of fire insurance was not commerce. The U.S. Supreme Court disagreed, holding that the *Sherman Act* applied to the fire insurance business. According to the Court:

> This business is not separated into 48 distinct temtorial compartments which function in isolation from each other. Interrelationship, interdependence, and integration of activities in all the states in which they operate are practical aspects of the insurance companies' methods of doing business. . . . The result is a continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts.[48]

With its decision in *South-Eastern Underwriters,* the Supreme Court acknowledged that insurance constitutes interstate commerce, thus ending three-quarters of a century of judicial deference to exclusive state authority over insurance.

THE *MCCARRAN-FERGUSON ACT*

For different reasons, the industry and the states immediately began lobbying efforts to reestablish state control over insurance. In his dissenting opinion in *South-Eastern Underwriters,* Justice Robert Jackson had intimated that state regulation and taxation of insurance may henceforth be deemed unlawful—"The Court's decision at very least will require an extensive overhauling of state legislation relating to taxation and supervision. The whole legal basis will have to be reconsidered."[49]

Although in previous eras some people in the insurance industry had favored federal regulation as a less onerous alternative to vigorous state regulation, by **1944,** the New Deal ushered in an era of federal activism leading the industry to favor state regulation. ***An*** industry bill that would have exempted insurance companies from the *Sherman* and *Clayton Antitrust* acts was defeated when President Franklin D. Roosevelt threatened to veto it. Justice Jackson's dissent also spurred the industry to challenge state premium taxes. Within one year after the *South-Eastern Underwriters* decision, insurers had filed lawsuits challenging premium taxes in **11 states.**[50] Because premium taxes made up a significant fraction of state tax revenues, the states reacted quickly. Through NAIC, the states proposed a bill to:

1) Declare state regulation and taxation acceptable under the commerce clause;

2) Exempt insurance from the *Federal Trade Commission Act;*

3) Exempt insurance from the *Robinson-Patman Act;* and

4) Limit the insurance exemption from the *Sherman* and *Clayton Antitrust* **acts.**[51]

Senators McCarran and Ferguson introduced an amended version of the states' bill. The *McCarran-Ferguson Act* was signed into law in March **1945.**

Broadly, the act gave primacy to state regulation of the business of insurance. Section **1** of the act contains a statement of this underlying policy:

> Congress declares that the continued regulation and taxation of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.[52]

Section 2 provided that no act of Congress would be interpreted to impair state regulation of the business of insurance, except to the extent that such business was not regulated by state law. **An** exception in section **3** made it clear that the *Sherman Antitrust Act* would continue to apply to agreements by insurers to boycott, coerce, or intimidate other firms or consumers.

States responded to *McCarran-Ferguson* by adopting new legislation to comply with the terms of the act. For example, by **1950,** all states had approved some form of rate regulation; later, states adopted unfair trade practice statutes. Some insurers responded by litigating the scope of the federal antitrust exemption under *McCarran-Ferguson.* This litigation continues.

Notes

1 **W.R. Vance, "The Early History of Insurance Law,"** *Columbia Law Review 8* **(1908): 1, 6; and see Marquis James,** *Biography of a Business, 1792-1942* **(Indianapolis: Bobbs-Merrill, 1942).**

2 **Edwin W. Patterson,** *The Insurance Commissioner in the United States* **(Cambridge, Massachusetts: Harvard University Press 1927), p. 514.**

3 **Ibid., p. 515.**

4 **James,** *Biography of a Business,* **p. 19.**

5 **Ibid.**

6 **Ibid.**

7 **Ibid., p. 20.**

8 **John Bainbridge,** *Biography of an Idea: The Story of Mutual Fire and Casualty Insurance* **(New York Doubleday & Company 1952), pp. 41-45.**

9 **Ibid.**

10 **Patterson,** *The Insurance Commissioner in the United States,* **pp. 522-523.**

11 **Ibid.; and see Kenneth J. Meier,** *The Political Economy of Regulation: The Case of Insurance* **(Albany: State University of New York Press, 1988), p. 49.**

12 **Patterson,** *The Insurance Commissioner in the United States,* **p. 523.**

13 **Ibid., p. 527.**

14 **Meier,** *The Political Economy of Regulation,* **p. 51.**

15 **Ibid.**

16 **Peter Nehemkis, "Paul v. Virginia: The Need for Reexamination,"** *Georgetown Law Review* **27 (1939): 519,521.**

17 **Ibid., p. 521 n.13.**

18 **Patterson,** *The Insurance Commissioner in the United States,* **p. 534.**

19 **Ibid., p. 536.**

20 **Bainbridge,** *Biography of an Idea,* **p. 259.**

21 **Ibid., p. 261.**

22 **Ibid.**

23 **Ibid., p. 317.**

24 **Ibid.**

25 **Ives v. South Buffalo Ry. Co., 201 N.Y. 271 (1911).**

26 **New York Central RR v. White, 243 U.S. 188 (1917)**

27 **Meier,** *The Political Economy of Regulation,* **p. 53; H. Roger Grant,** *Insurance Reform, Consumer Action in the Progressive Era* **(Ames: Iowa State University Press, 1979), p. 73.**

28 **8 Wall. 168, 183 (1869).**

29 **Grant,** *Insurance Reform, Consumer Action in the Progressive Era,* **p. 77.**

30 **Nehemkis, "Paul v. Virginia: The Need for Reexamination," p. 520.**

31 **Spencer L. Kimball and Ronald N. Boyce, "The Adequacy of State Insurance Rate Regulation: The McCarran Ferguson Act in Historical Perspective,"** *Michigan Law Review* **56 (1958): 548.**

32 **German Alliance Ins.** *Co.* **v. Hale, 219 U.S. 219, 316 (1911).**

33 **Grant,** *Insurance Reform: Consumer Action in the Progressive Em,* **pp. 84-85.**

34 **German Alliance Ins.** *Co.* **v. Kansas, 233 U.S. 389, 405 (1914).**

35 **233 U.S., 408, quoting Lord Chief Justice Hale.**

[36] 233 U.S. 412-413.

[37] Grant, *Insurance Reform: ConsumerAction in the Progressive Em*, p. 132.

[38] Ibid., p. 126.

[39] Ibid., p. 157.

[40] Ibid., p. 158.

[41] A complete list of the bills is set forth in U.S. v. South-Eastern Underwriters Ass'n., 322 U.S. 533,592, n. 15.

[42] U.S. v. South Eastern Underwriters Ass'n., 322 U.S. 576, citing Senate Report 4406, 59th Congress 1st Session; House Report 2491, 59th Congress, 1st Session, 12-25.

[43] Ibid.

[44] 322 U.S. 592, n. 15.

[45] 322 U.S. 533 (1944).

[46] Meier, *The Political Economy of Regulation*, p. 65.

[47] 322 U.S. 533, 534-535.

[48] 322 U.S. 541.

[49] 322 U.S. 590.

[50] Meier, *The Political Economy of Regulation*, p. 67.

[51] Ibid., p. 69.

[52] 15 U.S.C. secs. 1011 et seq.

2

Overview of the Modern Business of Property-Casualty Insurance

Descriptions of the business of insurance differ, depending on whether the term is used in its technical sense for purposes of construing the exemption under *McCarran-Ferguson* or to portray what it is that insurers do. This chapter examines the business of insurance from the latter perspective.

DEFINITION OF THE BUSINESS OF INSURANCE

A leading commentator defined insurance as follows:

> It is the characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all risks so as to enable the insurer to accept each risk at a slight fraction of [its] possible liability.[1]

Thus, the primary characteristic of the business of insurance is underwriting or spreading of risk among policyholders. Definitions of the terms "risk" and "underwriting" are essential to understanding the business of insurance.

Insurers classify risks as either "pure" or "speculative." Traditionally, insurers have covered only "pure" risks (i.e., those that involve the possibility of loss but not the possibility of profit). The risks of damage to or destruction of property, the loss of possession of property, and the loss of income or increased expenses are examples of pure risks. The risks of gambling or investment, which involve the possibility of profit as well as loss, are examples of speculative losses not ordinarily covered by insurance.[2]

Underwriting a policy of insurance is a complex process that involves several steps, including:

1) An evaluation of the dimensions of the loss exposure;

2) A determination of the premium;

3) A review of the contract conditions; and

4) An evaluation of the company's capacity to assume the entire exposure.[3]

In step 1, the insurer examines the information submitted and the coverage requested by the individual or entity seeking insurance in order to estimate the probability and cost of a potential loss. This step may require a safety inspection and credit and financial reports. Steps 2, 3, and 4 require similar reviews. The four steps are related. For example, a risk that appears unacceptable on its face may become acceptable if priced differently or if the contract terms are modified.

In sum, underwriting involves determining whether to accept a particular risk and the terms on which the risk will be accepted. As is described in the next chapter, the failure of insurance companies to implement and enforce underwriting standards and the practice of turning this important function over to managing general agents has played a significant role in recent insurance company failures.

STRUCTURE OF THE PROPERTY/CASUALTY MARKET

Roughly 3,900 domestic property/casualty insurers operate in the United States. Table 1 shows the average number of companies by state of domicile during the years 1969-1990. Of these, only about 1,900 firms play a significant role in the market, and 1,300 of these are clustered together in about 340 insurance groups under common ownership.[4] Thus, only about 1,000 independent entities operate in the property/casualty market. These insurers differ in the categories of risks they cover, as well as in the legal form of their ownership and their methods of distribution.

Table 1
Property-Casualty Companies by State of Domicile
(average number 1969-1990, in descending order)

State	Number
Illinois	291
Texas	211
New York	210
Pennsylvania	209
Wisconsin	201
Minnesota	178
Iowa	173
Ohio	150
Missouri	129
California	120
Indiana	100
Nebraska	71
Delaware	68
Florida	60
Michigan	59
North Carolina	56
South Dakota	55
Massachusetts	48
New Jersey	46
Vermont	46
Oklahoma	45
Virginia	45
Tennessee	42
Connecticut	40
North Dakota	39
Georgia	39
Colorado	38
Kentucky	36
Kansas	35
New Hampshire	30
South Carolina	30
Maryland	29
Maine	25
Alabama	24
Arkansas	24
Louisiana	24
Washington	22
Arizona	20
West Virginia	20
Rhode Island	18
Oregon	14
Washington, DC	13
Hawaii	12
New Mexico	11
Idaho	9
Mississippi	9
Montana	8
Utah	8
Alaska	7
Wyoming	4
Nevada	3

Source: **A.M.** Best Company Special Report, June 1991.

Regulatory Requirements

Historically, the structure of risk categories was heavily influenced by state regulatory requirements. For example, for many years, state regulators did not allow insurers to underwrite more than one kind of insurance, obliging companies to specialize in a particular line of business, such as fire insurance or casualty. Following the enormous losses suffered as a result of the **1871** Chicago fire, NAIC recommended legislation to separate casualty insurance from fire and life insurance. This regulatory restriction, which is called the *monoline* ***requirement,*** required businesses to purchase separate insurance policies for fire protection, theft, broken glass, etc.[5] Another effect of the monoline requirement was to insulate companies from competition.

States no longer enforce these specialization requirements, now allowing companies to write multiple-peril coverages, but many firms continue to specialize. Moreover, state reporting requirements continue to influence much of the structural terminology of the business. In order to analyze the profitability of the business sold by insurers, states require companies to break down their coverages into subcategories and allocate premiums, losses, loss adjustment expenses, commissions, taxes, and other expenses to each of the subcategories. These calculations are entered on separate lines on the standard form Annual Statement. Thus, the term "line of business" also refers to one of the lines on the standard form. Following this regulatory scheme, property, casualty, and multiline companies write "personal lines" and/or "commercial lines" insurance.

Legal Forms of Ownership

The legal forms of ownership of insurance companies under **U.S.** law fall into two groups—proprietary and cooperative.

Proprietary Insurers. These include stock insurance companies, Lloyds-type syndicates, and insurance exchanges. In the late 1980s, stock insurers accounted for nearly **63** percent of the property/casualty market. American Lloyds are, like their British relatives, insurance marketplaces in which insurance is written by or on behalf of individual members. Most American Lloyds are domiciled in Texas. The members of the Texas Lloyds syndicates are liable for losses only to the extent of their investment in the Lloyds. In the early 1980s, three insurance exchanges were organized in New York, Florida, and Illinois. Like Lloyds, insurance exchanges are marketplaces where the insurance purchased **is** underwritten by members who may be individuals, partnerships, or corporations. The New York and Florida exchanges are no longer in business due to financial problems. The Illinois exchange continues to write primary insurance but has discontinued its reinsurance operations.

Cooperative Insurers. These companies are owned, at least nominally, by their policyholders and include mutual insurance corporations, reciprocals, captive insurers, and fraternal organizations. Mutuals are managed by officers and employees chosen by a board of directors elected

by the policyholders. Fraternal organizations are similar to mutuals, but they typically limit their policyholders to members of a common social club. Reciprocals are associations of buyers who agree mutually to insure one another. Captive insurers are formed to insure the risk of the owners of the captive. "Pure" captive insurance is sometimes referred to as "formalized self-insurance." Another form of captive, known as an association captive, insures the risks of other unrelated businesses. In the late 1980s, mutuals and reciprocals accounted for approximately 30 percent of the total property/casualty market. The share of mutuals and reciprocals is over 50 percent in the private passenger auto, homeowners, and medical malpractice lines.

Marketing Channels

Insurance companies initiate and maintain contact with their policyholders through one of three types of marketing channels: independent agents, exclusive agents, and direct writers.

In the independent agency system, the companies have little direct contact with the buyers. Contact with the policyholder is handled primarily by independent contractors, either agents who represent the insurance company or brokers who represent the insurance applicant. An independent agent may represent several unrelated insurers. Because the independent agent owns the "expirations" (or renewals)[6] on the business it produces, it can move the business to another insurance company without fear that the original company will solicit the business. Personal contact with the insured and ownership of the expirations on the business they write have given independent agents significant control over the companies they represent. For example, independent agents often prefer to write a single commercial policy covering multiple risks even when several smaller policies could be written for a competitive premium. Packaging insurance into one policy increases the need for the primary insurer to have a large capacity, which in turn fosters the use of reinsurance.[7]

In contrast to the traditional independent agent, the exclusive agent represents only one insurer or group of insurers. Exclusive agents may be independent contractors or employees, but they do not own the expirations on the business they produce. A direct writer is an insurer that does not operate through agents but relies on the mail, telephone, television, and other mass media to sell insurance.

To a large extent, differences in insurance products determine what method of distribution an insurer will use. For example, policies in the private passenger auto and multiple-peril homeowners market are typically uniform and mass marketed; the policies are seldom customized. Under these conditions, the use of direct writers or exclusive agents enables companies to keep prices down. Direct writers and exclusive agents control approximately 65 percent of this market. In contrast, the independent agency system dominates the commercial market where large corporate buyers shop for customized policies.

Notes

1 G. Couch, *Cyclopedia of Insurance Law,* section 13 (2d ed. 1959).

2 Bernard L. Webb, Howard N. Anderson, John A. Cookman, and Peter R. Kensicki, *Principles of Reinsurance* (Malvern, Pennsylvania: Insurance Institute of America, 1990), pp. 2-3.

3 Teme E. Troxel, George E. Bouchie, and Lowell S. Young, *Property-Liability Insurance Accounting and Finance* (Malvern, Pennsylvania: American Institute for Property and Liability Underwriters, 1990), p. 136.

4 Best's Aggregates and Averages, 1990 Edition (Oldwick, New Jersey: A.M. Best, 1990).

5 Kenneth J. Meier, *The Political Economy of Regulation: The Case of Insurance* (Albany: State University of New York Press, 1988), p. 9.

6 "Expirations" are copies of an agency's insurance policies in force, which contain information that enables the agency to attempt to renew the policies on expiration. The rule in the insurance business that the agent owns the expirations is an exception to the general legal rule under which the principal owns the agent's records. John Alan Appleman and Jean Appleman, *Insurance Law and Practice* (St. Paul: West Publishing Company, 1981), sect. 9026, p. 352.

7 William H. Rodda, *Property and Liability Insurance* (Englewood Cliffs, New Jersey: Prentice-Hall, 1966), p. 88.

3

Critical Issues in State Regulation of Property-Casualty Insurance: Solvency

State regulatory mechanisms to measure and monitor the financial health of insurers depend heavily on the validity and accuracy of the accounting principles used by companies to report their financial data. Thus, property-casualty accounting is the obligatory starting point for a discussion of insurer solvency.

REGULATORY ACCOUNTING AND FINANCE

For regulatory purposes, property-casualty insurance company accounting is governed by statutory accounting principles.[1] Many of the assumptions of statutory accounting principles and the more commonly used generally accepted accounting principles (GAAP) are the same; where differences exist, the statutory accounting principles are said to emphasize current solvency. For example, according to accounting terminology, assets minus liabilities equals net worth. In insurance accounting, this relationship is expressed as admitted assets minus liabilities equals policyholder surplus, or surplus. Statutory accounting principles are designed to measure policyholder surplus conservatively by requiring companies to limit the assets that are recognized for balance-sheet purposes. Given the recent increase in insurer insolvencies and weakness in the balance sheets of many others, some observers question whether statutory accounting principles are fulfilling their purpose.[2]

Property-casualty insurance companies report the details of their assets, liabilities, policyholder surplus, and operating results according to statutory accounting principles on an Annual Statement filed with insurance regulators in every state in which they do business. The Annual Statement or Convention Blank is a 61-page document that was developed by the National Association of Insurance Commissioners (NAIC). The financial information required in the Annual Statement includes a balance sheet (assets, liabilities, and policyholder surplus), statement of income, capital and surplus account, and underwriting and investment information by line of business, as well as other financial data.

Balance Sheet Liabilities: Policyholder Surplus and Loss Reserves

It is easiest to understand an insurance company's balance sheet by beginning with the liability side. The liability side of the Annual Statement balance sheet (or claims against assets) consists primarily of loss reserve funds and policyholder surplus.

The purpose of policyholder surplus is to provide a cushion against fluctuating investment values and underwriting results. These fluctuations can render a company statutorily insolvent unless there is an adequate surplus account. Over the years, actuaries have developed several ratios to determine the appropriate relationship between premium and surplus. Although these ratios have served as informal guidelines for regulators, none of them has gained the status of law.

An early set of guidelines devised for property business, known as the Kenney rules, prescribed that policyholder surplus be greater than or equal to premium. That is, every dollar of premium written must be covered by a dollar of policyholder surplus. For casualty business, the Kenney rules dictated that every dollar of premium written must be covered by two dollars of policyholder surplus?[3] Expressed as ratios, the Kenney rules, required

$$\frac{\text{policyholder surplus}}{\text{premiums written}} \geq 1 \text{ (property)}$$

$$\frac{\text{policyholder surplus}}{\text{premiums written}} \geq 2 \text{ (casualty)}$$

Another ratio, developed in Great Britain and known as the "cover ratio," related premiums to loss reserves plus policyholder surplus and required loss reserves plus policyholder surplus to cover net premiums by 2.5 times or more. Expressed as a ratio, this rule required

$$\frac{\text{loss reserves} + \text{policyholder surplus}}{\text{premiums written}} \geq 2.5$$

NAIC's Insurance Regulatory Information System (IRIS) threshold level for further examination of an insurer's premium to surplus ratio is three-to-one, which can be expressed as

$$\frac{\text{policyholder surplus}}{\text{premiums written}} = .33$$

A surplus-to-premium ratio should have the beneficial effect of limiting a company's ability to increase its premium volume until the company has sufficient surplus to ensure its continued solvency. As shown, over the years, the rules have been relaxed *so* that states accept a far lower surplus-to-premium ratio than formerly was found necessary. Moreover, no state has codified even this lesser standard, so the ratios continue to serve only as informal guidelines.

NAIC believes that ratio analysis as a means of measuring the financial health of insurers is crude at best. A better measure, according to NAIC, would be a risk-based capital formula. NAIC is developing such a formula, which it believes will replace surplus-to-premium ratios as a screening device to detect company problems, as well as providing for progressively stricter levels of regulatory action when a company's adjusted capital and surplus fall below specified levels. Because the program is still being developed, it is not possible to evaluate its effectiveness. NAIC is testing a life risk-based capital formula, which it hopes to finalize and adopt in December 1992. The target date for a property-casualty formula is June 1993.

Loss reserve funds and policyholder surplus are intimately related. Insufficient reserves create the illusion of reduced liabilities and, thereby, can give the appearance of a healthy policyholder surplus account (assets minus liabilities equals policyholder surplus). Thus, insufficient reserves mask impending solvency problems. Property-casualty companies must set up three categories of loss reserve funds: an unearned premium reserve, an estimated loss reserve, and a loss expense reserve.

The Unearned Premium Reserve Fund. The unearned premium reserve fund, which typically represents about 25 percent of a company's liabilities, is the most straightforward of the three reserve funds. Typically, insurance premiums are paid in advance. Thus, an insured may pay a premium of $500 for a one-year policy covering loss to a home. According to statutory accounting principles, the insurer may not recognize premium income when it is paid and the policy is issued. Rather, the insurer must "earn" the premium pro rata over the policy period. Thus, the insurer must set up an unearned reserve fund consisting of the total premium payment at the time it issues a policy. As the premium is earned over the life of the policy, like amounts are released from the unearned premium reserve. For example, assume as above that an insurer issues a homeowner's policy for one year at a premium of $500. The insurer will set up an unearned premium reserve fund for that policy of $500 on the day it is issued. After one month, the insurer will have earned $1/12$ of the premium or **$41.67,** and its unearned premium reserve will be reduced by **$41.67** to $458.33.

Because the calculation of the unearned premium reserve is straightforward, underreserving in this area seldom creates a problem for regulators. The verification of the other two loss reserve funds is far more difficult.

The Estimated Loss Reserve Fund. The estimated loss reserve fund, which covers losses that have been incurred but not yet paid, is the largest single liability of insurance companies. Thus, an accurate estimate of policy losses is key to insurer solvency. If these reserves are set too high, the company's profits will appear to fall and premium rates may be increased unnecessarily. If the reserves are set too low, the company's financial condition may appear better than it is, and premium rates may be reduced unwisely. In computing loss reserves, companies consider four different kinds of losses:

1. Reported and settled but not yet paid;
2. Incurred and reported but not settled;
3. Liabilities to third parties incurred and reported but not yet settled; and
4. Incurred but not reported.

Category 1 losses create no problems because they are known and definite. Category 2 losses, which arise from so-called "short tail" lines of business (i.e., coverage for property damage in which the amount of loss can be determined within a short time period), can be estimated with a high degree of accuracy. For an average insurer, losses falling within this category make up most of an insurer's loss reserves. Category 3 losses, which arise from so-called "long tail" lines of business (i.e., coverage for auto bodily injury liability, worker compensation, and medical malpractice), are difficult to estimate with the same degree of accuracy as is possible for the first two categories because it may take several years to determine the ultimate cost of an injury. Although they are not yet reported, Category 4 losses can be estimated with some degree of accuracy based on a company's past history. Sometimes, however, these losses defy all historical data, for example, the massive losses for asbestos-related injuries that were undetected and unreported for several decades.

Insurers use several methods to calculate their loss reserves. For losses within the first three categories, the two most common methods are individual estimates made by claims adjusters (called the ***case reserve method)*** and an ***average value method*** based on the insurer's experience with various types of claims. For Category 4 losses, insurers must estimate the number and amount of unreported

claims. Generally, this estimate is made on the basis of experience, modified for current conditions, such as rising claim costs and severity and frequency of recent claims.

The Loss Expense Reserve Fund. The third fund is the loss expense reserve fund. The estimated loss reserve fund itself does not include the loss adjustment expenses associated with a loss payment. Instead, insurers establish a separate loss expense reserve fund. These expenses, which consist of the costs of investigating, adjusting, and processing claims, as well as legal fees, make up from 5 to 20 percent of an insurer's total reserves. Insurers calculate loss expense reserves using one of two methods: individual estimates made by claims adjusters and a formula method.

Balance Sheet: Assets

Like any other U.S. corporation, a property-casualty insurer's assets include stocks and bonds, real estate, mortgages, collateral loans, and cash. Unlike other corporations, insurance company assets are limited by the concept of "admitted assets." State insurance laws designate which assets are "admitted" and can therefore appear on a company's balance sheet. The admitted asset concept reflects the insurance regulator's concern that if a company becomes insolvent, its assets should be available to pay claims (i.e., of certain value and easily liquidated). For example, states typically deem office furniture a nonadmitted asset, and many states limit the amount of real estate that an insurer can claim as an asset. Investments in excess of statutory limitations are deemed "nonadmitted assets."

Bonds typically make up the largest category of an insurer's investments. NAIC's securities valuation office classifies bonds into one of six risk categories. Medium and lower quality bonds (categories 3 through 6) are valued at market. The highest grade bonds (categories 1 and 2) are valued at amortized cost. Stocks constitute the second largest category of property-casualty insurance company investments. Stocks are valued at current market value at year's end as set forth in the "Valuation of Securities."

Because of the need for liquidity, real estate, mortgage loans, and collateral loans are not usually a significant portion of a property-casualty company's investments. In connection with their real estate holdings, most state regulators require insurers to value land at cost and buildings at cost less depreciation. First mortgages (and second mortgages under certain limited conditions) are valued at cost, but, in most states, if a mortgage exceeds 75 percent of the appraised value of the property, the excess is considered a nonadmitted asset. Collateralized loans are an admitted asset if the unpaid balance does not exceed the market value of the collateral and the collateral itself is an authorized investment.

The most important of other insurance-specific assets are agents' balances or uncollected premiums, reinsurance recoverables on loss payments, and investments in affiliates. The agent balance asset account represents insurance premiums (net of agent commissions) due from agents. Virtually all states treat such balances or premiums overdue more than three months as nonadmitted assets. Many insurance companies reinsure a portion of their loss exposure by entering into a contract with another insurance company (the assuming company) which accepts a portion of the premium and promises to pay a proportionate share of the losses to which the primary (or ceding) insurer is exposed. The primary insurer then reduces its loss reserves by the amount ceded to the reinsurer. When a policyholder's claim is settled, the primary insurer issues a draft for all of the loss to the policyholder and then bills the reinsurer for its portion of the settlement. Disputes frequently arise in reinsurance due accounts. To the extent that these disputes reduce the amount received by the primary insurer, the insurer's assets and policyholder surplus are overstated, misleading regulators and market analysts.

Insurers often invest in the securities of affiliated companies (i.e., companies under the common control of a parent holding company). Because these securities may not be publicly traded, no accurate method exists to value them.[4] The value for such securities will be set by the parent holding company and may reflect financial goals of the parent rather than a market-based price.

THE ROLE OF REINSURANCE

Insurance companies purchase reinsurance in order to spread their risk, reduce their reserve liabilities (thereby allowing them to increase their policyholder surplus and write more business), and for other purposes described in the next section. The treatment of reinsurance under statutory accounting principles may not present an accurate picture of an insurer's true financial condition. Current statutory accounting principles (like GAAP) allow a primary insurer to take credit against its reserves for reinsurance ceded to reinsurers. The effect of this provision is to increase the primary insurer's policyholder surplus, allowing it to write more business.[5] Yet, the picture of financial health created by statutory accounting for reinsurance may be illusory for several reasons.

First, the direct insurer remains responsible for the entire amount originally insured, regardless of the fact that some fraction has been ceded to a reinsurer.[6] In practice, therefore, the direct company has not reduced its legal liability to its policyholders, although accounting principles (both statutory and GAAP) make it appear as though it has, and the insolvency of a reinsurer can trigger the insolvency of a primary insurer. Second, in most states, judicial interpretations and/or statutory law allow a reinsurer to rescind its contract with the primary insurer if the latter has misrepresented a material term or condition of the insurance ceded.[7] Third, states do not directly regulate unauthorized alien reinsurers (domiciled in a foreign country and unlicensed in any state), requiring instead collateral to cover losses either in the form of earmarked trust funds or letters of credit. Fourth, reinsurers often cede a portion of their business to retrocessionaire companies, but states do not even collect data on alien retrocessionaires. Fifth, reinsurers are sometimes late in reimbursing the ceding company for their share of the losses, creating severe cash-flow problems for the ceding company. Sixth, some forms of reinsurance agreements, called financial reinsurance, do not transfer any risk of loss to

the reinsurer and appear to be loans rather than reinsurance. Nevertheless, some state regulators allow ceding companies to "dress up" their financial statements by using these financial reinsurance agreements to reduce reserves and increase stated profit and policyholder surplus. These problems are described in more detail below.

Purposes and Forms of Traditional Reinsurance

In law and in practice, reinsurance is a financial transaction between the primary insurer and its reinsurer or between a reinsurer and its retrocessionaire.[8] Commentators cite several reasons for and purposes of reinsurance. Among the most important are that the use of reinsurance:

1) Serves as a means of leveling earnings (underwriting income) by protecting ceding companies from shock losses and placing a cap on the maximum losses of a ceding company from any one risk or occurrence;

2) Facilitates the departure of a company from business or from one of its lines of insurance by allowing it to cede that business or line of business to a reinsurer, which then becomes the primary insurer,

3) Enables the reduction of reserves, a concomitant increase in policyholder surplus, and the writing of new business;

4) Increases the profits of a primary insurer;

5) Enables a small or new company to expand or write nonstandard risks by relying on an experienced reinsurer to counsel it; and

6) Affords the ceding company a better spread of risk. That is, a company with reinsurance can spread its risk over a larger number of units, insuring each unit for a smaller net amount.

There are two basic forms of reinsurance, facultative and treaty.

Facultative reinsurance This is a system whereby a primary insurer offers to cede to a reinsurer one or more specific risks. The primary insurer and reinsurer negotiate the terms under which the reinsurer will accept the particular risk(s) offered. Facultative reinsurance is optional; that is, the reinsurer is not bound to accept the offer made by the primary insurer.

Treaty reinsurance. This reinsurance is negotiated in advance of actual coverage. The treaty covers all risks written by the primary company that fall within the class of risks contemplated by the treaty. For example, a treaty may cover an insurer's entire worker's compensation business or its entire business in a particular state? Treaty reinsurance is obligatory. That is, a reinsurer may not refuse to accept any class of insurance that comes within the terms of the treaty. Treaties typically remain in force for a long time and are frequently renewed automatically. A reinsurer does not underwrite each risk individually in a treaty reinsurance contract as it does with facultative reinsurance; instead, the reinsurer relies on the underwriting expertise and good faith of the primary insurer. In property-casualty insurance, treaty contracts account for most of the reinsurance sold.

Both facultative and treaty reinsurance are issued in one of two forms, excess of loss or pro rata. Under an excess-of-loss agreement, the primary company pays all losses up to a predetermined amount, called the "retention." The reinsurer then reimburses the ceding company for the losses it pays in excess of the retention up to the limits of their agreement. The reinsurer receives a portion of the original premium paid to the primary insurer. Under a pro rata agreement, the primary insurer and the reinsurer split all premiums, liabilities, and losses on a predetermined basis.[10]

Problems *with* Reinsurance

Overdue Balances. The failure of reinsurers to pay their agreed share of the losses in a timely manner can be a significant problem for state regulators. Late payments can signal that a reinsurer is having solvency problems. Even when the reinsurer is solvent, late payments can create trouble for the primary insurer, which has already paid the losses and may be experiencing severe cash-flow problems. Some fraction of overdue reinsurance receivables is uncollectible and should be written off by the primary insurer. Few statistics exist on the magnitude of the problem, however.

In 1989, NAIC issued an Annual Statement instruction that it hopes will shed light on the magnitude of the problem and encourage ceding companies to speed up their recovery efforts. The instruction requires a primary insurer to reduce its surplus in an amount equal to 20 percent of reinsurance owed and overdue by more than 90 days. (In contrast, generally accepted accounting principles require an evaluation of the collectibility of the entire amount recoverable and could result in a 100 percent write down. According to the U.S. General Accounting Office (GAO), GAAP accounting would reflect the "amount of reinsurance ultimately expected to be collected, a better measurement than the arbitrary percentage required by statutory accounting principles."[11])

All licensed insurers must report overdue reinsurance balances on their Annual Statements. Data compiled from the Annual Statements on overdue reinsurance balances indicated that in 1990, U.S. property-casualty insurers could have incurred penalties (reductions in their surplus) totaling $382 million, less than 1 percent of industry-wide surplus.[12] Industry-wide statistics tell only a partial story, however. According to GAO, the insolvencies of the Mission, Transit, and Integrity insurance companies were a direct result of the inability and/or refusal of their reinsurers to pay amounts due the ceding insurers.[13]

Loopholes in the Annual Statement instruction make the data suspect, however. First, in most cases, the instruction does not require insurers to report (or reduce their surplus by) overdue reinsurance that is in dispute.[14] In one reported case, the amount of overdue reinsurance balances was doubled when disputed balances were included. According to a report in *Business* Insurance, Crum

& Forster's United States Fire Insurance Company unit reported $100.9 million in unauthorized reinsurance balances more than 90 days past due in its 1990 Annual Statement. Yet, only $44 million of this amount was undisputed and therefore subject to penalty.[15]

Second, under many contracts, reimbursement from the reinsurer is not "due" the primary insurer until 30 days after proof of loss is presented to the reinsurer.[16] Thus, the 90-day period in the model rule does not begin to run until 30 days after proof of loss, increasing the penalty threshold to 120 days.

Third, primary insurers can extend the payment period "simply by asking reinsurers if they have all the information they need to complete a proof of loss filing. If the answer is no, as ceding insurers expect it would be, the loss is not officially payable . . . and the 90-day clock hasn't started running.''''

Fourth, NAIC has not adopted a model law or regulation that would require states to take some regulatory action to correct the problem. At least in connection with property-casualty insurance, NAIC apparently believes that reporting overdue balances on the Annual Statement is sufficient protection without mandatory state regulatory action. Yet, NAIC's faith in the use of uncodified accounting procedures and/or instructions in the Annual Statement as an effective regulatory tool may be misplaced. A recent audit of the New York state insurance department's procedures and practices for monitoring insurer solvency criticized the department's failure to follow NAIC standards.[18] Because the New York department is considered by many to be among the strongest in the nation, the criticisms are particularly significant.

Given the loopholes in the 90-day penalty rule for overdue reinsurance recoverables, a better solution to the problem may be to adopt a rule that treats overdue reinsurance balances (balances that are not paid within 90 days after payment is due under the terms of the contract) as nonadmitted assets. This is apparently the solution adopted by the Illinois Department of Insurance. Such a rule would give a truer picture of a company's financial health because "dubious reinsurance claims" would be eliminated from the company's financial statements.[19]

Unauthorized Alien Reinsurers. The problem of overdue reinsurance balances is potentially even more intractable in connection with unauthorized alien reinsurers. An unauthorized reinsurer is one that is domiciled outside the United States and not licensed in any state. Estimates of the size of the unauthorized alien reinsurer market vary. According to the Reinsurance Association of America, in 1990, unauthorized reinsurers comprised approximately 40 percent of the property-casualty reinsurance market.[20] State regulators exercise no direct control over unauthorized alien reinsurers and do not even analyze their financial statements. Instead, regulators in the 29 states that have adopted a NAIC Model Law on Credit for Reinsurance prohibit primary insurers from taking credit for reinsurance ceded to unauthorized alien reinsurers unless the reinsurer has demonstrated that it will be able to meet its obligations. For this purpose, the model law requires an unauthorized alien reinsurer to set up a trust account or establish a letter of credit[21] with an approved U.S. bank in favor of the ceding insurer.

Both methods have weaknesses. The value of the assets in the trust account or the amount of the letter of credit must be equal to the reserves ceded to the reinsurer. To the extent that ceded reserves are understated, the collateral supporting the reinsurers' obligation to the ceding company will be insufficient.[22] *Also,* according to an industry official, ceding insurers are reluctant to draw down their letters of credit when reinsurance balances are overdue because they do not want to disrupt an ongoing relationship with their reinsurer.[23]

State reliance on indirect regulation of alien reinsurers can create serious problems. When the indirect remedies prove inadequate, state regulators may not be able to pursue direct legal remedies against alien reinsurers because they lack the requisite jurisdictional power as well as political clout to get a U.S. judgment recognized by a non-U.S. court.

In recognition of the regulatory problems with unauthorized alien reinsurers, NAIC has drafted a proposed federal Non-U.S Reinsurers Act. According to the draft act, the Congress would authorize NAIC to maintain a list of eligible non-U.S. primary insurers and reinsurers. Non-U.S. primary insurers would not be permitted to write business in the United States unless listed as an eligible direct writer by NAIC. In addition, domestic companies would not be permitted to take credit for reinsurance from a non-U.S. company unless that company was listed as an eligible reinsurer by NAIC. In both cases, a non-U.S. insurer/reinsurer wishing to do business in the United States would have to comply with certain requirements, including submitting to NAIC's authority to examine its books and records, maintaining a certain net worth, and appointing a U.S. agent for service of process. NAIC's draft law presumes the need for some federal assistance with alien insurers and reinsurers, while attempting to retain state control over the examination process. The particular form of the draft is awkward, however.

Another option that might accomplish the same goal—to utilize the greater jurisdictional reach and political clout of the federal government while recognizing the greater insurance regulatory expertise of state governments—would be for the federal government to maintain a list of alien insurers and reinsurers who agree to subject themselves to state regulation, as well as agreeing to the entry and enforcement of a valid U.S. judgment in the courts of the country of their domicile. Such a list would be consistent with the developing international norm of national treatment. The principle of national treatment requires countries to allow foreign entities to compete on essentially equal terms with domestic institutions in the host country. Under the existing insurance regulatory setup, foreign entities are allowed to compete on more favorable terms than are domestic and/or licensed entities in that they need not subject themselves to state regulation.

Financial Reinsurance

Traditional reinsurance contracts cover losses that occur after the effective date of the contract and transfer a portion of the risk of those losses to the reinsurer. In contrast, financial reinsurance[24] contracts typically cover losses that occurred before the effective date of the contract. The objectives of financial reinsurance are to improve the stated profit of the reinsured and/or the stated policyholders' surplus of the reinsured company.

These goals are accomplished by selling reserves to a reinsurer at their discounted present value. For example, under a common form of financial reinsurance—loss portfolio transfer—the reinsurer may agree to accept $7 million worth of loss reserves in return for a premium payment from the ceding insurer. The parties set the premium by calculating the present value of $7 million using an appropriate interest rate and time period over which the losses will be paid. Assuming that the parties agree on a 5-year period over which the losses will be paid and an average interest rate of approximately 1125 percent (compounded monthly), the premium paid would be $4 million, which is the discounted present value of the $7 million of loss reserves removed from the ceding company's balance sheet. Through the use of financial reinsurance, insurers can in effect discount their reserves, a practice that is prohibited by state regulators.

In the example above, the reinsurer assumed two risks: the risk that the primary insurer would in fact pay claims sooner than anticipated and the risk that the interest rate earned on the $4 million would be lower than expected. Some financial reinsurance contracts—called finite risk reinsurance—eliminate all risk to the reinsurer by building a "contingency loading" into the contract. The contingency loading may provide for an increase in premium or a reduction in the amount the reinsurer must pay if claims are paid sooner than anticipated or the interest rate earned is less than expected. The exhibit below illustrates the effect of financial reinsurance on the balance sheet of an insurance company." In this example, the Quaking Casualty Company purchased $7 million of financial reinsurance. Because the parties anticipated a delay in settling the claims and high interest rates, the premium for the financial reinsurance was $4 million.

Balance Sheet for Quaking Casualty Company Before Purchase of Financial Reinsurance

Assets	
Cash	$ 5,000,000
Investments	50,000,000
Total Assets	$ 55,000,000
Liabilities	
Unearned Premiums	$ 7,000,000
All loss reserves	45,000,000
Total Liabilities	$ 52,000,000
Policyholder Surplus	3,000,000
Total Liabilities and Policyholder Surplus	$ 55,000,000

Balance Sheet for Quaking Casualty Company After Purchase of Financial Reinsurance

Assets	
Cash	$ 1,000,000
Investments	50,000,000
Total Assets	$ 51,000,000
Liabilities	
Unearned Premiums	$ 7,000,000
All loss reserves	38,000,000
Total Liabilities	$45,000,000
Policyholder Surplus	6,000,000
Total Liabilities and Policyholder Surplus	$ 51,000,000

The reduction of reserves by an immediate $7 million in return for a $4 million premium doubled the company's policyholder surplus in a single transaction. Many accountants view financial reinsurance as a loan rather than as a reinsurance agreement and conclude therefore that insurance companies should not be permitted to dress up their balance sheets through the use of financial reinsurance. Some states agree and prohibit primary insurers from taking a credit against their reserves for financial reinsurance transactions. For example, under New York law, if a contract of financial reinsurance does not transfer *underwriting* risk, the primary insurer may not record the transaction as an underwriting transaction.

Recently, NAIC established a property-casualty accounting requirement that would eliminate the use of financial reinsurance. According to the new requirement, every contract of reinsurance must include a transfer of underwriting risk, as well as timing and investment risks. A primary insurer who enters into a contract of reinsurance that does not contain the requisite risk transfers would not be permitted to take credit for the insurance ceded. This new accounting requirement could resolve many of the problems with financial reinsurance.

Yet several problems remain. First, NAIC's requirement that a contract of reinsurance must include a transfer of underwriting risk has not been codified and adopted by the states. Unless states adopt NAIC's accounting requirement as a regulation or law, industry abuses in connection with financial reinsurance will remain. Second, according to Vincent Laurenzano, Assistant Deputy Superintendent and Chief of the Property Companies Bureau for New York, some problems remain even in those states that have adopted a law similar to NAIC's accounting requirement.[26] For example, reinsurance contracts are very difficult to interpret and require actuarial analysis. Moreover, insurers are not required to provide copies of their reinsurance agreements to state insurance departments in connection with reinsurance among affiliated companies. Laurenzano does not advocate a requirement that states must receive copies of all reinsurance contracts, however, noting that it would be nearly impossible to review all such contracts.

GAO CRITICISM OF STATUTORY ACCOUNTING AND SUMMARY

In addition to the problems described in the previous sections, GAO has noted several areas in which state statutory accounting principles hinder effective monitoring of an insurer's financial condition. Although all states require insurance companies to file a standard Annual Statement developed by NAIC, some states allow accounting practices that differ from those codified in NAIC's practices and procedures manual.[27] Because a multistate insurer prepares its Annual Statements in accordance with the statutory accounting principles of its state of domicile, the financial data filed may not be consistent with or comparable to that of other states.[28] Frequently, other states in which a multistate insurer is licensed may require the insurer to file supplements in accordance with their own statutory accounting principles. Two NAIC working groups (for life insurance and for property-casualty insurance) are attempting to codify statutory accounting principles, which then could be adopted by all states. NAIC expects the project to be completed by 1994.

NAIC maintains that a second GAO criticism—that most states do not require independent verification of the data or actuarial certification of the adequacy of reserves —has been corrected. Independent CPA audits and actuarial certification (the actuary need not be independent) of reserves are now required as part of the uniform Annual Statement filed by all licensed insurers.

In summary, the conservatism of statutory accounting principles is undermined by lack of uniformity and the failure to place meaningful limits on reinsurance as an admitted asset. These omissions weaken the usefulness of the Annual Statements to states and rating agencies.

STATE SOLVENCY REGULATION

The primary goal of state solvency regulation is to ensure the financial health of insurance companies. Because a contract of insurance protects policyholders against future losses, state regulators must not only prescribe initial capitalization but also monitor the ongoing ability of companies to pay future claims.

In theory, an insurer cannot operate in a state without a license from the appropriate state administrative agency, usually a division or department of insurance. Each state is responsible for the financial health of insurers operating within its boundaries. State licensure requirements are the same for domestic insurers (incorporated in the regulating state) and for foreign insurers (incorporated in another state). Prior to receiving a license, all companies must meet minimum capital and surplus requirements. Once the companies are in operation, most states monitor the ongoing financial health of only their domestic insurers by reviewing their Annual Statements and conducting field examinations.[29] NAIC aids states in this task by administering a statistically based early-warning system that identifies companies that should receive close regulatory scrutiny. Unfortunately, as described below, problems exist in each of these areas of state solvency regulation.

State Minimum Capital and Surplus Requirements

Appendix A lists the state minimum capital and surplus requirements for licensure, which vary from state to state and by line of business. For example, the capital and surplus required of a domestic life insurer varies from a low of $400,000 ($200,000 capital plus $200,000 surplus) in Montana to a high of $6 million ($2 million capital plus $4 million surplus) in New York. Capital and surplus serve different purposes. Capital is not used to pay off the obligations of an ongoing company. In fact, state insurance laws provide that a company's capital may not be drawn down without throwing the company into statutory insolvency.[30] Rather, capital is a "last ditch" fund to permit "an orderly receivership and liquidation [if the] insurer does not succeed, with minimal or no loss to policyholders and other claimants."[31]

Given this purpose, it is readily apparent that current minimum capital requirements are inadequate. For example, in a high-volume business like automobile insurance, a new company can easily acquire 20,000 policyholders and a premium volume of $4 million in a year or two. If the new company's premium structure turns out to be 15 percent inadequate, a capital of $600,000 would be needed to absorb the loss. Expenses, unwise investments, and the cost of receivership could easily raise the deficiency to $1 million or more.[32] Moreover, the required minimum capital is unrelated to the quantity and quality of risk assumed by a company. A large insurer with a high-volume and/or high-risk business is subject to the same capital requirements as a small insurer with a low-volume and/or low-risk business. Moreover, even the minimal capital of many companies is overstated because the insurer's loss reserves are understated.[33]

Most states view the initial surplus requirement as a working fund to pay expenses until the new company has a sufficient volume of business to pay its expenses and cover losses. In most states, insurer surplus can drop below the initial statutory minimum without triggering the statutory definition of insolvency, but some state laws tie their definitions of insurer insolvency directly to their minimum capital and surplus standards.

Some states justify the low capital and surplus requirements as a method of encouraging new competitors to enter the business. The low barriers to entry into the property-casualty business do appear to encourage new entrants, and in doing so, they provide a response to critics who argue for removal of the *McCarran-Ferguson* federal antitrust exemption for insurers. Antitrust experts cite low bamers to entry as an important measure of the competitiveness of a market, where prices are set competitively. Thus, minimum capital and surplus requirements serve two different goals. The minimums must be set high enough to protect policyholders in the event that the company fails, yet low enough to encourage new entrants and convince critics of the insurance antitrust exemption that the industry is competitive.

Many state regulators recognize that minimum capital requirements are not an appropriate measure of capital adequacy for established concerns. A NAIC committee is drafting risk-based capital standards, based on the

size and risk of each insurer, for property-casualty and life insurers. A company that falls below the standard would be subject to differing levels of mandatory regulatory action, depending on the level of deficiency. The target date for adoption of the property-casualty risk-based capital standard is June 1993.

Fronting and Managing General Agents

A serious problem with state licensure standards for insurers is the failure of states to enforce them. For example, despite state laws requiring insurers to obtain a license prior to beginning operations, an unlicensed insurer can operate in most states through the use of "fronting." Fronting is a "rent-a-license" arrangement, whereby a duly licensed fronting insurer writes policies for another, unlicensed insurer. The fronting insurer then cedes a large fraction of the business to the unlicensed insurer. The fronting insurer also cedes control over all of its primary duties to the unlicensed insurer, including underwriting, claims handling, and reserve setting. Because the fronting insurer has ceded all control, it is unable to adjust premiums to match experience. Nevertheless, legally, the fronting insurer remains liable for all losses.

Working through NAIC, a state/industry committee is drafting a model law to limit fronting. Industry representatives on the committee have rejected several drafts that would have prohibited a fronting insurer from delegating reserving, underwriting, and claims handling to a reinsurer except in connection with fronting arrangements for captive insurers.[34] Some observers believe that even stronger restrictions on fronting are needed, such as prohibiting licensed insurers from ceding more than 50 percent of their business to unlicensed insurers and requiring fronting insurers to set underwriting standards and calculate the appropriate reserves.[35]

Such restrictions on fronting appear to comply with the basic, common sense notion that the company underwriting insurance and setting reserves should be subject to state solvency examinations. Some industry representatives, however, cite two examples to illustrate the need for fronting. First, it is far more efficient for an insurer based outside the United States that wants to insure its U.S. operations but does not want to wait the five to ten years necessary to become licensed in all 50 states[36] to pay an American insurer to front for it. Likewise, a multistate U.S. business that does not want to buy workers' compensation insurance in every state may set up a captive insurance company and pay a licensed insurer to front for it.

Although some industry representatives maintain that fronting should be viewed as just another form of reinsurance, there are significant differences between the two arrangements. Under a typical reinsurance agreement, the licensed insurer cedes only a portion of its business to a reinsurer and retains control over underwriting standards, sets its own reserves, and adjusts premiums as needed. In contrast, licensed insurers who front for unlicensed companies may cede 100 percent of their business to an unlicensed company and do not retain responsibility for underwriting standards, reserving, and premiums.

Similar problems exist with the use of managing general agents (MGAs). Primary insurers use MGAs as intermediaries to negotiate reinsurance agreements. Although MGAs are not licensed as insurance companies, primary insurers frequently grant them authority to perform all of the essential tasks of insurance companies, including underwriting, pricing, and billing. In return for their services, MGAs receive commissions based on the volume of business they write and earn interest on the premiums that they collect and hold for the primary insurer. Both GAO[37] and the House Subcommittee on Oversight and Investigations (the Dingell Report) have noted that this fee structure gives MGAs "strong incentives to operate recklessly or dishonestly."[38]

In 1991, NAIC issued its amended Managing General Agents Act. The act requires an MGA to be licensed as a producer in any state in which it performs certain defined acts.[39] Further, the act requires insurers and MGAs to enter into written contracts that contain the provisions listed in the act. As of September 1992, approximately 29 states have adopted the model act or similar legislation.

Monitoring the Financial Health of Insurers

States monitor the financial health of insurance companies by reviewing their licensees' Annual Statements and by conducting field examinations of domestic companies, Both methods have defects, as described below.

All states require licensed insurers to submit a year-end Annual Statement by March of the following year. The lack of uniformity in state accounting rules was noted in the previous section. Another shortcoming of the use of the Annual Statement as a monitoring tool is the time lag in state review of the data. For year end 1991, for example, state laws required licensed insurers to submit their Annual Statement by March 1, 1992. Typically, state reviews of the financial data in the report take from six weeks to three months. As noted by GAO, a company can have a problem for more than a year before a state regulator is aware of it.[40] NAIC maintains that the time lag is not a problem because many states require companies to file abbreviated (and unaudited) quarterly financial reports, which contain sufficient data to allow states to observe any significant changes in a company's financial condition. As of September 1992, 27 states require insurers to file quarterly financial reports; 24 of these states require companies to file with NAIC and three require companies to file with the state directly.

Through field exams, state regulators can detect problems that do not show up on Annual Statements. Most state statutes provide for periodic (from three to five years) field exams of domestic companies. Depending on the size of the insurer, field exams can take a year or more to complete. NAIC has recently taken several steps to remedy this problem. For example, NAIC's Examination Processes Committee has substantially revised the official Examiner's Handbook, begun work on a comprehensive training program to teach examiners about the new approach, and developed a training program for senior level financial regulators.

Another new project recently initiated by NAIC is the Financial Analysis Working Group (FAWG). FAWG first

identifies insurance companies of national significance, using as measurement criteria gross premium written and the number of states in which companies are licensed. Then, the financial statements of those companies deemed nationally significant are analyzed, and the companies are classified as needing either immediate, priority, or routine regulatory attention. Finally, **FAWG** monitors the actions taken by the domiciliary state regulator to ensure that the domiciliary state is aware of the nature of the company's problems, has a corrective plan of action in place, and has communicated with other states whose policyholders may be at risk.

Detecting serious problems in the financial condition of insurers is only half of the regulatory equation, however. Regulators also must be willing to take timely supervisory actions to stem losses when an insurer's financial condition has become perilous. In a recent joint audit report, the National State Auditors Association reviewed state regulatory treatment of 16 insurers, all of which were domiciled in either New York or California and were eventually the subject of state delinquency actions. The report found that, frequently, 10 or more years elapsed from the time of the initial discovery of serious financial problems until the regulators initiated formal delinquency proceedings.[41]

Monitoring Reinsurers and Reinsurance

Like primary insurers, licensed reinsurers file Annual Statements with regulators in the states in which they are licensed,[42] but unlicensed alien reinsurers do not. Reinsurers also purchase reinsurance (i.e., retrocede a portion of their business to another insurer, which becomes the retrocessionaire). Although licensed reinsurers list their retrocessionaires on their Annual Statements, the retrocessionaires are not required to file financial data, and regulators cannot assess the financial condition of each retrocessionaire from the financial statements of the reinsurers.[43]

Moreover, as each party deducts its commissions and fees from the original premium, the layers of retrocessions can reduce funds available to the reinsurers in the chain to cover losses. **GAO** has noted that the insolvency of retrocessionaires can "ripple through the reinsurance chain to affect the original ceding companies."" As an example, **GAO** cites the recent failures of Integrity Insurance Company and its reinsurer Mission Insurance Company. The inability of Mission Insurance Company to collect the amounts due it from its retrocessionaires led to the failure of Mission to make reinsurance payments to Integrity and brought down both companies.[45]

MULTISTATE INSURANCE HOLDING COMPANIES

Special problems exist for states attempting to ensure the solvency of insurers that operate through multistate holding companies, whereby a parent holding company domiciled in one state controls separate insurance subsidiaries operating in several states. Insurers form holding companies[46] for many reasons, including diversification of their business. In many states, insurers are prohibited from engaging in non-insurance activities. Through the use of a holding company, an insurer can diversify into other activities through separately incorporated affiliates. Another reason for an insurer to form a holding company is to circumvent state regulatory restrictions on investments. Once funds are transferred to a holding company, they are not subject to state regulatory restrictions.

The problems associated with supervising a financial company that operates through a holding company structure in several jurisdictions are well known. Although separately incorporated, the parent holding company tends to treat subsidiaries that are engaged in the same or similar businesses as one economic enterprise. Most assets held by financial companies consist of intangible property that can be moved with ease among affiliates located in different jurisdictions. In most cases, a change in a book entry will suffice to transfer assets from one affiliate to another. Moreover, the affiliated group typically receives shared administrative services from its common parent holding company, and the prices for such services are not necessarily those that would be charged by an unrelated company. That is, the price that the parent holding company charges its subsidiaries for such services may be set to serve goals, such as tax avoidance, other than the efficient provision of services.

Intercompany transactions and intermingling of assets make it nearly impossible to estimate the solvency of an insurer without looking at the various entities that are a part of the holding company, including the parent. Effective regulation of insurance holding company systems requires state regulators to review consolidated financial statements with uniform accounting standards and to examine the financial transactions among the parent holding company and its affiliates as a unitary economic enterprise. **GAO** has noted that only 13 states require companies to file consolidated financial statements,[47] and no state regulates either non-insurance holding company parents or noninsurance affiliates."" **A** NAIC working group is attempting to develop reporting guidelines for the preparation of consolidated group Annual Statements.

NAIC's Model Holding Company Act

The most recent version of NAIC's model act on holding company systems requires an insurer to notify its domestic regulator at least 30 days in advance of its intention to engage in any one of certain transactions with its parent or an affiliate if the transaction will equal or exceed the lesser of 3 percent of the insurer's admitted assets or 25 percent of its surplus (property-casualty companies), or 3 percent of the insurer's admitted assets (life companies). The statute covers the following transactions: sales, purchases, exchanges, loans, or extensions of credit, guarantees, or investments. **A** NAIC model regulation sets forth the rules and procedural requirements necessary for the state insurance commissioner to carry out the provisions of the model act. It also includes the forms used by insurers to notify the insurance department of specified affiliate transactions. As of March 1992, 28 states had adopted the most recent version of the model act and 14 states had adopted the model regulation!'

The restrictive language in the model act appears conservative at first glance; in practice, the restrictions have little force. First, the restriction is not self-executing. The transactions described are not forbidden unless and until a state regulator disapproves them using a "reasonableness" standard. Second, the restrictions are applied transaction by transaction and affiliate by affiliate. That is, in calculating the percentage limits, neither the transactions nor the affiliates are aggregated over a given time period. Thus, insurers can easily avoid the threshold level for notification by splitting a large transaction into two or more smaller ones or by engaging in several transactions with more than one affiliate.

The model act makes some attempt to close this loophole by giving the commissioner authority to penalize a company that enters into a series of transactions "if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur." Not only are such after-the-fact penalties difficult to enforce, but they may also be too late.

It is instructive to compare NAIC's model law covering transactions with affiliates with the federal laws restricting transactions among bank holding company affiliates. For example, subsection 1 of 12 U.S.C. section 321c contains a restriction on interaffiliate transactions that prohibits a bank from engaging in certain transactions with (1) any one affiliate unless the aggregate amount of all such transactions does not exceed 10 percent of the capital stock and surplus of the member bank, and (2) all affiliates unless the aggregate amount of covered transactions of the member bank and its subsidiaries will not exceed 20 percent of the capital stock and surplus of the bank.

Federal regulators have found even this tough, self-executing standard insufficient to solve the perennial problem of abusive transactions among affiliated companies within a holding company structure that includes regulated industries. In addition to the statutory restrictions on interaffiliate transactions, federal regulators have two other important tools to control holding company abuses. One is a system of congressionally mandated cross guarantees. In 1989, the Congress enacted the *Financial Institutions Reform, Recovery, and Enforcement Act* (FIRREA). Section 206 (e)(i) of FIRREA was designed to prevent multibank holding companies from abandoning failing insured affiliates.[50] The act accomplishes its purpose by overcoming the judicial wall between separately incorporated but commonly controlled depository institutions and establishing a system of cross guarantees among affiliated depositories.[51] This congressional mandate links depository affiliates across state lines in a web of warranties, treating the affiliates as branches of one bank rather than separately chartered banks.

FIRREA does not extend the cross-guarantee liability to bank holding company parents or to nonbank affiliates. Another tool used by federal regulators, however, does extend responsibility to holding company parents. The federal reserve board's "source-of-strength" doctrine makes bank holding company parents responsible for the financial health of their bank subsidiaries. GAO has recommended that the Congress enact a law codifying the source-of-strength doctrine. According to GAO,

> it is keeping with market realities to view holding companies as consolidated entities for operating purposes. Market reaction.. . assumes that serious financial problems associated with a holding company subsidiary are likely to negatively affect the health of the holding company and all of its other subsidiaries. . . . The holding company parent is the "nerve center" of the company and determines how its subsidiaries are operated.[52]

Of course, the activities of bank holding companies are limited by federal statute to businesses deemed closely related to banking. In contrast, insurance holding company parents and their subsidiaries are frequently engaged in businesses unrelated to insurance. Some state regulators and industry representatives contend that a source-of-strength doctrine may be impractical in connection with such diversified holding companies. Yet, recently, the Bush administration's bank restructuring bill (S.713) proposed a similar requirement for so-called diversified holding companies.[53]

The federal experience with abusive interaffiliate transactions in national and international holding company structures illustrates the depth of the problem.

STATE REGULATORY RESOURCES AND INSURER FAILURE RATES

It would be helpful to compare the number of insolvencies per state with state regulatory resources, including budgetary dollars and number of examiners. Unfortunately, no such studies exist. A recent special report from A.M. Best Company contains some intriguing correlations that deserve further study. According to the study, six states accounted for 187 or 50 percent of the 372 insolvencies from 1969 to 1990.[54] The six states are Texas (47), California (35), Pennsylvania (35), New York (30), Illinois (22), and Florida (18). Four of these states—Illinois, Texas, New York, and Pennsylvania—also were among the top six in the average number of domiciled companies per state. It is not surprising that the states with the largest number of domiciliary companies should have the largest number of insolvencies. What is surprising is that when the number of failures was adjusted to take into account the average number of domiciled companies in each state, only four of the six had a failure frequency rate above the all-state average of 0.68 percent—California (1.33%), Florida (1.63%), Pennsylvania (0.76 percent), and Texas (1.01%). The average failure rate for Illinois at 0.34 percent was well below the all-state average, while the average failure rate for New York at 0.65 percent was just below the average.

As Table 2 shows, the apparently superior performance of Illinois and New York does not appear to depend on greater regulatory resources in terms of budget dollars per domiciliary company or in the number of domiciled companies per examiner. Nevertheless, this table (as well as other similar tables in the A.M. Best Company report) may be misleading. A better measure of the relationship, if any, between regulatory resources and failure rate would focus on the size (by premium dollar) of the domi-

Table 2
1990 Regulatory Resources by State

State	Budget (millions)	Number of Examiners	Number of Domiciled Companies	Budget per Domiciled Company	Domiciled Companies per Examiner	Average Failure Frequency 1969-1990
Alabama	$3.2	11	99	$32,267	9	0.38%
Alaska	2.0	5	14	139,743	3	0.67
Arizona	2.7	30	894	3,040	30	1.13
Arkansas	3.0	8	90	33,164	11	0.19
California	60.4	89	260	232,392	3	1.33
Colorado	3.1	20	293	10,432	15	0.71
Connecticut	4.3	19	137	31,095	7	0.00
Delaware	2.7	33	193	13,942	6	0.73
District of Columbia	2.1	6	32	64,406	5	0.00
Florida	39.0	35	182	214,490	5	1.63
Georgia	6.3	12	131	47,937	11	0.70
Hawaii	2.0	3	37	52,209	12	0.37
Idaho	3.2	12	34	92,771	3	0.00
Illinois	13.2	67	445	29,689	7	0.34
Indiana	3.3	20	186	17,733	9	0.41
Iowa	4.2	33	243	17,225	7	0.13
Kansas	4.5	13	70	64,108	5	0.00
Kentucky	5.3	16	71	74,586	4	0.38
Louisiana	5.7	21	229	24,843	11	2.10
Maine	3.1	14	33	94,599	2	0.18
Maryland	7.5	43	96	78,285	2	0.31
Massachusetts	5.9	6	99	59,790	17	0.66
Michigan	6.7	36	146	45,930	4	0.31
Minnesota	4.3	13	220	19,373	17	0.05
Mississippi	2.6	16	65	40,000	4	0.00
Missouri	2.1	26	220	9,571	8	0.42
Montana	1.0	9	21	46,186	2	1.76
Nebraska	3.5	14	150	23,235	11	0.32
Nevada	6.2	24	18	342,532	1	1.61
New Hampshire	1.9	13	43	43,859	3	0.00
New Jersey	12.1	36	115	105,104	3	0.79
New Mexico	2.3	3	34	67,553	11	1.29
New York	54.2	220	364	148,928	2	0.69
North Carolina	18.7	38	112	167,312	3	0.16
North Dakota	1.0	3	62	13,770	21	0.00
Ohio	11.8	49	278	42,354	6	0.36
Oklahoma	4.3	23	136	31,518	6	1.20
Oregon	4.6	13	89	51,755	7	1.00
Pennsylvania	11.3	44	347	32,490	8	0.76
Puerto Rico	2.1	14	68	31,082	5	1.64
Rhode Island	2.0	14	39	50,331	3	1.55
South Carolina	5.5	15	63	86,530	4	0.91
South Dakota	1.0	2	60	12,482	30	0.16
Tennessee	3.7	18	103	35,489	6	0.54
Texas	50.7	83	745	68,019	9	1.01
Utah	2.0	9	58	35,107	6	0.56
Vermont	1.5	6	188	7,923	31	0.10
Virginia	8.9	30	99	89,862	3	0.20
Washington	6.2	14	94	65,842	7	0.41
West Virginia	1.7	5	23	73,806	5	1.13
Wisconsin	4.9	22	304	16,268	14	0.18
Wyoming	1.0	5	9	111,847	2	3.75
State Average	**$ 8.2**	**26**	**157**	$ 64,323	8	0.68%

Sources:National Association of Insurance Commissioners and the A.M. Best Company.

ciled companies and compare the number of examiners (or budget) per premium dollar to a weighted failure rate (i.e., the sum of the premium dollars of all failed domiciliary companies divided by the sum of the premium dollars of all domiciliary companies).

SUMMARY OF MAJOR AREAS IN WHICH STATE SOLVENCY REGULATION OF PROPERTY-CASUALTY COMPANIES COULD BE IMPROVED

This study has reported on nine areas in which state solvency regulation falls short and could be improved:

1) ***The lack of uniformity of accounting principles*** for purposes of financial reporting;

2) ***Accounting for reinsurance in a manner that may provide an inaccurate picture*** of an insurer's true financial condition;

3) ***The failure to regulate alien reinsurers effectively;***

4) ***Minimum capital and surplus requirements that are unrelated to the size of a company or the risk it assumes;***

5) ***The use of fronting and managing general agents*** to circumvent state licensure and regulatory requirements;

6) ***A significant time lag in examining insurance companies;***

7) ***The failure to initiate formal proceedings after discovery that an insurer is operating in a perilous financial condition,*** thus increasing the costs to consumers and taxpayers of the eventual demise of the company;

8) ***The use (in areas in which laws are needed) of uncodified accounting requirements and reporting requirements as regulatory tools*** in lieu of model laws and regulations; and

9) ***The failure to effectively regulate transactions between insurers and their parent and among insurers and their affiliates.***

All of the above problems, with the possible exception of the last one, could be corrected through individual state action without federal intervention. Indeed, NAIC has adopted model laws that address many of these problems and has instituted an accreditation program, described in Part Three. The adoption of the new model laws by states would be a step in the direction of strengthening state regulation. To date, many states have not adopted the models, and only a handful of states has become accredited.

With respect to the last problem listed above, effective regulation of insurance holding company systems is difficult to accomplish on a state-by-state basis. Lax regulation and weak laws in a few states (or in even one state) can lead to insolvencies that affect policyholders in many states. Given that domiciliary states are the primary regulators of their domestic multistate insurers, the consequences of inadequate regulation by one state are exported to all states. Coordination among states is thus an essential ingredient for effective state solvency regulation of multistate insurance holding companies.

Notes

[1] The discussion of insurance accounting in this section is taken primarily from Terrie E. Troxel and George E. Bouchie, ***Property-Liability Insurance Accounting and Finance,*** 3rd ed. (Malvern, Pennsylvania: American Institute for Property and Liability Underwriters, 1990).

[2] Many of the accounting problems discussed in this section are not peculiar to statutory accounting principles but exist also with GAAP (generally accepted accounting principles).

[3] Roger Kenney, ***Fundamentals of Fire and Casualty Strength*** (Dedham, Massachusetts: Kenney Insurance Studies Press, 1957) p. 29.

[4] NAIC believes that the method used by its securities valuation office to value investments in affiliated companies—book value—is an accurate method.

[5] The Reinsurance Association of America (RAA) notes that not every reinsurance transaction results in immediate surplus relief. For example, neither an excess of loss treaty without a ceding commission nor a catastrophe treaty would have such a result.

[6] In some few cases specific contract terms change this general rule. Two such cases, assumption reinsurance and cut-through clauses, are discussed later in the report.

[7] The Reinsurance Association of America (RAA) correctly asserts that general contract law allows parties to rescind their contract if it contains a material misrepresentation. Yet, reinsurance contracts, like insurance contracts, are not contracts between private parties. Rather, they are contracts with a public purpose, subject to the police power of the state to regulate in the public interest.

[8] Except where specifically noted, the information in this section is taken from Bernard L. Webb, Howard N. Anderson, John A. Cookman, and Peter R. Kensicki, ***Principles of Reinsurance, Volume 1*** (Malvern, Pennsylvania: Insurance Institute of America 1990).

[9] Statement of Franklin W. Nutter, President, Reinsurance Association of America, submitted to the U.S. Senate, Governmental Affairs Committee, Permanent Subcommittee on Investigations, June 26, 1991.

[10] Ibid.

[11] Statement of Richard L. Fogel, Assistant Comptroller General, before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations (Washington, D C U.S. General Accounting Office, May 1991), p. 10. Industry observers note that statutory accounting principles do not differ significantly from GAAP. An Annual Statement instruction requires that, if experience has shown that a greater amount will be uncollectible, a greater provision should be established.

[12] Douglas McLeod, "'Late Payer' Penalties to Get Tougher: NAIC Proposal to Extend Sanctions to Unauthorized Reinsurance Recoverables," ***Business Insurance,*** November 4, 1991, p. 16.

[13] U.S. General Accounting Office (GAO), ***Insurance Regulation: State Reinsurance Oversight Increased but Problems Remain*** (Washington, DC, May 1990), p. 21.

[14] According to NAIC, amounts in dispute are "added back to the calculation of the penalty if overdue recoverables represent. . . more than 20 percent of paid loss recoverable plus amounts actually recovered during the calendar year preceding the date of the statement." NAIC letter to ACIR, April 24, 1992.

[15] McLeod, " 'Late Payer' Penalties to Get Tougher," p. 16. The Reinsurance Association of America has noted that in 1990, overdue reinsurance owed represented only 2.3 percent of the net premiums written by 26 members of RAA. According to

RAA, this percentage, which is calculated from data reported on Schedule F of the reinsurers' 1990 Annual Statements, includes amounts in dispute. Letter of Franklin W. Nutter to ACIR, September 15, 1992. Yet, according to NAIC, reinsurers were not required to report amounts in dispute on their 1990 Annual Statements. Even the new reporting requirement (for 1992) requires reinsurers to report only a fraction of the amounts in dispute. Phone conversation with Ed Kelly of NAIC, October 9,1992. See also Douglas McLeod, "Overdue Reinsurance Penalties to Tighten: Regulators Want to Close Loopholes in Current Regulations, *Business Insurance,* October *26,* 1992, p. 19.

[16] Ibid.

[17] Ibid.

[18] State of New York, Office of the State Comptroller, Division of Management Audit, *State Insurance Department Monitoring of Insurer Solvency* (Albany, April *8,* 1992).

[19] National Association of Independent Insurers, *Insurer Solvency: Public Policy Recommendations for Improvement* (Des Plaines, Illinois: 1989). This excellent report contains a wealth of information for regulators and policymakers.

[20] Statement of Franklin W. Nutter. In contrast, one law firm notes that the alien reinsurance market constitutes only 25 percent of the U.S. market. Letter to ACIR from William Marcoux of LeBoeuf, Lamb, Leiby & MacRae, September 1, 1992.

[21] The letter of credit must be irrevocable and unconditional and have at least a one-year term.

[22] Some state regulators, recognizing the problem of understated reserves, require an actuarial certification of an insurer's gross reserves (ceded reserves as well as retained reserves). This new practice may improve the accuracy of ceded reserves reported by primary companies.

[23] In fact, some observers note that "the vast majority of [letters of credit] were negotiated with the bank with the understanding that they would not be drawn on. If banks are. . . forced to honor these LOCs, they will demand more money from reinsurers for the instruments, and reinsurers will pass the costs along to ceding companies. . .." McLeod, " 'Late Payer' Penalties to Get Tougher," p. 16, quoting Edmond Rondpierre, Senior Vice President and General Counsel, General Reinsurance Corporation.

[24] Except where specifically noted, the information in this section is from Webb et al., *Principles of Reinsurance, Volume 1.*

[25] The exhibits are taken from Webb et al., *Principles of Reinsurance, Volume 1,* p. 163.

[26] Phone conversation with Vincent Laurenzano, May 11,1992.

[27] Statement of Richard L. Fogel.

[28] Ibid., p. 9.

[29] National Association of Insurance Commissioners (NAIC), *Insumnce Department Resources Report* (Washington, DC, 1990). NAIC notes that the data in its report do not include zone examinations.

[30] See, for example, Colorado Revised Statutes section 10-3-212, "A stock insurance company is deemed insolvent when its admitted assets are less than all of its liabilities, excluding from such liabilities the aggregate amount of its capital stock, and is deemed impaired when its admitted assets are less than its liabilities, including as a liability the aggregate amount of its outstanding capital stock. . . ."

[31] Spencer L. Kimball and Herbert S. Denenberg, eds., *Insurance, Government, and Social Policy: Studies in Insurance Regulation* (Homewood, Illinois: Richard D. Irwin, Inc., 1969), p. 151.

[32] Ibid., p. 154.

[33] Robert E. Litan, "Back to Basics: Solvency as the Primary Objective of Insurance Industry Regulation," August 1991.

[34] The history of the various NAIC drafts of fronting laws and industry opposition has been reported in *Business Insurance* over several years. For example, see Meg Fletcher, "NAIC to Reconsider Fronting Restrictions" (December 10, 1990, p. 1); Michael Bradford, "States Seek Middle Ground on Fronting" (May 13, 1991, p. 36); Meg Fletcher, "Latest Fronting Proposal Eases Rules for Captives" (October 14,1991, p. 2); "RIMS, Insurers Criticize Clauses in Fronting Bill Widening Oversight" (June 8, 1992, p. 1); Michael Bradford, "AIG Execs Leery of Fronting Law" (March 23, 1992, p. 18); Michael Schachner, "Fronting Act Challenged, RIMS, Others Press for Changes to Draft As Group Readies it for NAIC Approval" (March 16, 1992).

[35] One draft of a proposed "Limitations on Reinsurance Activities Insurers Act" would have prohibited a licensed insurer from ceding to an unlicensed company if the reinsurer assumed 50 percent or more of the risk and received authority over underwriting, marketing, or policyholder services. See Meg Fletcher, "NAIC to Reconsider Fronting Restrictions."

[36] See Robert M. Hall, "Fronting: Here We Go Again!" *Best's Review, Properiy-Casualty Edition,* December 1990, p. 52.

[37] GAO, *Insumnce Regulation: State Reinsurance Oversight Increased but Problems Remain,* p. 20.

[38] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Failed Promises, Insurance Company Insolvencies,* February, 1990, p. 30.

[39] Basically, a managing general agent who meets the act's definition must be licensed. The act defines a managing general agent as a person, firm, association, or corporation that negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer and underwrites an amount of gross direct written premium equal to or more than 5 percent of the policyholder surplus of the insurer in any one quarter or year.

[40] See GAO, *Insurance Regulation: Problems in the State Monitoring of Property/Casualty Insurer Insolvency* (Washington, DC, September 1989), p. 13.

[41] National Association of State Auditors, Comptrollers and Treasurers, *Regulation of Insurance Company Solvency* (Lexington, Kentucky, June 1992), pp. 11-13.

[42] GAO, *Insumnce Regulation: State Reinsurance Oversight Increased, but Problems Remain,* p. 14.

[43] In some cases, however, the retrocessionaires are themselves licensed primary insurers who file annual reports in the states in which they are licensed. Also, like alien reinsurers, the retrocessionaires are generally required to set aside collateral to cover the reserves ceded to them by a reinsurer.

[44] GAO, *Insurance Regulation: State Reinsurance Oversight Increased, but Problems Remain,* p. 21.

[45] Ibid.

[46] Insurance companies can form upstream holding companies by transferring a portion of their surplus funds to the newly-formed parent.

[47] GAO, *Insurance Regulation: Assessment of the National Association of Insurance Commissioners* (Washington, DC, May 22, 1991).

[48] Ibid.

[49] American Council of Life Insurance, *Status Report on Implementation of the Recommendations of the ACLI Task Force on Solvency Concerns* (Washington, DC, March 27, 1992).

[50] Testimony of L. William Seidman, Chairman, Federal Deposit Insurance Corporation, before the U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs, Subcommittee on Financial Institutions Supervision, Regulation, and Insurance, March 14, 1990.

[51] Subsection 206 (e) of FIRREA provides:

(A) LIABILITY ESTABLISHED—Any insured depository institution shall be liable for any loss incurred by the [Federal Deposit Insurance] Corporation, or any loss which the Corporation reasonably anticipates incurring, after the date of the enactment of the . . . Act in connection with—

(i) the default of a commonly controlled insured depository institution; or

(ii) any assistance provided by the Corporation to any commonly controlled insured depository institution in danger of default.

[52] "Expanded Powers for Banking Organizations," Statement of Charles A. Bowsher, Comptroller General of the United States, before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Telecommunications and Finance (Washington, DC: U.S. General Accounting Office, July 10, 1991).

[53] The Bush administration apparently believed that the use of a source of strength or analogous doctrine would be both practical and necessary in connection with a national regulatory scheme. The Bush administration's 1991 bank regulatory restructuring bill (which failed to become law) would have permitted nonbank parents to own bank subsidiaries and would have regulated the transactions among the affiliates of such diversified holding companies. The administration's bill (S. 713) would have regulated transactions between a bank subsidiary and a nonbank subsidiary of a diversified holding company. In fact, the bill would have allowed federal bank regulators to examine (under certain circumstances) the nonbank affiliates of diversified holding companies as well as the bank affiliates.

[54] *Best's Solvency Study, Property/Casualty Insurers 1969-1990,* (Oldwick, New Jersey: A.M. Best Company, June 1991), pp. 19-20.

4

Critical Issues in State Regulation of Property-Casualty Insurance: Liquidation Laws and State Guaranty Funds

All states have laws specifying the actions that an insurance commissioner can take to protect the policyholders of a financially troubled insurance company. These laws give insurance commissioners authority to institute delinquency proceedings against financially troubled companies. Permissible delinquency proceedings range from supervision to liquidation. As is the case with solvency regulation, liquidation of an insolvent insurer, even a multistate insurer, is handled primarily by the domiciliary state. In contrast, state guaranty funds, which provide protection for policyholders and claimants of an insolvent insurer, must be activated in the nondomiciliary states where policyholders or claimants of the insolvent multistate insurer reside.

STATE DELINQUENCY PROCEEDINGS

Virtually every state delinquency law is based on either or both of two acts, the Uniform Insurers Liquidation *Act* (UILA) and the Insurers Supervision, Rehabilitation, and Liquidation *Act* (Model *Act*). UILA was promulgated in 1939 by the National Conference of Commissioners on Uniform State Laws and the American Bar Association. As its title implies, UILA is targeted specifically at liquidation proceedings and is designed to solve the problems that arise in connection with the liquidation of insurers that have assets and liabilities in more than one state. Approximately 24 states have adopted UILA. The Model *Act,* issued by the National Association of Insurance Commissioners (NAIC) in 1969, is broader, covering delinquency proceedings short of liquidation as well as liquidation of multistate insurers. Roughly 29 states have adopted the Model *Act.*

The purposes of the two acts are similar—to protect the interests of insureds, claimants, creditors, and the public and to reduce the problems of interstate liquidation by facilitating cooperation among states. To accomplish these purposes, the acts limit where delinquency proceedings can be brought and control the disposition of the assets of the insolvent insurer. The two acts have many similar provisions. For example, both acts vest exclusive authority to institute delinquency proceedings in the insurance commissioner, both designate the domiciliary state as the primary location for all delinquency proceedings, and both specify that all delinquency proceedings be administered under the supervision of a court. Table 3 compares pertinent provisions of the two acts.

In addition to differences between UILA and the Model *Act,* several other problems have arisen in delinquency proceedings. Not surprisingly, many of the problems involve reinsurance. Other difficulties arise from the lack of uniformity among state laws and state/federal clashes over claim priorities. These problems and the litigation they engender, along with the lawsuits of third-party claimants against policyholders of the insolvent insured, increase the time and expense of liquidations.

Marshaling General Assets: Reinsurance

As was described in Chapter 3, insurance companies purchase reinsurance in order to reduce their reserve liabilities, thereby allowing them to increase their policyholder surplus and write more business. Insurers that have purchased reinsurance are permitted to reduce their reserve liabilities because the reinsurer has agreed

Table 3
UILA and the Model Act Compared

	UILA	Model Act
Domiciliary State	State in which U.S.-based insurer is incorporated; domiciliary state is deemed to be the primary location for delinquency proceedings	Same
Ancillary State	Any state other than a domiciliary state, where delinquency proceedings parallel to those of domiciliary state may be instituted because assets of delinquent company are located there	Same
Reciprocal State	Any state that has enacted the substance of UILA	Any state that has enacted certain sections of the Model Act
Summary Proceedings	No provisions	Allows commissioner to petition court for possession of insurer's property while ascertaining what further actions are needed; protects property until formal proceedings are initiated; petition is confidential.
Rehabilitation	No provisions	Commissioner of domiciliary state may petition the court for order of rehabilitation of a company, allowing commissioner to take possession of all assets and administer them under court supervision and to take all actions necessary to reform and revitalize insurer
General Assets	All property not specifically mortgaged, pledged, or deposited for benefit of specified persons or a limited class of persons; reinsurance proceeds are general assets	Same
Special Deposits	Any deposits made pursuant to statute for benefit of limited class of persons	Same
Domiciliary Receiver	Commissioner of domiciliary state	Same
Ancillary Proceedings	Commissioner of domiciliary state must petition court for appointment of an ancillary receiver if (1) there are "sufficient" assets of the company located in the ancillary state, or (2) ten or more state residents petition commissioner requesting receiver	Commissioner of ancillary state may initiate proceedings if "the protection of creditors or policyholders in ancillary state requires"
Federal Receiver	No specific provision, but courts have allowed when the state of domicile was unable or unwilling to conduct delinquency proceedings	No provision
Stays and Injunctions	No provision	After entry of order of liquidation, all prosecution of claims stayed; other states must give full faith and credit to anti-injunction orders entered in liquidation proceedings *if* domiciliary state would do likewise
Control Over Assets	Domiciliary receiver given title to all property, contracts and rights of action of delinquent company wherever *situated* as of date of entry of an order giving receiver possession of company; ancillary receiver in a reciprocal state has sole right to recover assets of company in ancillary state; assets not needed to satisfy secured claims in ancillary state must be returned to domiciliary receiver	Same
Filing Claims	Claimants residing in reciprocal states may bring claims against delinquent company in either domiciliary or ancillary proceeding; if no ancillary proceeding is commenced, then must bring claims in domiciliary state	Same, but specifically allows claimants in nonreciprocal states to file claims with domestic state
Priority of Preferred Claims	Claimants have priority in special deposits held for their benefit, according to the particular state provisions; in all other cases, priority scheme of domiciliary state controls	Same

to share the risk of loss. Given that insurers purchase reinsurance for the purpose of indemnifying the primary insurer for its losses from policyholder claims, it would be reasonable to assume that on the insolvency of the primary insurer the reinsurance proceeds would be used solely to satisfy the claims of policyholders. This is not the case, however. In fact, until 1939, reinsurers often refused to pay the claims of policyholders left stranded by the insolvency of their insurer, claiming that their duty to indemnify arose only on payment of the claim by the primary insurer.

Legally, a reinsurance policy is a contract of indemnity between a primary company and its reinsurer. The policyholder has no rights in the reinsurance contract. These legal principles led early reinsurers to argue that they had no duty to pay the losses of the policyholders of an insolvent company. Because the primary company was insolvent and could not pay policyholder claims, there were no losses to indemnify. After the U.S. Supreme Court upheld a similar argument based on the contractual language in the reinsurance agreement between a New York-based primary insurer and its reinsurer,' the New York legislature passed a law that prohibited a primary insurer from taking credit for reinsurance unless the reinsurance was payable undiminished by the insolvency of the ceding insurer.

Most states followed the lead of New York and adopted similar statutes. These laws effectively obligated reinsurers to indemnify the primary insurer even in the event of insolvency of the primary insurer, but the laws did not require that reinsurance proceeds be used solely for the protection of policyholders. In all states, reinsurance proceeds are treated as general assets that are subject to the control of the liquidator and distributed according to the state's priority scheme. A typical priority scheme requires the liquidator to pay the creditors of the insolvent insurer in the following order:

1) Costs and expenses of the administration of the estate by the liquidator and the administrative expenses of the state guaranty funds;

2) Employee wage claims, subject to certain limitations;

3) Claims by policyholders, beneficiaries, insureds, and liability claims against insureds covered under insurance policies issued by the company, and claims by state guaranty funds and associations for payments of covered claims;

4) All other claims of general creditors not falling within any other priority, including claims for taxes and debts due the federal government or any state or local government which are not secured claims;

5) Preferred shareholders; and

6) Proprietary claims.

Thus, although the amount of payments made by the reinsurer is based on its liability to indemnify the primary insurer for policyholder losses, policyholders are at best third in line for reimbursement; in some states, policyholder claims are fourth priority, following state tax claims. Typically, policyholders receive only a small fraction of their claims from the liquidating estate.

Litigation over the fate of reinsurance proceeds on the insolvency of the reinsured involves four key issues: (1) the effect of misrepresentations made by the ceding insurer, (2) set offs, (3) cut-through clauses, and (4) state/federal clashes involving federal tax liens and arbitration agreements.

Curiously, state laws and judicial decisions favor reinsurers in liquidation proceedings by treating them as players in need of special protection.' State laws and judicial rulings favoring reinsurers on the above issues can diminish drastically the size of the insolvent insurer's estate available for distribution to policyholders. State guaranty funds cover some, but not all, of the losses of policyholders of an insolvent insurer. In addition, unlike the case with reinsurance proceeds, taxpayers and policyholders ultimately bear the burden of the payments initially made by the funds to cover policyholder losses.

The Effect of Misrepresentations Made by the Ceding Insurer

The legal principles governing reinsurance were developed largely in the 18th and early 19th centuries,[3] an era in which insurers and reinsurers dealt with each other on a handshake. The relationship between the two was said to be one of "the utmost good faith." Judicial interpretations of this phrase vary. Most state courts have interpreted the duty of utmost good faith to require the ceding insurer to disclose all known information material to the risk and to file timely notice of claims. The failure of a ceding company to comply with either of these conditions will absolve the reinsurer of its duty to reimburse the ceding insurer, if the reinsurer can prove that the failure of the ceding insurer to disclose information or to file timely notice of claims prejudiced it in some material way.[4] These courts have followed the general rule that, "A basic duty of the reinsured is to disclose to the reinsurer all known information touching on the risk of loss. Failing in that duty. . . the reinsurance contract may be rescinded or cancelled."'

In contrast, some state courts have denied reinsurers the right to rescind their contracts even with evidence of fraud. These courts have found a duty in the reinsurer to monitor the business practices of its ceding insurer. For example, in Glacier General *Assur.* Co. v. *Casualty Indemnity Exchange*,[6] a federal district court refused to allow Glacier, a reinsurer, to rescind its contract even though the ceding insurer had deliberately understated its loss reserves. The court noted that "if the . . . agreement were rescinded, then the reinsurance obligations undertaken in it would be discharged, the preexisting reinsurance would not be reinstated, and the burden of open claims would fall on the policyholders or claimants, or some state-created fund. . . . Glacier entered into the . . . agreement with information which should have warned it of the precarious nature of the venture it was undertaking."' In the majority of states, then, reinsurers can rescind their agree-

ments if the ceding insurer misrepresents a material term of the contract or does not provide timely notice of claims.

Set Offs (Offsets)

Set off has been defined as the right between two parties to net their respective debts when each party owes the other an obligation? In the context of insurance liquidations, the bulk of set offs involve incurred but not reported (IBNR) claims and occur in connection with assumed-ceded reinsurance, a situation in which the insolvent insurer has both ceded some business to a reinsurer and assumed some business from the reinsurer. A NAIC model law prohibits set offs in such a situation, but few states have adopted the NAIC model.

Most states allow set offs either by statute or judicial interpretation? A small number of courts have denied offsets in order to retain the reinsurance proceeds for policyholders.[10] These courts have noted that reinsurers have the right to terminate their contracts with ceding insurers who are overdue on their premiums. Thus, reinsurers that choose not to pursue that remedy while the primary insurer is solvent may not do *so* to the detriment of policyholders after an insolvency. In the recent case of ***Bluewater Ins. Ltd.* v. *Balzano,*** the Colorado Supreme Court found that the commissioner of insurance had the power to regulate reinsurance contracts by excluding offset clauses. The court focused on the accounting treatment of reinsurance and overdue premiums. According to the court, primary insurers are permitted to take a credit for reinsurance because the reinsurance makes up the difference, maintaining the reserve at a prescribed minimum. Allowance of set offs would destroy the statutory quid pro quo.

In general, the legal theories for set offs in the setting of an insurance liquidation are murky. The Reinsurance Association of America (RAA) makes the case for setoffs, contending that they have their basis in common law, as well as in federal bankruptcy law. The allowance of set offs provides a kind of security interest for reinsurers, thereby assuring the continued financial health of reinsurers in the event of the insolvency of the primary insurer. In the long run, RAA maintains, a state prohibition against set offs will disrupt the market and make reinsurance more expensive and less available. According to RAA, if states restrict set offs, reinsurers will simply demand another form of security interest from the ceding insurer, such as a letter of credit.

From a liquidator's point of view, a reinsurer's assertion of the right of set off is a preference. Reinsurance proceeds are often the primary asset of an insolvent insurer; therefore, the grant of set off rights to a reinsurer not only gives the reinsurer (and other general creditors) a priority status in the estate of the insolvent insurer but also decreases the size of the estate available for distribution to all other claimants and increases the burden on state guaranty funds. Opponents of set offs maintain that the common law basis for set offs is not clear; in fact, some courts have specifically denied the existence of such a common law right. Moreover, insurance regulatory statutes are frequently said to be in derogation of the common law. For example, many insurance statutes specifically require or forbid certain contract terms between an insurer and its policyholder, an insurer and its agents, and an insurer and its reinsurer. Thus, examples abound to prove that a state can, through its police power, prohibit set offs by statute in order to protect policyholders. Analogies to federal bankruptcy law are not relevant because insurance insolvencies are specifically excluded from that law.

Both sides can claim judicial victories for their theories, and a definitive judicial resolution of this issue is unlikely. One way to address the set off issue is to analyze the effects of allowing or restricting set off rights. RAA may be correct in asserting that a restriction on set offs will be disruptive for a period of time. Yet, all government regulation can be said (and has been said) to disrupt the market. Inevitably, markets adjust and pass the costs along as competition allows.

RAA may also be correct that a restriction on set offs will increase the cost of reinsurance, and that such increase may be passed along to consumers of insurance. Yet, state taxpayers (through the premium tax offset) and policyholders (through recoupment laws) are paying the costs of guaranty fund payments now, and those costs are higher when set offs are permitted to reduce an insolvent insurer's estate. Moreover, the current system results in costs that are hidden and not subject to public scrutiny because state taxpayers and policyholders are seldom aware that they are picking up the tab for guaranty fund payments. Nor does the current system subject the costs of increased taxes to the competitive pressures of the marketplace. In contrast, if states restricted set offs, any resulting increased costs would be open, exposed to public scrutiny, and subject to the competitive forces of the marketplace. A basic premise of free markets is that economies operate most efficiently when costs are openly assigned to those who incur them.

Cut-Through Clauses

Cut-through clauses change the general rule that no legally enforceable agreement exists between a reinsurer and the original policyholder. A cut-through clause is an agreement between a reinsurer and the ceding insurer made for the benefit of a third-party policyholder. The agreement, entered into at the request of the policyholder/beneficiary, obligates the reinsurer to pay any loss due under the policy directly to the policyholder in the event that the ceding insurer becomes insolvent. One reason that a policyholder might seek a cut-through clause is to cover for uncertainty about the financial health of the primary insurer. Cut-through clauses allow some policyholders to be paid in full (in an amount that is not limited by state statutes) without having to file a claim in liquidation, thereby gaining a priority over other, less knowledgeable policyholders and reducing the estate of the insolvent insurer. Some state laws implicitly allow cut-through clauses; other state laws explicitly allow them.'' At least one court, the Supreme Court of Puerto Rico, has held cut-through clauses unenforceable, finding them to be a preference unauthorized under UILA.[12]

Again, no studies exist that measure the size of the

problem, including the effect of cut through clauses on an insolvent insurer's estate. Such a study might enable regulators to craft a solution.

State/Federal Clashes

The *McCarran-Ferguson Act* provides that state laws regulating the "business of insurance" prevail over conflicting federal laws when a particular federal law does not specifically address insurance.[13] Conflicts between state and federal laws in the context of insurer insolvencies arise mainly in two areas, federal claims against the insolvent insurer's estate and attempts by reinsurers to enforce their arbitration clauses.

Priority of Claims. Typically, the clash between state and federal law in the context of priority-of-claims' payment arises from federal government claims either as a policyholder or for back taxes. The statute governing priority of federal claims[14] provides that a claim of the federal government will be paid first when the debtor is insolvent. In contrast, many state priority statutes grant federal and state government claims lower priority than those of policyholders. At first glance, the *McCarran-Ferguson Act* appears to solve the potential clash between the two laws:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance. . . .[15]

The federal claims priority statute does not specifically relate to the business of insurance. Yet, federal circuit courts of appeal in the 9th and 4th circuits have interpreted the *McCarran-Ferguson* Act narrowly in connection with insurer insolvencies, finding that the liquidation of an insurance company is not the "business of insurance." In *Soward* v. *United States*,[16] the 9th Circuit Court of *Appeals* reviewed the conflict between Idaho state law, which treated federal govemment claims as Class 5 (the lowest priority status) claims, and the federal claims priority statute. According to the 9th circuit court, state priority statutes do not constitute regulation of the business of insurance because a liquidation is not the business of insurance.

The court applied the three-part test announced by the U.S. Supreme Court in an antitrust case, *Union Labor Life Insurance Company* v. *Pireno*.[17] According to that test, a state law purporting to regulate the business of insurance must (1) involve the spread or transfer of risk, (2) relate to the policyholder/insurer relationship, and (3) be limited to entities solely within the insurance industry. The *Soward* court found that the Idaho priority statute failed all three tests. Accordingly, the court allowed the federal tax claims against the insolvent insurer to be reclassified from Class 5 to Class 1. Using similar reasoning, the 4th Circuit Court of Appeals in *Gordon* v. *United States*,[18] allowed the federal government to increase its priority status under Maryland law from Class 3 to Class 1.[19]

In *Fabe* v. *U.S. Department of Treasury*,[20] the 6th Circuit Court of Appeals also applied the three-prong test of *Pireno* to determine whether the Ohio liquidation priority statute was regulation of the business of insurance and reached a different conclusion. Given Ohio's "comprehensive scheme for orderly liquidation of Ohio insurance companies" and the importance of state regulation "to the protection of the insurance consumer," the court found that the state's priority statute was the business of insurance. Accordingly, the court held that the claim of the United States was governed by Ohio law, not by the federal priority statute. The U.S. Supreme Court has agreed to review the decision.

The effect of treating the federal government as a "super creditor'' is, of course, to reduce the amount of the insolvent insurer's estate that is available to pay policyholders. The reduction can be dramatic.[21] Recently, IRS placed a $643 million lien against the insolvent Executive Life Insurance Company of California. Some commentators have suggested that the Congress should amend the law to treat policyholders of insolvent insurers similarly to depositors of defunct banks. In the latter situation, the Internal Revenue Code provides that the federal government's claims are subordinate to those of depositors of banks in liquidation.[22]

Reinsurance Arbitration Clauses. A second area in which state insurance laws often clash with federal law or international convention involves the arbitration clauses generally found in reinsurance agreements. These clauses typically require the use of arbitration in the event of "any difference of opinion between the Reinsurer and the [ceding] Company with respect to the interpretation of this [reinsurance] certificate or the performance of the obligations under the certificate. . . ."[23] Reinsurers frequently dispute the amount due upon the insolvency of the ceding insurer and invoke their right to settle their dispute in arbitration rather than before the liquidator. Courts in such cases must determine whether the *Federal Arbitration Act*[24] or the *McCarran-Ferguson Act* controls. The arbitration act provides that:

> If any suit or proceeding be brought in any of the courts of the United States upon any issue referable to arbitration under an agreement in writing for such arbitration, the court in which such suit is pending, upon being satisfied that the issue involved in such suit or proceeding is referable to arbitration under such an agreement, shall on application of one of the parties stay the trial of the action until such arbitration has been had in accordance with the terms of the agreement. . . .[25]

The issue in these cases is similar to that in the federal priority statute cases. State liquidators maintain that liquidation is the regulation of the business of insurance and that arbitration proceedings would "invalidate, impair, or supersede" state laws that typically vest exclusive jurisdiction over insolvent insurers in the state liquidator. The conclusions reached by courts differ, some holding that the *McCarran-Ferguson Act* bars application of the *Federal Arbitration Act*,[26] and others finding that the arbitration act takes precedence over *McCarran-Ferguson*.[27] In the most recent case on arbitration clauses, the 9th Circuit Court of Appeals upheld a contractual arbitration agree-

ment against a state liquidator, finding that the *McCarran-Ferguson Act* did not take precedence over the *Federal Arbitration Act*.[28]

Lack of Uniformity among State Liquidation Laws

As noted, approximately 24 states have adopted UILA and 29 states have adopted the Model Act. These laws define a reciprocal state as one that has adopted the substance of UILA or one that has adopted certain key provisions of the Model Act. If all of the assets of an insolvent insurer are located in the domiciliary state or in an ancillary state which is a reciprocal state (a state that has adopted the same law as the domiciliary state), then an injunction issued by a domiciliary receiver will be honored by the courts in the ancillary state. If the domiciliary state and an ancillary state are not reciprocal states, then the ancillary state is not obligated by state law to honor an injunction issued by the domiciliary receiver. Such situations can lead to protracted litigation over rights to assets, depleting the estate of the insolvent insurer. Domiciliary receivers have relied on three doctrines to convince courts in nonreciprocal states to enforce their anti-lawsuit injunctions, comity, full faith and credit, and abstention.[29]

Comity. Literally, comity means courtesy or civility. Under the doctrine of comity, courts may recognize the legislative, executive, or judicial acts of another jurisdiction. Although the comity doctrine is discretionary, some courts have found that states should honor the judicial decisions of a foreign state unless to do so would contravene strong local public policy or prejudice local citizens. Other courts have refused to apply the doctrine. For example, in *Fuhrman* v. *United American Insurers*,[30] the Minnesota Supreme Court considered the validity of an injunction issued by the Iowa domiciliary receiver of United American. The injunction purported to restrain all nonresident claimants, including Fuhrman, from pursuing claims against United American. Relying on the "general rule. .. that an injunction operates in personam, and a court therefore may not enjoin persons who are not within its territorial jurisdiction," the Minnesota court ruled that the Iowa injunction had no effect on Fuhrman's lawsuit in Minnesota. According to the Minnesota Supreme Court, the Iowa court could not enforce its injunction against Fuhrman because he did not have sufficient contacts with Iowa. That is, Fuhrman was not present in Iowa and did no business in Iowa.

Full Faith and Credit. Full Faith and Credit is a constitutional principle[31] that requires a court in one state to honor the decision of a court in another state if the court in the first state had jurisdiction over the relevant parties and the subject matter of the suit. Few courts have deemed themselves bound by the Full Faith and Credit Clause to honor injunctions issued by a domiciliary receiver. Typically, courts in the second state refuse to be bound by the injunction, finding that the out-of-state issuing court lacked jurisdiction over its resident policyholders.[32]

Abstention. Abstention is a discretionary doctrine under which federal courts refrain from hearing cases in order to avoid piecemeal litigation, allow state courts to interpret their own state statutes, and/or refrain from interfering with judicial proceedings that have already begun in a state court. Several federal courts have abstained from hearing claims when a state court has taken jurisdiction over an insolvent insurance company. Other federal courts have refused to abstain, particularly when a reinsurer invokes the provisions of the *Federal Arbitration Act.*

None of these doctrines, alone or in combination, has been adopted by courts in a majority of states, and so litigation over rights to the multistate assets of an insolvent insurer continues. The Model Act attempts to deal with this problem by penalizing claimants who reside in states in which an ancillary receiver fails to transfer assets (other than special deposits) to the domiciliary receiver. The UILA has no penalty provisions. The penalty imposed under the Model Act for noncooperation is the subordination of the claims filed in the ancillary proceeding to the next-to-last priority status.

STATE PROPERTY-CASUALTY GUARANTY FUNDS

The estate of an insolvent property-casualty insurer is seldom sufficient to pay more than a small fraction of the claims of policyholders and third-party claimants.[33] Consequently, prior to the enactment of legislation creating state guaranty funds, policyholders and third-party claimants often went uncompensated.[34] Media coverage of this situation in the 1960s led first to congressional investigations, then to calls for federal intervention, and finally to the creation of state guaranty funds.

Thus, as with a number of reforms implemented by state regulators and legislators, state guaranty funds arose out of congressional investigations (1965[35]) and the introduction of federal legislation (1966[36] and 1969[37]). For several years prior to the congressional investigations, state regulators had discussed proposals for an industry-funded backup plan for paying claims of insolvent insurers, but the insurance industry had strongly opposed such proposals. Some industry representatives objected to being required to pay for the mismanagement of their competitors. Others believed that the funds might create a disincentive to effective regulation, in a manner akin to the moral hazard of bank deposit insurance.

Faced with the threat of federal regulation, the industry chose what it "considered the lesser of two evils,"[38] and worked with NAIC to prepare a model insurance guaranty fund act. Fearing that federal regulation would lead to the loss of their regulatory control and tax revenues, states rushed to adopt the model legislation. Between 1970 (when NAIC issued the Model Act) and 1972, 45 states passed guaranty fund legislation.[39] All states now have some form of property-casualty guaranty fund legislation, most of them patterned after NAIC's model law.

The purpose of the Post-Assessment Property and Liability Insurance Guaranty Association Model Act (Guaranty Fund Model Act), is to:

> provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the

insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

As its full name suggests, the Guaranty Fund Model Act establishes a mechanism to collect funds from assessments on solvent insurers and to disburse those funds to policyholders and claimants of an insolvent insurer.

The National Committee on Insurance Guaranty Funds, an industry committee, was organized in 1971 to assist states in implementing their guaranty fund laws. Funded by three industry trade associations and some unaffiliated insurers, the committee developed uniform accounting procedures, issued assessment reports, and served as a clearinghouse of information on insurer insolvencies and related litigation. In 1989, the National Conference of Insurance Guaranty Funds (NCIGF) replaced the committee. Membership is mandatory for all insurers who are licensed to write lines of property-casualty insurance covered by the guaranty association in the state.

The work of the guaranty funds is handled by individual states. The Guaranty Fund Model Act calls for an insurance guaranty association in each state. Each association is headed by a board of directors chosen from the member insurers.[40] The primary duty of the board is to oversee payment of covered claims and includes assessing member insurers the amounts necessary to pay the obligations of the association.

Membership in the national conference is limited to guaranty funds that are post-insolvency assessment funds based on the model act. NCIGF continues to perform a clearinghouse function and attempts to increase cooperation and coordination among state guaranty funds and liquidators involved in multistate insolvencies.

Procedures for Payment of Covered Claims

The primary duty of state guaranty fund associations is to pay covered claims up to the limits set forth in state law. According to the Guaranty Fund Model Act, a covered claim is one that:

> arises out of. . . an insurance policy to which the Act applies issued by an insurer, if such insurer becomes an insolvent insurer after the effective date of the Act and:
>
> (a) The claimant or insured is a resident of this state at the time of the insured event,. . . for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or
>
> (b) The property from which the claim arises is permanently located in this state.[41]

The Guaranty Fund Model Act has both a deductible and a statutory cap. Thus, the guaranty funds typically pay covered claims in excess of $100 up to a limit of $300,000 per claim. As Table 4 shows, actual state statutory caps vary considerably.

After a state guaranty fund association has investigated the covered claims arising out of an insolvency, it assesses member insurers an amount sufficient to pay the settled claims. These initial assessments are based on estimates of ultimate guaranty fund liability and the particular insurer's proportionate share of the premiums written in the state, subject to a cap. State assessment caps range from 1-2 percent of an insurer's total annual premium written in the state. Depending on the number and size of claims, the cap may require assessments to be made over a number of years. Rather than basing assessments on market share, some commentators have suggested that guaranty fund assessments should be based on the riskiness of an insurer's operation.[42]

Problems with the Guaranty Fund Model Act

At first glance, the relatively simple language defining a covered claim obscures the difficulties with the conceptual basis of host-state coverage as well as the potential for forum shopping built into the definition. Three of the most serious problems will be discussed here—the territoriality principle, coverage, and forum shopping.

Territoriality Principle of the Guaranty Funds. Payments under the Guaranty Fund Model Act are based solely on a territoriality principle. That is, the act places responsibility for payment of a covered claim with the state of residence of the policyholder or claimant. Thus, concurrent guaranty funds can be triggered and payments administered (but not duplicated) in each state in which the insolvent insurer was licensed and a policyholder or claimant resides. Not only does the multiplication of guaranty fund proceedings increase the administrative expenses, but it can also lead to disagreements among guaranty funds as to which fund must pay a particular claim. Moreover, policyholders and claimants in some states will be paid a greater portion of their debt than similar creditors in other states. Both statutory caps and the breadth of coverage differ from state to state.

Some critics contend that these state-law variances violate a basic principle of fairness that requires similarly situated policyholders to be treated equally. Under the present system, two policyholders with identical coverage from the same insolvent insurer receive different guaranty fund payments because they live in different states. A U.S. General Accounting Office (GAO) example illustrates the potential inequity. Consider a small business with $500,000 theft coverage which is burglarized and has a $500,000 claim against its insolvent insurer. The business could collect the entire claim if it were located in Rhode Island, more than half ($300,000) if in Ohio, and one-fifth ($100,000) in Colorado.[43] Others maintain that different state coverage limits reflect legitimate differences in economic policies. For example, because state taxpayers and/or policyholders bear the ultimate burden of insurer insolvencies, a state may decide to limit guaranty fund coverage so as to limit the cost to resident taxpayers.[44]

As noted previously, the domiciliary or home state is primarily responsible for examining its insurers and monitoring their financial health. Although an out-of-state insurer must receive a license in the host states in which it

Table 4
State-by state Comparison of Property-Casualty Guaranty Fund Provisions

State	Lines of Insurance Covered[a]	Claim limits	Maximum Annual Assessments
Alabama	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	1.0%
Alaska	NAIC standard coverage plus Ocean marine	$500,000 per claim and unlimited workers' compensation	2.0%
Arizona	NAIC standard coverage	$100,000 per claim, workers' compensation covered through other provision	1.0%
Arkansas	NAIC standard coverage	$300,000 per claim including workers'compensation	2.0%
California	NAIC standard coverage	$500,000per claim and unlimited workers' compensation	1.0%
Colorado	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	1.0%
Connecticut	NAIC standard coverage	$300,00 per claim and unlimited workers' compensation	2.0%
Delaware	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
District of Columbia	NAIC standard coverage plus surety and fidelity, credit, and Ocean marine	$300,000 per claim and unlimited workers' compensation	**2.0%**
Florida	NAIC standard coverage except ex-cludes wet marine	$300,000per claim and unlimited workers' compensation	**2.0%**
Georgia	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%
Hawaii	NAIC standard coverage	$300,000 per claim and unlimitedworkers' compensation	2.0%
Idaho	NAIC standard coverage	$300,000 per claim and unlimitedworkers' compensation	1.0%
Illinois	NAIC standard coverage plus title and credit	$300,000per claim and unlimited workers' compensation	1.0%
Indiana	NAIC standard coverage except excludes general damages	$100,000 per claim and $300,000 per occurrence; both limits apply to workers' compensation claims	1.0%
Iowa	NAIC standard coverage	$300,000per claim and unlimited workers' compensation	2.0%
Kansas	NAIC standard coverage plus surety and fidelity and Ocean marine	$300,000per claim and unlimited workers' compensation	**2.0%**
Kentucky	NAIC standard coverage plus surety and fidelity	$100,000per claim and unlimited workers' compensation	1.0%
Louisiana	NAIC standard coverage	$150,000 per claim and $300,000 per Occurrence and un-limited workers' compensation	2.0%
Maine	NAIC standard coverage plus surety and fidelity and some marine	$300,000 per claim and unlimited workers' compensation	**2.0%**
Maryland	NAIC standard coverage plus surety and fidelity, title, credit, and ocean marine	$300,000 per claim and unlimited workers' compensation	**2.0%**
Massachusetts	NAIC standard coverage	$300,000 per claim including workers' compensation	**2.0%**
Michigan	NAIC standard coverage plus surety and fidelity, title, credit, mortgage guar-anty, and Ocean marine	1/20 of 1percent of aggregate premiums written by mem-ber insurers during the preceding year, and unlimited workers' compensation	**1.0%**
Minnesota	NAIC standard coverage plus surety and fidelity	$300,000per claim and unlimited workers' compensation	**2.0%**
(Mississippi	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%
Missouri	NAIC standard coverage except excludes general damages	$300,000 per claim and unlimited workers' compensation	1.0%
Montana	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%

Table *4 (cont.)*
State-by state Comparison of Property-Casualty Guaranty Fund Provisions

State	Lines of Insurance Covered‘	Claim limits	Maximum Annual Assessments
Nebraska	NAIC standard coverage except excludes general damages	$300,000 per claim and unlimited workers' compensation	1.0%
Yevada	NAIC standard coverage plus credit	$300,000 per claim including workers' compensation claims	**2.0%**
Yew Hampshire	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
Yew Jersey	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	**2.0%**
Vew Mexico	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	**2.0%**
Vew York	NAIC standard coverage plus surety and fidelity, and Ocean marine	$1 million per claim including workers' compensation	**2.0%**
Vorth Carolina	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	**2.0%**
North Dakota	NAIC standard coverage	$300,000 per claim including workers' compensation claims	2.0%
Ohio	NAIC standard coverage	$300,000 per claim including workers' compensation claims	1.5%
Oklahoma	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	The lesser of 2 percent of net premiums or 1 percent of surplus
Oregon	NAIC standard coverage except excludes transportation	$300,000 per claim and unlimited workers' compensation	**2.0%**
Pennsylvania	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	**2.0%**
Rhode Island	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
South Carolina	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%
South Dakota	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%
Tennessee	NAIC standard coverage except excludes general damages	$100,000 per claim and unlimited workers' compensation	1.0%
Texas	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	**2.0%**
Utah	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
Vermont	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
Virginia	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	**2.0%**
Washington	NAIC standard coverage	$300,000 per claim, unlimited workers' compensation covered through other provision	**2.0%**
West Virginia	NAIC standard coverage	$300,000 per claim, unlimited workers' compensation covered through other provision	**2.0%**
Wyoming	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	1.0%

Source: National Conference on Insurance Guaranty Funds; updated by U.S. General Accounting Office, April 1990.

does business, most host states do not monitor nondomiciliary insurers. Under the territoriality theory of the Guaranty Fund Model Act, the host state must nevertheless "pick up the pieces" of the regulatory failures of a sister state. That is, the cost of insolvency of a multistate insurer is borne by each state in which a policyholder resides rather than by the state of the primary regulator (the insolvent insurer's domiciliary state). For this reason, the domiciliary state has little incentive to work with other states to reduce the potential cost of an insolvency. In fact, the insurer's home state may even have a motive to withhold information about its troubled insurers from sister states. If such information is disclosed to a sister host state, the host state may require the troubled insurer to stop writing new business in the state, cutting off a flow of new funds to the troubled insurer and hastening its demise. Thus, only a few states provide their sister states with regular reports on the condition of their domestic multistate companies.

In contrast, the use of a universality theory, by which the guaranty fund of the home state would pay all covered claims of a domestic insolvent insurer, would increase the incentive for the home state to take prompt action. The incentive would be increased even further in those domiciliary states that allow insurers to recoup their assessments through either a credit against their premium taxes or a surcharge on policyholders. The loss of revenue from premium tax credits and/or the political pressure from policyholder surcharges, *if publicized*, can be strong incentives for effective regulation, counteracting the tendency for insurance companies to choose to domicile in a state with lax regulatory standards.

The primary argument against requiring the guaranty fund of the domiciliary state of an insolvent insurer to pay the claims of policyholders wherever situated is that such a policy would severely restrict capacity. That is, assessments on domiciliary state insurers at the present level would not be sufficient to cover the policyholders of a large multistate insurer, and if the assessments were increased, they would have a dangerous effect on company surplus. Moreover, the attendant premium tax offsets would drain state coffers. Given the current state guaranty fund system, the territoriality principle of guaranty fund payments appears to be the only practical way to assure sufficient capacity and minimize the effects of premium tax offsets on state revenues. Nevertheless, states could adopt provisions to mitigate some of the negative effects of the territoriality principle. For example, a prefunded plan could solve both the capacity problem described below and the state revenue problems. Part Three of this report describes several proposed solutions to the exclusive reliance on post-assessment guaranty funds.

Coverage. A second problem with the Guaranty Fund Model Act is that it provides the same protection to *so*phisticated, high-net-worth consumers of insurance as it does to unsophisticated consumers.[45] Lessons learned from the Savings and Loan crisis have taught us that guaranty funds create a "moral hazard"; that is, high-net-worth corporate insureds, who know that they will not bear the full loss if their insurer fails, feel free to shop by price and ignore quality. (Given the complexity of insurance coverages, individual consumers of insurance are seldom able to gauge the financial strength of insurance companies. Moreover, the entities that could provide unsophisticated consumers with valid information about the financial stability of a company—e.g., state insurance departments—will not do *so,* usually citing confidentiality requirements.)

Using agency theory, one commentator, Arthur **M.B.** Hogan, has found a correlation between the existence of guaranty funds and the degree of risk acceptable to corporate insurers. According to Hogan, in the absence of guaranty fund protection, corporate insurers balance their desire to benefit stockholders by investing in higher yield, higher risk products with their need to minimize the risk of loss to their policyholders by investing conservatively. The presence of guaranty funds upsets the balance by "reduc[ing] the risk that claims will not be paid, thereby reducing the conflict of interest between stockholders and policyholders. . . . [r]ational consumers . . . will not seek information regarding the risk of the insurer, since there will be no effect upon their wealth."[46]

Market discipline could be reintroduced into guaranty funds by excluding or restricting the coverage of sophisticated corporate insurers. Large multistate corporations with professional benefits officers are well able to shop for stability as well as price and should be encouraged to do so. As some states have recognized, these corporate consumers of insurance can exert market pressure on insurers to remain financially sound. For example, Michigan and Colorado have enacted laws that deny guaranty fund coverage to high-net-worth policyholders.

The Michigan law excludes from coverage insureds whose net worth exceeds one-tenth of **1** percent of the aggregate premiums written by member insurers in the state in the preceding calendar year.[47] In **1989,** Borman's Inc., the corporate owner of a supermarket chain in Michigan, challenged the law when its insurer became insolvent and the Michigan guaranty fund refused to pay a **$1.15** million tort judgment against Borman's even though the judgment was covered under Borman's policy with the insolvent insurer. The Michigan guaranty fund association rejected Borman's claim because the company's net worth exceeded the statutory limits. Borman's filed suit against the guaranty association, maintaining that the law violated the Equal Protection Clause of the U.S. Constitution. The 6th Circuit Court of Appeals upheld the Michigan law, finding that the state had a reasonable basis for the classifications in the law.[48]

The Colorado law excludes from guaranty fund coverage all persons who have a net worth in excess of $50 million.[49] In all, nine states have adopted similar net worth exclusions.[50] A common criticism of these exclusionary laws is that third-party claimants would be unable to tap the liability coverage of a corporate multistate policyholder, although such claimants are neither sophisticated nor in control of the purchase of insurance. This criticism has some merit, but it may go too far.

A loss of guaranty fund coverage does not mean that the third party has lost a claim against the corporate entity. Other options are available, including excluding from

guaranty fund coverage only the first-party claims of high-net-worth policyholders and/or extending guaranty fund coverage to third-party claimants if the corporate policyholder is bankrupt. Another way to introduce market discipline into the process would be to require insurers to prefund some portion of state guaranty fund programs. Many commentators believe that the exclusive reliance on post-assessment guaranty funds reduces market discipline and subsidizes the riskiest firms.[51] Part Three describes several options for prefunded plans.

Forum Shopping. A third problem with the property-casualty Guaranty Fund Model Act is the potential for forum shopping. The combination of coverage of large corporate multistate policyholders, variances among state statutory caps on coverage, and the imprecise definition of residence creates opportunities for policyholders and claimants to seek to have their claims settled in states with larger statutory limits. For example, in the Guaranty Fund Model Act, the claim of a corporate claimant or insured is said to be covered by the state of its "principal place of business," a phrase that may allow a multistate business to choose where it will request payment.

Some states have attempted to limit the circumstances under which their guaranty funds are a potential forum for payment of claims by directing their domiciliary corporations to file their claims elsewhere. According to Delaware law:

> . . . if the insured is a corporation which transacts business outside of the state of incorporation, recovery shall be sought in that jurisdiction where a principal place of business most closely related to the claim is located.[52]

Other states have gone to great lengths to limit the coverage of their guaranty funds. The Connecticut guaranty fund will pay only if the *claimant* (rather than the policyholder) is a resident of Connecticut. The statute contains one exception to the rule: if the claimant is not a resident of Connecticut, the state's guaranty fund will pay if the policyholder is a Connecticut resident *and* the claimant has been refused coverage by another state's guaranty fund because the insolvent insurer was not licensed in the other state.

Who Pays the Assessments?

Although member insurers must pay the assessment in the short run, taxpayers and/or many policyholders pay the assessments in the long run.[53] The federal government and many states allow guaranty fund payments as a deduction from corporate income taxes. For an insurance company that pays federal taxes, 34 percent of the assessment is offset through a reduction in federal taxes. In addition, approximately 15 states allow insurers a state premium tax credit against the assessments. As with all deductions/credits from federal and state taxable income, the governmental entity makes up for the loss of revenue by looking to other revenue sources. In states that allow a premium tax credit, the federal deduction is lower than 34 percent because the state tax credit reduces a company's state income tax and that reduction increases the firm's federal income tax (state income taxes are deductible against federal income taxes; therefore, a reduction in state income taxes results in a corresponding increase in federal taxes). NAIC's Model Act provides insurers with an offset of 20 percent of an assessment per year for 5 years. The actual amounts of credit vary among states, although most of the 43 states that allow a credit for life companies grant those companies a full credit. James Barrese and Jack M. Nelson of the College of Insurance estimate that the weighted average tax offset for property-casualty insurers is 51 percent, a 10 percent federal tax offset and a 41 percent state tax offset.[54]

In addition to these federal and state tax deductions and credits, section 16 of the Model Act allows member insurers to include in their rate structure "amounts sufficient to recoup a sum equal to the amounts paid to the Association." Thirty-four states provide recoupment through rates and premiums, and four states require a policyholder surcharge.[55] Model regulations instruct insurers how to calculate the recoupment. No studies exist that measure the amounts recouped by insurers through policy rate increases under the Model Act.

Insurers often argue that a benefit of the premium tax offset is that it creates an incentive for the public to pressure states to regulate more effectively. Yet, the failure to publicize either the existence of guaranty funds or the amount of the loss of revenue from offsets nullifies any such incentive. Moreover, under the current state-by-state guaranty fund scheme, it is the host (nondomiciliary) state that grants the premium tax credits and must make up the shortfall by increasing taxes on its residents. The primary regulator of a failed insurance company resides elsewhere. Public pressure against weak regulation is unlikely either to materialize or to be effective in a host state that is not the primary regulator of the insolvent company.

Finally, a direct relationship exists between reinsurance offsets, rescissions, cut-through clauses, coverage limitations, and tax credits. To the extent that the estate of an insolvent insurer is increased through prohibitions or limitations on reinsurance offsets and cut-through clauses, etc., the assessments made against host state insurers (which give rise to the tax credits) will be reduced.

The Capacity of State Property-Casualty Guaranty Funds

The number of property-casualty insurer insolvencies rose from four in 1980 to 25 in 1985, and the nationwide guaranty fund assessments rose from $19 million in 1980 to $292 million in 1985.[56] Trends in property-casualty insolvencies are hard to find after 1985. For example, according to data collected by NCIGF, the number of insolvencies and the amount of assessments for the years 1985 through 1991 were:

	Number of Insolvencies	Assessments (millions)
1986	16	$525
1987	14	$902
1988	12	$427
1989	23	$716
1990	14	$455
1991	27	$408

Neither the number of insolvencies nor the level of assessments has returned to the pre-1985 lows. **A** recent **GAO** report suggests that most state guaranty funds do not have the capacity to handle the insolvency of a large property-casualty insurer. According to **GAO,** the insolvency of one or more large property-casualty insurers could outstrip the guaranty fund capacity of 33 to 38 state guaranty funds.[57] **A** 1985 study by the Illinois Department of Insurance was only slightly more optimistic, concluding that the insolvency of a large national property-casualty insurer could exceed the guaranty fund capacity in a majority of states.[58] Table *5,* which lists state property-casualty guaranty fund assessments and capacity in 1991, lends support to these studies. NCIGF maintains that the federal claims priority statute, which gives the federal government a "super priority" status, has reduced the "early access" payments (made by the liquidator from the estate of the insolvent insurer to the guaranty funds) made to guaranty funds. According to NCIGF, the result has been a decrease in state guaranty fund capacity because "early access funds have the effect of a dollar-for-dollar increase in guaranty fund capacity."[59] No data exist to prove or disprove this claim.

States have at least four options to increase the capacity of their guaranty funds. First, all states could increase their assessment limits to at least 2 percent, thereby increasing the nationwide capacity, or all states could increase their assessment limits beyond 2 percent. Second, states could reduce coverage by, for example, restricting payments to all policyholders to 80 percent of state maximums or excluding coverage for large corporations. Third, states could adopt a prefunded guaranty fund program. Such a program would increase the capacity of the guaranty system and would introduce some market discipline into the system. Under a fourth option, state guaranty funds would jointly establish a reinsurance or excess insurance mechanism.[60] The latter two options would involve joint action and might be best accomplished through the mechanism of an interstate compact, discussed in Chapter 11.

SUMMARY OF MAJOR AREAS IN WHICH STATE LIQUIDATION AND GUARANTY FUND LAW COULD BE IMPROVED

This report has identified eight areas in which state liquidation and guaranty fund laws could be improved as follows:

1) *The treatment of reinsurers under state law as players in need of special protection when a ceding insurer becomes insolvent.* The effect of this treatment is to reduce the assets available for distribution to policyholders (and thereby increase state taxes) by allowing reinsurers to:

   a) Rescind their contracts with insolvent insurers when the reinsurers can prove a material misrepresentation;

   b) Offset (without limitation) balances due from an insolvent insurer against the amount the reinsurer owes as reimbursement for the liabilities of the insolvent insurer; and

   c) Use cut-through clauses granting some policyholders special treatment by allowing them to receive payments directly from the reinsurer without complying with state liquidation procedures.

2) *Clashes between federal and state law that diminish the amount of reinsurance proceeds available for policyholders.* The federal priority statute allows the federal government in its status as policyholder and/or tax collector to take first priority in liquidation proceedings, despite state laws to the contrary. The *Federal Arbitration Act* allows reinsurers to bring their disputes over coverage to a private forum outside of the state liquidation proceedings.

3) *A lack of uniformity among state liquidation laws,* leading to conflicts among states and gaps in coverage.

4) *The failure to disclose to the public that insurers may recover their guaranty fund assessments by state tux offsets andlor policyholder surcharges and publicizing the effects of such recoveries on state revenues andlor the price of insurance.*

5) *The failure to adopt measures to mitigate the negative effects of the use of a territoriality (or host-state) concept in the administration of state guaranty funds,* whereby responsibility for payment of claims rests with the state of residence of the policyholder or claimant. The negative effects of the use of this concept include:

   a) Concurrent guaranty fund proceedings in each state in which a policyholder or claimant resides;

   b) Disagreements among state guaranty funds as to which fund must pay a particular claim;

   c) The regulatory failures of the domiciliary state (the primary regulator) being paid for by host states, reducing the incentive for domiciliary states to regulate effectively; and

   e) Multistate policyholders being able to forum shop by bringing their claims to the state guaranty fund that offers the broadest coverage.

6) *The failure to introduce market discipline into state guaranty fund plans* by disallowing or limiting guaranty fund coverage for high-net-worth policyholders and adopting a fully or partially prefunded guaranty fund plan.

7) *The failure to adopt measures to increase the capacity of state guaranty funds.* Options to increase the capacity of state guaranty funds include:

   a) All states could increase their assessment limits to at least 2 percent or beyond 2 percent, thereby increasing nationwide capacity;

   b) States could reduce guaranty fund coverage by, for example, restricting payments to all policyholders to 80 percent of state maximums, or excluding/limiting coverage for large corporations;

Table **5**

Property/Casualty Guaranty Assessments and Capacity

State	1991 Net Assessments	Maximum Rate	Assessable Premiums	Estimated 1991 Capacity	Assessments as a Percent of Capacity	Estimated Capacity at 2%	Assessments as a Percent of Capacity at 2%
Alabama	0	1.0%	2,658,521,000	26,585,210	0.0%	53,170,420	0.0%
Alaska	2,185,089	2.0	580,181,250	11,603,625	18.8	11,603,625	18.8
Arizona	0	1.0	2,982,706,000	29,827,060	0.0	59,654,120	0.0
Arkansas	0	2.0	1,621,973,100	32,439,462	0.0	32,439,462	0.0
California	0	1.0	31,525,837,000	315,258,370	0.0	630,516,740	0.0
Colorado	(5,000,000)	1.0	2,650,544,600	26,505,446	-18.9	53,010,892	-9.4
Connecticut	16,456,050	2.0	4,277,326,000	85,546,520	19.2	85,546,520	19.2
District of Columbia	425,717	2.0	721,014,050	14,420,281	3.0	14,420,281	3.0
Delaware	8,239,000	2.0	764,683,150	15,293,663	53.9	15,293,663	53.9
Florida	48,119,360	2.0	10,767,426,350	215,348,527	22.3	215,348,527	22.3
Georgia	0	2.0	5,356,100,050	107,122,001	0.0	107,122,001	0.0
Hawaii	0	2.0	1,131,530,400	22,630,608	0.0	22,630,608	0.0
Idaho	(1,000,000)	1.0	662,873,700	6,628,737	-15.1	13,257,474	-7.5
Illinois	(4,516,835)	1.0	9,764,438,500	97,644,385	-4.6	195,288,770	-2.3
Indiana	1,900,000	1.0	3,844,880,100	38,448,801	4.9	76,897,602	2.5
Iowa	(7,000,000)	2.0	1,946,635,950	38,932,719	-18.0	38,932,719	-18.0
Kansas	0	2.0	1,846,896,400	36,937,928	0.0	36,937,928	0.0
Kentucky	5,793,462	1.0	2,517,960,600	25,179,606	23.0	50,359,212	11.5
Louisiana	62,651,940	2.0	3,168,253,150	63,365,063	98.9	63,365,063	98.9
Maine	7,509,874	2.0	1,128,976,950	22,579,499	33.3	22,579,499	33.3
Maryland	10,500,000	2.0	4,290,168,200	85,803,364	12.2	85,803,364	12.2
Massachusetts	30,000,000	2.0	6,755,551,750	135,111,035	22.2	135,111,035	22.2
Michigan	(810,599)	1.0	7,873,618,400	78,736,184	-1.0	157,472,368	-0.5
Minnesota	13,425,000	2.0	3,850,758,950	77,015,179	17.4	77,015,179	17.4
Mississippi	0	1.0	1,748,600,000	17,486,000	0.0	34,972,000	0.0
Missouri	7,072,147	1.0	3,565,777,500	35,657,775	19.8	71,315,550	9.9
Montana	(4,500,000)	2.0	530,859,750	10,617,195	-42.4	10,671,195	-42.4
Nebraska	112,839	1.0	1,140,544,800	11,405,448	1.0	22,810,896	0.5
Nevada	(1,037,228)	2.0	932,100,650	18,642,013	-5.6	18,642,013	-5.6
New Hampshire	4,869,688	2.0	1,090,063,550	21,801,271	22.3	21,801,271	22.3
New Jersey	20,502,256	2.0	3,147,332,100	62,946,642	32.6	62,946,642	32.6
New Mexico	0	2.0	1,073,821,000	21,476,420	0.0	21,476,420	0.0
North Carolina	6,000,000	2.0	3,882,714,100	77,654,282	7.7	77,654,282	7.7
North Dakota	0	2.0	491,584,000	9,831,680	0.0	9,831,680	0.0
Ohio	31,400,000	1.5	6,452,150,467	96,782,257	32.4	129,043,009	24.3
Oklahoma	(66,834)	2.0[a]	2,123,456,350	42,469,127	-0.2	42,469,127	-0.2
Oregon	1,998,621	2.0	2,310,807,700	46,216,154	4.3	46,216,154	4.3
Pennsylvania	0	2.0	8,897,692,000	177,953,840	0.0	177,953,840	0.0
Puerto Rico	0	2.0	626,958,550	12,539,172	0.0	12,593,172	0.0
Rhode Island	19,661,783	2.0	1,008,089,150	20,161,783	97.5	20,161,783	97.5
South Carolina	4,740,588	2.0	1,354,260,750	27,085,215	17.5	27,085,215	17.5
South Dakota	0	1.0	467,511,800	4,675,118	0.0	9,350,236	0.0
Tennessee	0	1.0	3,425,443,700	34,254,437	0.0	68,508,874	0.0
Texas	110,855,184	2.0	14,836,797,250	296,735,945	37.4	296,735,945	37.4
Utah	0	2.0	898,829,700	17,976,594	0.0	17,976,594	0.0
Vermont	501,131	2.0	521,027,450	10,420,549	4.8	10,420,549	4.8
Virgin Islands	0	3.0	62,395,985	1,871,880	0.0	1,871,880	0.0
Virginia	10,736,440	2.0	4,342,246,250	86,844,925	12.4	86,844,925	12.4
Washington	7,500,000	2.0	3,233,432,700	64,668,654	11.6	64,668,654	11.6
West Virginia	2,645,000	2.0	3,743,369,800	74,867,396	3.5	74,867,396	3.5
Wisconsin	(3,473,008)	2.0	3,500,513,000	70,010,260	-5.0	70,010,260	-5.0
Wyoming	(750,000)	1.0	274,860,100	2,748,601	-27.3	5,497,202	-13.6
Total[b]	407,646,215		188,372,093,752	2,984,763,	13.7	3,768,065,836	10.8

[a] Oklahoma's cap is the lesser of 2 percent of premiums or 1 percent of surplus. This table uses 2 percent of premiums as the cap.

[b] New York has a pre-insolvency assessment guaranty fund and is not included here. Therefore, the total system capacity is understated.

Source: National Conference on Insurance Guaranty Funds and National Association of Insurance Commissioners.

c) States could adopt a prefunded guaranty fund program that would increase the capacity of the guaranty system and introduce some market discipline into the system; and

d) State guaranty funds could jointly establish **a** reinsurance or excess insurance mechanism.

A solution to the problem of clashes between federal and state law may require the Congress to exempt state insurance liquidations from the effects of the federal priority statute and the *Federal Arbitration Act.* These laws sharply curtail the ability **of** state liquidators to collect and distribute the assets **of** the insolvent insurer's estate in an orderly manner.

All of the other problems listed above could be corrected through individual or coordinated state action without federal intervention. Problems **1, 4,** and **6** could be handled by states individually; indeed, states are experimenting with remedies. Problems **3,** ***5,*** and **7 may** be difficult to solve without coordinated state action. Part Three examines alternative methods for coordinated state action, as well **as** proposals for federal intervention.

Notes

[1] Fidelity & Deposit v. Pink, 302 U.S. 224, reh'g denied, 302 U.S. 780 (1938).

[2] Reinsurers maintain that they are not given special protection. Instead, they claim that recognition of their right of set off is in line with federal bankruptcy law. There are, however, important distinctions between the private corporations and creditors seeking protection under the federal bankruptcy law and insurance companies being liquidated under state insurance laws. Using their police power to protect policyholders, states **supervise** all aspects of the business of insurance, including contract terms. A state can, thus, eliminate or restrict set offs in the context of liquidations.

[3] Note, "Distribution of the Proceeds of a Reinsurance Policy upon the Insolvency of the Reinsured," *Harvard Law Review 50* (1936): 93.

[4] See, for example, Highlands Ins. Co. v. Employers' Surplus Lines Ins. Co. 497 E Supp. 169 (E.D. La. 1980); Fortress Re, Inc. v. Jefferson Ins. Co. of New York, ***465*** F. Supp. 333 (E.D.N.C. 1978), affd. 628 F.2d 860 (4th Cir. 1980); Great American Ins. Co. v. C. G. Tate Construction Co., 279 S.E.2d 769 (1981); and see Donald W. Rees and Carol E. Reese, "Reinsurance: The Basics and Bad Faith Considerations," FICC ***Quarterly*** 39 (Summer 1989): 351 "The duty of utmost good faith requires the ceding insurer to disclose all known information material to the risk"; and see cases cited in Jonathan E Bank and Karen L. Bizzini, " 'Fraud' in the Context of Reinsurance," FICC *Quarterly* **40** (Winter 1990).

[5] Kramer, "The Nature of Reinsurance," in Robert W. Strain, ed., ***Reinsurance*** (New York Strain Publishing Co., College of Insurance, 1980).

[6] 435 E Supp. 855 (D. Montana, 1977).

[7] 435 F. Supp. at 861.

[8] R. Mabey, "Setoff in a Non-Insurance Commercial Setting," quoted in Stephen W. Schwab, Debra J. Anderson, Carolyn S. Reed, and David E. Mendelsohn, "Onset of an Offset Revolution: The Application of Set Offs in Insurance Insolvencies," *Dickinson* ***Law Review*** 95 (1991): 449.

[9] See, for example, O'Connor v. Insurance Company of North America, 622 F. Supp. 611 (1985).

[10] Hager v. Davis Transport, 901 F.2d 1470 (1990); Bluewater Insurance Ltd v. Balzano, 823 P2d 1365 (1992).

[11] See, for example, Illinois Revised Statutes, ch. 73, section 785.3 (1988); New York Insurance Code Section 1308 (1989); California Insurance Code, Section 922.2 (1989); Florida Insurance Code Section 631. 205 (1988).

[12] Warranty Association v. Commonwealth Ins. Co., No. 80-330-4, slip. op. (Sup. Ct. P.R., April 13, 1983).

[13] 15 U.S.C. sec. 1011-1015.

[14] 31 U.S.C. sec. 3713.

[15] 15 U.S.C. sec. 1012(b).

[16] 858 F2d 445 (9th cir., 1989), cert. denied, sub. nom. Fagiano v. United States, 109 S. Ct. 2063 (1989).

[17] Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); and see Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979).

[18] *846* F.2d 272 (4th Cir., 1987), cert denied, 109 S. Ct. 390 (1988).

[19] Maryland Code Ann. art. 48A secs. 158 and 158A.

[20] 939 F 2d 341 (6th Cir., 1991); cert. granted, 118 L. Ed 2d 541, 112 S. Ct. 1934 (1992). The National Conference of Insurance Guaranty Funds notes that a recent decision from an Iowa district court has followed the Fabe ruling. See Lyons v. U.S., No. 4-91-10209, S.D. Iowa, Cen. Div.).

[21] The National Conference of Insurance Guaranty Funds notes that "in addition to the impact of the amount claimed as a right for 'super priority,' the federal government also claims to not be bound by the liquidation court ordered requirements for the timely filing of claims. . . . This assertion would, if carried to the ultimate, require a liquidator to obtain a release from every *potential* federal claimant or, simply, not close the estate and make not distribution of any estate assets on the assumption that there might 'someday' be a claim." Letter from Dale E Stephenson to Sandra B. McCray, August 18, 1992.

[22] 26 U.S.C. 7507.

[23] Cited in Bernstein v. Centaur Ins. Co., 606 E Supp. 98 (1984).

[24] 9 U.S.C. sec. 1 et. seq.

[25] 9 U.S.C. sec. 3.

[26] See, for example, Washburn v. Corcoran, 643 E Supp. 554 (1986).

[27] See, e.g., Bernstein v Centaur, 606 E Supp. 98 (1984).

[28] Bennett v. Liberty Fire Insurance, 1992 U.S. App. LEXIS 15088 (9th Cir., July 6, 1992).

[29] This subsection of the report relies heavily on James R. Stinson, "Insurance Insolvency—Jurisdiction of the Federal and State Courts," in Francine L. Semaya ed., ***Law and Practice of Insurance Company Solvency Revisited*** (Chicago: American Bar Association, 1989), pp. 262-267.

[30] 269 NW2d 842 (1978)

[31] U.S. Constitution, Art. IV, sec. 1.

[32] Matter of Kenilworth Ins. Co., 428 So. 2d 1187 (La. App., 1983); Insurance Affiliates, Inc. v O'Connor, 522 E Supp. 703 (1981).

[33] The National Conference of Insurance Guaranty Funds notes that this statement may not be entirely accurate. In a letter to the author, NCIGF cited 14 insolvencies handled by the Indiana Guaranty Association from 1975 to 1986. For these insolvencies, the percentage of claims and expenses recovered from the assets of the insolvent estates ranged from 18 percent to 100 percent, with a mean of 58.8 and a median of 61 percent. These figures would be more meaningful if they were weighted according to the size of the insolvency; however these data were not available to the author. Letter from Dale E Stephenson to Sandra B. McCray, August 18, 1992.

[34] In 1935, Wisconsin created the first state guaranty fund, covering only worker's compensation. In 1937, New York also

created a worker's compensation fund, and in 1939, New York was the first state to establish an automobile insurance guaranty fund. But by 1960 only two states had guaranty funds for auto insurance, and only five states had such funds for worker's compensation. See GAO, ***Insurer Failures: Property/Casualty Insurer Insolvencies and State Guamnty Funds*** (Washington, DC, July 1987).

[35] "High-Risk Automobile Insurance," Hearings before the U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, 89th Congress, 1st Session (1965); see Paul G. Roberts, "Insurance Company Insolvencies and Insurance Guaranty Funds: A Look at the Nonduplication of Recovery Clause," ***Iowa Law Review*** 74 (1989): 927; Bernard E. Epton and Roger A. Bixby, "Insurance Guaranty Funds: A Reassessment," ***De Paul Law Review*** **25** (1976): 227.

[36] S. 3919, 89th Congress, 2d Session (1966). The bill, introduced by Senator Dodd, would have created a federal fund to pay pending claims against insolvent insurance companies.

[37] S. 2236, 91st Congress, 1st Session (1969), this would have created a federal insurance guaranty corporation.

[38] Roberts, "Insurance Company Insolvencies and Insurance Guaranty Funds" pp. 927,933.

[39] Ibid., p. 934.

[40] The National Conference of Insurance Guaranty Funds notes that in some states the boards of directors are appointed by the commissioner of insurance and are public representatives chosen from outside of the insurance industry.

[41] The National Conference of Insurance Guaranty Funds notes that a covered "claim must be an unpaid claim covered by a policy to which the guaranty fund act applies, and that such claims are typically required to be timely filed with the receiver or guaranty fund, and are not covered claims to the extent that they are covered by other insurance." Letter from Dale Stephenson to Sandra B. McCray, August 18, 1992.

[42] David Foppert, "Can the State Guaranty Fund System Hold Up?" ***Best's Review, Property-Casualty Insurance Edition,*** October 1991, p. 22.

[43] The example is given in GAO, ***Insurer Failures: Property/Casualty Insurer Insolvencies and State Guaranty Funds,*** p. 29.

[44] According to a recent survey of several guaranty funds by the National Conference of Insurance Guaranty Funds, less than 0.2 percent of all claims against guaranty funds equalled or exceeded the statutory cap. Letter from Dale E Stephenson to Sandra B. McCray, August 18, 1992.

[45] Section 11 of the NAIC Model Act allows a state guaranty fund to recover payments made to insureds with a net worth in excess of $50 million. This "solution" is less than ideal, however, because it places an after-the-fact burden on the guaranty fund to litigate coverage.

[46] Arthur M.B. Hogan, "Guarantee Funds and Regulation: The Case of the Insurance Industry" (1991).

[47] Michigan Comp. Laws, sec. 500.7925(3). The National Conference of Insurance Guaranty Funds notes that 15 states have net worth provisions. Letter from Dale E Stephenson to Sandra B. McCray, August 18, 1992.

[48] 925 F. 2d 160 (6th Cir., 1991).

[49] C.R.S., 1987, sec. 10 4 504, cum. supp. 1991.

[50] Foppert, "Can the State Guaranty Fund System Hold Up?" p. 22.

[51] The National Conference of Insurance Guaranty Funds notes that many believe that exclusive reliance on post-assessment guaranty funds enhances regulatory discipline. "Because of the limited capacity available to protect individuals, regulators must be conscious of the point at which that protection would be compromised and seek to identify financially impaired insurers before that capacity is breached." Letter from Dale E Stephenson to Sandra B. McCray, August 18, 1992.

[52] Delaware Insurance Code, sec. 4212.

[53] The following summary of the tax consequences of guaranty fund assessments against member insurers is based on calculations made by James Barrese and Jack M. Nelson, Professors of Economics at the College of Insurance in New York City.

[54] James Barrese and Jack M. Nelson, "The Consequences of Insurance Insolvencies," June 1991.

[55] National Conference of Insurance Guaranty Funds, letter from Dale E Stephenson to Sanrda B. McCray, August 18, 1992.

[56] National Conference of Insurance Guaranty Funds.

[57] GAO, ***Insurer Failures: Differencesin Property/Casualty Guaranty Fund Protection and Funding Limitations*** (Washington, DC, March 1992). The National Conference of Insurance Guaranty Funds disagrees with the GAO report and notes that some of the assumptions made by GAO rendered its conclusions suspect. For example, GAO assumed that insurer assets were unavailable to guaranty funds during the first year, while in fact in many cases "early access" funds would be available. GAO also assumed that losses incurred but not reported were included in the expected first-year payout, which, according to NCIGF, is unlikely. Moreover, GAO failed to recognize the borrowing ability of state guaranty funds. National Conference of Insurance Guaranty Funds Response to General Accounting Office Report, June 17, 1992.

[58] Robert Klein, "Issues Concerning Insurance Guaranty Funds," June 5, 1992, p. 22. Klein deems the Illinois study more reliable. He questions the assumption in the GAO study that state guaranty funds would have to pay all or a significant portion of the claims incurred by a major insurer in one year, rather than over a number of years as is generally the case. Further, Klein notes that the estate of an insolvent insurer frequently pays a portion of covered claims.

[59] Letter from Dale E Stephenson to the General Accounting Office, June 17, 1992.

[60] Ibid.

Part II

Life Insurance

5

History of State Regulation of Life Insurance Companies

Like property-casualty insurance, the early life insurance industry was subject to abuses, consumer complaints about dishonest practices and insolvencies, and calls for federal regulation. The abuses in the industries differ, however. Unlike the typical property-casualty company, life insurance companies receive large cash payments and have predictable, deferred liabilities. Consequently, life companies have less need for liquidity and can make long-term investments. Not surprisingly, problems in the life insurance industry have, from the beginning, typically involved investments in speculative ventures followed by worthless securities and, finally, insurance company insolvencies.

EARLY HISTORY OF LIFE INSURANCE

The first contracts providing for payments on death covered masters of ships. One early law provided that "if the merchant obliges the master to insure the ship, the merchant shall be obliged to insure the master's life against the hazards of the seas."[1] These early forms of life insurance were known as wager policies and were usually temporary, lasting for the duration of a particular voyage. Wager policies were outlawed as a form of gambling in the 16th century in France, the Netherlands, and Spain.[2]

In England, Queen Elizabeth I encouraged the development of life insurance by granting persons the right to make and register all kinds of insurance policies. By the late 16th century, a life insurance regulatory system existed in England, including a Chamber of Insurance that registered life policies and a group of commissioners appointed to settle disputes. The early life policies in England were, like early property insurance policies, Lloyds-type agreements made by individual underwriters who agreed to pay a fraction of the total insured amount in return for a proportionate share of the premium. These early policies were typically of short duration, and the proceeds were used to protect creditors against the death of a debtor or to protect families and friends against the failure of a voyager to return from his journey.[3]

Life insurance in the modern sense, as a contract whereby in return for a premium an insurer agrees in advance to pay a certain sum of money to the insured's estate or chosen beneficiary, developed in England in the latter half of the 16th century. Nearly a century passed before the individual life insurance contract evolved into a life insurance industry based on distribution of risk. The scientific basis for such an industry was given a boost in 1693 when Edmund Halley (the astronomer who discovered the comet later named after him) constructed the first mortality tables. The tables provided a basis on which to determine the value of life annuities, which were the most common form of life insurance at the time. Halley developed his tables by comparing the number of deaths in the population of Breslau, Silesia, at different ages. He published the resulting table in 1693 in a paper entitled "An Estimate of the Degree of Mortality of Mankind, etc."[4]

In 1706, the first life insurance organization that survived beyond the lives of the original members was chartered in England. The Amicable Society for a Perpetual Assurance Office was a mutual assessment society, but unlike other mutual assessment societies in which each member paid a stipulated sum only when a death occurred, each member of the Amicable Society paid a fixed amount per year. Then, the beneficiaries of the members who died each year would divide a fraction of the total amount paid in.[5]

Other life insurance projects followed, most of which had strong elements of speculation. For example, several

mutual assessment societies were formed between 1708 and 1721 in which all persons, particularly those in poor health, were encouraged to join. The managers of these organizations, who were not financially responsible for claim payments, were thus able to reap quick fortunes by taking fees from the initial premiums and deductions from the death claims paid. Moreover, many of these societies also invested in highly speculative ventures. One favorite investment was in the South Sea Company! In 1721, the failure of the South Sea Company rendered most of the securities held by these societies worthless and led to the downfall of all of the existing mutual assistance societies except the Amicable.'

Meanwhile, several works published between 1725 and 1742 advanced the "science of life contingencies." These works included generalized formulas for calculating the value of life annuities, interest tables, and accurate mortality tables for London.[8] The new formulas and tables made it possible for companies to base their premiums on the probability of death at the age of insuring. In 1762, the Society for Equitable Assurances on Lives and Survivorships (the Equitable) became the first company to take advantage of the new information. Unlike prior mutual assessment societies, the Equitable functioned like a modem insurance company, by having a stipulated premium, using mortality tables to measure average risk, and investigating the health and occupation of the insured to evaluate individual risk. The company charged extra for women under age 50 and for men who engaged in hazardous occupations. If an insured misrepresented the state of health or occupation on the application, the policy was deemed void.

A different form of life insurance developed on the European continent. In 1653, Lorenzo Tonti, an Italian physician, developed a plan by which the government of France could raise money by selling annuities to its citizens. The first so-called tontine plan worked as follows: Subscribers purchased their annuities from the state; in return for an initial payment, the government promised to pay subscribers a life annuity at dividend periods of 10, 15, and 25 years. Tontine plans had no cash surrender value, and the subscribers who died before the dividend payment period received nothing. The plan participants were divided into classes according to age. On the death of a subscriber in a particular class, the payments formerly paid to that member increased the amounts paid to the remaining members of that age group. The state's obligation ceased on the death of the last survivor in the group. The tontine plans differed from traditional annuities in that the surviving annuitants, rather than the insurer, benefited from the early death of an annuitant. Tontine plans differed also from the typical life insurance policy in that plan members who survived the longest received the largest benefits.[9]

Early Life insurance in the United States

The use of life insurance in the colonies began in the same manner as it had in England, with Lloyds-type policies on lives of maritime traders. The first life insurance associations formed were religious societies. In 1759, the Presbyterian Synod of Philadelphia established "The Corporation for the Relief of Poor and Distressed Presbyterian Ministers and for the Poor and Distressed Widows and Children of Presbyterian Ministers." As its name suggested, the corporation supported needy ministers, as well as the surviving families of deceased ministers. In return for a minister's yearly contribution, his widow and children would receive an annuity for life. The amount of the annuity depended on the contribution and was reduced if the minister died before he had contributed to the plan for 15 years. Over the following decade, other churches formed similar life insurance corporations. Until the adoption of the U.S. Constitution, these religious corporations were the only entities organized in America to provide life insurance.[10]

The first commercial insurance companies formed in the United States covered marine and fire risks. Although most of these companies had the right under their charters to underwrite life insurance policies, few did so. Before the 19th century, The Insurance Company of North America was the only private corporation in the United States to issue life insurance policies, and did not write more than a half-dozen policies." About 1790, tontine plans were introduced into the United States. Several cities used the plans to finance public and private buildings, as well as to raise money for charitable purposes. Because most of them failed after a short time, tontine plans fell into disrepute. Although the life insurance industry failed to flourish in pre-industrial 18th century America, scholars from Yale and Harvard universities were paving the way for a viable industry by preparing mortality tables. For example, in 1789, Edward Wigglesworth of Harvard University presented a paper to the American Academy of Arts and Sciences that contained the first American mortality table,[12] enabling insurers to calculate reserves.

Companies began to make use of this work in the early to mid-19th century. The first commercial company organized to engage solely in the business of selling life insurance to the public at large was The Pennsylvania Company. Chartered in 1810 with $500,000 of capital stock, the company offered term and whole life insurance policies, as well as deferred annuities. As general business prospered in the 1820s and 1830s, the number of new insurance companies mushroomed.

These new companies introduced new methods of marketing life insurance that signaled the birth of the modem life insurance company. For example, The New York Life and Trust Company, chartered in 1830, was the first to market its products actively through advertising and the use of an agency system. The New England Mutual Life Insurance Company, which was the first chartered mutual life insurance company, introduced a "part-note" premium plan in 1843.[13] According to the part-note plan, a policyholder paid part of the premium in cash and gave a note for the remainder. Because mutual companies shared their surplus earnings with their members/policyholders, the policyholder could redeem the premium note with policy dividends.

Some observers condemned this premium financing plan, arguing that it encouraged persons to purchase more

life insurance than they could afford. Other critics of the burgeoning industry complained that companies failed to maintain adequate reserves and to allow policyholders who were unable to maintain premium payments and let their policies lapse to share in the reserves (i.e., the premium payments made by the policyholder) on forfeiture.

One of the most vocal critics was Elizur Wright, who in 1853 published 203 pages of net valuation tables showing the reserve that should be held at the end of each year during the life of various kinds of life insurance policies. Wright used his work to advocate the passage of regulatory legislation in Massachusetts. Specifically, Wright sought a nonforfeiture law, which would require life companies to provide lapsed policyholders who had paid premiums for at least two years with a paid-up policy in the amount of the policyholder's reserve, less an 8 percent surrender charge. The Massachusetts General Court passed the law in 1880.

During this period, companies also developed a new form of life insurance policy. In 1875, the Prudential Friendly Society began selling industrial life insurance. Unlike regular life insurance, which was sold primarily to the middle and upper classes, industrial life insurance was sold to lower and lower middle class people. These policies had a low face value, with a minimum as low as $25 in contrast to the $500 minimum face value on regular policies.[14] Company salesmen sold industrial life policies door to door and collected premiums weekly.

The "new" life insurance policy that generated the most interest, then criticism, and finally major reforms in the industry, was the tontine investment policy issued first by the Equitable. The new policy was based on the original tontine principle and, like the original policies, offered 10, 15, and 25- year dividend periods, depending on the age of the policyholder. The Equitable's modified version of the tontine contained several limitations. If the policyholder died before the end of a designated period, the beneficiary received the face value of the policy but no dividends. Everything was forfeited if the policyholder failed to continue premium payments to the end of the designated period. Policyholders who paid premiums to the end of their periods, however, shared in the division of the dividends, including those of lapsed policyholders. Henry B. Hyde, president of the Equitable, appealed to the self-interest and gambling instincts of the population by advertising the tontine investment policy as one under which the investor could win by living rather than by dying. The advertising ploy paid off as the Equitable sold millions of policies and received a "pyramiding income."[15]

Tontine policies became the rage in the early 1880s, and most other life insurance companies began selling them. The so-called "tontine wars" erupted between the Equitable and the Mutual Life Insurance Company (the Mutual), each of which was determined to be the leader in sales. The tontine wars were waged in New York newspapers, the insurance press, and in pamphlets. To gain the upper hand, the Mutual offered its new policyholders a rebate of 30 percent on the first two premiums on whole life policies.[16] The tontine wars focused the public's attention on the insurance industry and eventually led the muckrakers of the early 20th century to scrutinize the industry in general and the Equitable in particular. What they found was internal squabbling among the officers of the Equitable, fueled by speculative investments, manipulation of investment funds through subsidiary companies, and schemes to build a huge insurance trust through mergers with other life and oil companies.[17] News of the growing scandal was widely reported in the press.

The Armstrong Committee Investigations and Regulatory Reform

With public confidence in the life insurance industry at an all-time low and with newspapers advocating prosecution of the managers and officers of the Equitable, the company was soon reorganized under new management. Almost immediately, critics complained that some of the new managers had histories of unethical conduct. Finally, the New York insurance department issued the Hendricks report, which described numerous shady dealings between the Equitable and its subsidiaries. A public outcry for further investigations followed, and in 1905 the New York legislature appointed an investigating committee to examine the "affairs of the life insurance companies authorized to do business in the state of New York, the investments of said companies, the relation of their officers to such investments, the relation of the companies to subsidiary organizations and to their policyholders, the expenses of the companies. . . ."[18]

The Armstrong Committee (named after its chairman, New York State Sen. William Armstrong) asked Charles Evans Hughes to become its counsel. Hughes began the hearings with the testimony of the officers of the largest insurance companies. The practices that captured the public's interest and generated the most public ire seem commonplace today: use of the companies' enormous cash surpluses to pay large sums to lobbyists in Albany, cash contributions to political campaign funds, and lavish salaries paid to company officers and managers.[19]

Abuses in the use of the agency system were strongly criticized by the Armstrong Committee. The committee noted that the practice of competing for the loyalty of general agents by paying them large bonuses and raising their commissions increased the cost of life insurance to the public. Moreover, the pressure on agents for sales led to rebating (whereby agents would engage in price discrimination by discounting the cost of policies for certain policyholders), and twisting (whereby agents would encourage a policyholder of one company to forfeit his policy and purchase a policy from another company). The New York Department of Insurance came in for its share of criticism, too. Characterized as ignorant, evasive, neglectful, and subject to political manipulation, the department's reputation was badly damaged by the Armstrong hearings.

The Armstrong Committee submitted its report to the New York legislature in February 1906. Among the recommendations were: a prohibition of investments in stocks, a limitation on new business to $150 million a year for the largest companies, standard policies for all companies, annual distribution of dividends, a limitation on agents' commissions, an amendment to the anti-rebate law to make the

receiver equally guilty with the giver, and caps on the salaries and pensions of company officers.[20]

Some of the recommendations became law in April 1906, including the limitation on new business, annual distribution of dividends, a ban on political contributions, prohibition of rebating, nonforfeiture provisions, standard policy forms, prohibition of investments in common stock and real estate, and caps on the salaries and pensions of the officers.

The Armstrong Committee report stimulated activity in other states, among industry representatives, and among advocates for federal intervention. Surprisingly, few states followed the lead of New York; Iowa, Massachusetts, Indiana, Texas, and Wisconsin did take some action. To the consternation of the life insurance industry, the Texas legislature passed the Robertson law, which provided that 75 percent of the reserves on Texas policies must be invested in Texas securities, and that such securities must be kept on deposit in Texas where they would be subject to the state's ad valorem taxes. Only the Wisconsin legislature adopted reforms that rivaled those of New York, enacting legislation in 1907 to limit premiums, expenses, and salaries of company officers, as well as to require an annual apportionment of dividends.

The life insurance industry, too, was active following the Armstrong Committee investigations. The American Life Convention, an organization of the smaller western and southern life companies,[21] grew into a national group that began to play a leadership role in the life insurance industry. In November 1906, some representatives of this industry group met in Chicago with a number of state commissioners and members of the Iowa and Wisconsin investigating committees. The purpose of the meeting was to draft model laws, 16 of which were endorsed by the industry. These model laws covered such subjects as standard policy forms, annual apportionment of dividends, prohibition of discrimination and rebating, and prohibition of political contributions. The models were introduced in a dozen or so states, but few were passed.[22]

Another effect of the Armstrong Committee investigations was a call for federal supervision of the insurance industry. President Theodore Roosevelt recommended in April 1906 that the Congress provide for federal regulation of interstate transactions of insurance. Several bills were introduced, but they died when the congressional committees determined that, given the opinion of the U.S. Supreme Court in *Paul* v. *Virginia*, the Congress had no authority under the Constitution to supervise and regulate the business of insurance.

The period from approximately 1910 to the 1960s was characterized primarily by the growth of state regulatory bureaucracies and a more conservative style of management by life insurers. When major life insurance scandals surfaced again in the 1960s, they involved the use of the holding company structure and the formation of conglomerates.

New York as Super Regulator: The Appleton Rule

It is thought that New York adopted the Appleton Rule a short time before the Armstrong Committee investigations. The real power of the rule was not felt, however, until the New York legislative reforms of 1907 were complete. The rule, issued by New York Deputy Superintendent of Insurance Henry Appleton, provided that

> . . . no foreign insurer and no United States branch of an alien insurer shall be or continue to be authorized to do an insurance business in this state if it fails to comply substantially with any requirement or limitation of this chapter, applicable to similar domestic insurers hereafter to be organized, which in the judgment of the superintendent is reasonably necessary to protect the interests of the people of this state.

The rule applied all aspects of New York regulatory law to foreign as well as domestic companies. Thus, a foreign life insurance company that chose to do business in New York would have to comply with the state's investment restrictions. At least with regard to foreign companies that did business in New York, the effect was to extend New York's regulatory law to all companies wherever domiciled.[23] For that reason, the Appleton Rule was not popular with the insurance commissioners of other states.

The Firemen's Insurance Company of New Jersey challenged the Appleton Rule, claiming that New York's attempt to exercise extraterritorial power violated the Fourteenth Amendment to the U.S. Constitution. Judge Learned Hand, writing for a three-judge federal district court, upheld the rule. Judge Hand found that, practically, New York had two choices: to accept the judgment of other insurance superintendents as to the safety of certain investments and practices or to apply its own regulatory law to protect New York policyholders. According to Hand, the former choice would result in differential treatment between New York-based and foreign insurers and allow "each state to set the standard of security for the rest of the Union, an intolerable limitation upon the autonomy of each community."[24] The latter choice would have some extraterritorial effects, but those would be "ancillary to the accomplishment of genuinely local purposes. . . ."[25] In upholding the constitutionality of the Appleton Rule, Hand appeared to limit the court's ruling to extraterritorial laws that related to solvency:

> Perhaps the power may be limited by the purpose and the fitness of the measure to accomplish it. . . . As we have said, scarcely any condition can be imposed touching the *financial stability* of a foreign corporation, which will not involve some results elsewhere. . . .[26] (emphasis supplied)

The U.S. Supreme Court affirmed Hand's opinion in a memorandum opinion.

Eventually, New York enacted the Appleton Rule as part of the state insurance code, and New York was the super regulator of the insurance industry. By the 1960s, however, insurers had found a structural way to avoid the effects of the Appleton Rule. If a foreign insurer did business in New York through a separate subsidiary incorporated there, it could confine the rule's impact to that subsidiary, leaving the parent and affiliated companies free from strict New York regulation.[27]

Notes

[1] R. Carlyle Buley, *The American Life Convention: A Study in the History of Life Insurance* (New York Appleton-Century-Crofts, 1953), p. 13.

[2] Charles Kelley Knight, *The History of Life Insurance in the U.S. to 1870* (Philadelphia: University of Pennsylvania, 1920), p. 11; Buley, *The American Life Conventions,* p. 13.

[3] Knight, *The History of Life Insurance,* p. 23.

[4] Ibid., p. 20.

[5] Ibid., p. 30.

[6] The South Sea Company, the brain child of Daniel Defoe, was incorporated in 1711. The English Parliament granted the company a monopoly on trade with South America and the Pacific Islands. In return, the South Sea Company agreed to take over the national debt of 51 million pounds and to pay 3.5 million pounds. The national debt consisted primarily of annuities held by thousands of citizens. The company hoped to induce the annuity holders to exchange their annuities for its own watered stock. When the company failed, the stock became worthless.

[7] Knight, *The History of Life Insurance,* p. 33.

[8] Ibid., p. 37.

[9] Buley, *The American Life Convention,* p. 6.

[10] Knight, The *History* of *Life Insurance,* pp. 60-65.

[11] Ibid., p. 68.

[12] Ibid., p. 70.

[13] Ibid., p. 106.

[14] James E. Post, *Risk and Response* (Lexington, Massachusetts: D.C. Heath and Company, 1976), p. 51.

[15] Buley, *The American Life Convention,* pp. 98-100.

[16] Ibid., p. 100.

[17] Ibid., p. 200.

[18] Ibid., p. 206.

[19] Ibid., p. 221.

[20] Ibid., p. 169.

[21] bid., p. 284.

[22] Ibid., p. 300.

[23] Kenneth J. Meier, *The Political Economy of Regulation: The Case of Insurance* (Albany: State University of New York Press, 1988), p. 58; Steven N. Weisbart, *Extraterritorial Regulation of Life Insurance* (Homewood, Illinois: Richard D. Irwin, 1975), p. 4.

[24] Firemen's Ins. Co. of Newark, N.J. v. Beha, 30 F.2d 539 (1928); aff'd mem. opinion, 278 U.S. 580 (1929).

[25] Ibid.

[26] 30 E2d 539 (1928).

[27] Weisbart, *Extraterritorial Regulation of Life Insurance,* p. 47.

6

Overview of the Modern Business of Life Insurance

Like property-casualty insurance, the function of life insurance is to protect against the financial effects of loss. Like all insurance, life insurance involves transferring risk from the individual to a group and sharing losses among members of the group. Life insurance is big business in the United States, with **2,228** U.S. life insurance companies operating in 1990. Table 6 (page 60) shows the number of life insurance companies by state of domicile as of mid-1991. In 1990, these companies had assets valued at $1.4 trillion, received over $76 billion in life insurance premiums and over $129 billion in annuity considerations, and paid out over **$88** billion worth of life insurance and annuity benefits.[1]

TYPES OF LIFE INSURANCE

Typically, life insurance is classified into one of three broad groups, depending on how the promised benefits are delivered. The three groups are term life insurance, whole life insurance, and **annuities.**[2] Insurers define subgroups within each of these groups, based on whether the premium and/or the face amount of the policy increases, decreases, or remains level during the policy period.

Term Life

The purchaser of a term life policy receives protection (i.e., a cash payment for a designated beneficiary) only if the insured dies during the stipulated policy period. If the insured lives beyond the policy term, there is no benefit. The term of the policy may range from one year to several decades. Term life policies usually have level death benefits and increasing premiums over the policy period.

Whole Life

In contrast to term insurance, whole life insurance pays the face amount of the policy on the death of the insured regardless of when death occurs, hence the name. Most whole life policy premiums are constant throughout the payment period, and most are based on mortality tables that assume all insureds die by age **100;**[3] therefore, most whole life policies are prefunded. That is, the likelihood of death is slight at the beginning of the policy period, and the premium paid is more than needed to fund the promised death benefits. For this reason, whole life policies have cash values, in the amount of the prefunding. Policyholders can use the cash value either by surrendering the policy or borrowing the cash from the life company. In the latter case, the insurer will charge interest and deduct the amount of the loan from the remaining cash value of the policy or from the death benefit.

Two types of whole life insurance have become very popular recently, variable life insurance and universal life insurance. A variable life insurance policy differs from an ordinary policy in that its death benefits and/or cash values vary to reflect the investment experience of a separate pool of **assets.**[4] The policyholder chooses among several investment options, including money market funds, common stock funds, and bond funds. The death benefits and cash values are tied to the investment performance of the policyholder's chosen funds, although the benefits/values cannot fall below a guaranteed minimum.

Universal life insurance has a flexible premium and an adjustable death benefit. The premiums are flexible in that after making an initial minimum payment, policyholders may "pay whatever amounts and at whatever

Table 6
Life Insurance Companies by State of Domicile
July 22,1992
(in descending order)

State	Number	State	Number
Arizona	668	North Carolina	23
Texas	217	Washington	20
Louisiana	102	Maryland	19
New York	86	South Carolina	19
Illinois	79	Kentucky	18
Delaware	59	Massachusetts	17
Pennsylvania	56	Utah	16
Indiana	52	Kansas	15
California	50	New Jersey	12
Missouri	48	Virginia	12
Ohio	48	North Dakota	11
Oklahoma	46	Hawaii	6
Florida	44	South Dakota	6
Iowa	36	Washington, DC	5
Arkansas	34	Idaho	5
Wisconsin	32	New Mexico	5
Alabama	28	Oregon	5
Colorado	27	Rhode Island	5
Minnesota	27	Vermont	5
Mississippi	27	Montana	4
Georgia	26	Maine	3
Michigan	26	New Hampshire	3
Nebraska	25	Nevada	2
Connecticut	24	Alaska	1
Tennessee	24	West Virginia	1
		Wyoming	1

Source: American Council of Life Insurance.

times they wish, or even skip premium payments as long as the cash value will cover policy charges. . . . Also policy owners may raise. . .or lower their policies' death benefits as they deem appropriate."[5]

Annuity

An annuity is an insurance policy that promises to make a series of payments for a fixed period or over a lifetime. A life annuity is a contract in which the insurer agrees, in return for a cash "deposit" or premium, to make lifetime payments to an annuitant. An annuity safeguards the annuitant against the possibility of outliving income and/or savings.

Under a "pure" life annuity, the insurer is deemed to have earned the entire premium at the death of the annuitant; thus, no payments or refunds are made after death, even if the annuitant dies before the age of life expectancy.[6] In contrast, a "refund" life annuity provides a refund if the annuitant dies shortly after the payments have begun. Part of the purchase price of a refund life annuity is invested to meet the cost of the refund, lowering the periodic income payments to the annuitant. Like variable whole life policies, the amount of variable annuity benefits changes according to the investments chosen by the annuitant.

Notes

[1] The data are from American Council of Life Insurance, "1991 Life Insurance Fact Book Update" (Washington DC, 1991).

[2] Some include a fourth group—endowment insurance. By 1984, however, endowment insurance accounted for only 1 percent of all life policies sold in the United States. Endowment insurance is like term insurance in that it pays the face amount of the policy on the death of the insured during the policy term. Unlike term insurance, endowment policies also pay the face amount of the policy at the end of the term if the insured is still living. See Kenneth Black, Jr., and Harold Skipper, Jr., Life *Insurance* (Englewood Cliffs, New Jersey: Prentice-Hall, 1987), p. 59.

[3] Ibid., p. 61.

[4] Ibid., p. 69.

[5] Ibid., p. 85.

[6] Ibid., p.100.

7

Critical Issues in State Regulation of Insurance: Life Insurance Solvency

Some of the issues involved in state life insurance solvency regulation were discussed in detail in Part I in connection with property-casualty regulation. Except where noted in this chapter, the prior discussion is relevant to life insurance as well. This chapter focuses on those aspects of solvency regulation that are unique to the life insurance industry.

REGULATORY ACCOUNTING

Like property-casualty insurance, life insurance accounting is governed by statutory accounting principles. Life insurers, too, report the details of their assets, liabilities, surplus, and operating results according to statutory accounting principles on an Annual Statement filed with insurance regulators in every state in which they are licensed.

Balance Sheet Liabilities: Surplus and Reserves

Life companies have far fewer problems than do property-casualty companies with estimating their losses because life company liabilities are typically certain in time and fixed in amount. Nevertheless, the current permissible methods of valuing reserves for claim payments have been subject to much criticism.

Policy Reserve. In terms of size, the most important reserve fund of a life insurer is the policy reserve—the amounts deemed necessary to provide the benefits promised in the company's life and annuity contracts.[1] All states have laws controlling the bases on which reserves are calculated. The widely used ***net-level premium method*** defines the needed reserves at a valuation date as the excess of the present value of future death benefits over the present value of future premiums. This method requires the use of net-level premiums even if the policy contract calls for a variable premium. If, for example, the present value of future death benefits is $2,557,900 and the present value of future premiums is $1,589,988, then the net-level premium reserve would be $967,912. To calculate the present values, a life company must make certain assumptions about the interest rates on its investments and the mortality rates of its policyholders. Insurers that use the net-level premium method must comply with state laws that prescribe the maximum rate of interest that can be assumed and the mortality tables that can be used. If the assumed rate of interest is increased, the size of the reserve fund will decrease; or, in other words, larger anticipated earnings can be supported by a smaller fund and vice versa.

Although the allowable interest rates and mortality tables are said to be conservative, the net-level premium method does not necessarily produce conservative levels of reserves. Critics of the net-level premium method note that the unrealistic assumptions used—hypothetical rather than actual premiums, the disregard of expenses, and the failure to take into account policy dividends and lapse rates —undermine the conservatism of the interest and mortality rates.[2] According to some observers, the conservative margin in the interest rate assumptions is not sufficient to cover the disregarded expenses, dividends, and lapse rates.

Two other permissible methods used to calculate policy reserves typically produce lower reserve funds than the net level premium method. The ***full preliminary term method*** assumes that the first year of a whole life insurance policy is term insurance, which requires no policy reserves. The original contract then goes into effect at the beginning of the second policy year, and the reserve is based on a policy issued in that latter year. The deferred first-year reserve is amortized over the period of the contract; nevertheless, the yearly additions to reserves re-

main lower throughout the policy period than under the net-level premium method. The ***commissioners' reserve valuation method*** is similar to the full preliminary term method, but requires higher reserves for plans with higher premiums due to greater expenses.[3]

Asset Valuation Reserve. The second largest reserve required for life insurers is the new asset valuation reserve **(AVR).** Beginning with their 1992 Annual Statements, life companies are required to set up a reserve to absorb potential losses on all of their assets. The AVR grew out of an earlier mandatory securities valuation reserve (MSVR), which was designed to absorb potential losses on only the common and preferred stocks and bonds held by life companies.

Changes in the financial climate in the late 1970s and early 1980s led some state regulators and the National Association of Insurance Commissioners (NAIC) to reevaluate the effectiveness of MSVR. For example, when interest rates soared in the early 1980s, many of the assumptions built into **MSVR** (e.g., that fluctuations in bond prices were not significant) became untenable. Moreover, to remain competitive, some life companies introduced new interest-sensitive products and shifted their investment strategies to shorter term, higher yield assets. To meet the regulatory challenges of these changes in company strategies, NAIC and state regulators developed AVR, a comprehensive reserve that covers all life company assets. AVR has two components — default and equity. The default component provides for future credit-related losses on fixed-income investments, such as bonds, preferred stock, and farm, commercial and residential mortgages. The equity component contains the reserve provisions for all types of equity investments, including common stock and real estate.

Interest Maintenance Reserve. The interest maintenance reserve (IMR), like **AVR,** is required of all life companies beginning with the 1992 Annual Statements. The reserve grew out of a realization by regulators that the traditional method used by valuation actuaries to calculate policy reserves was deficient. Typically, policy reserves are calculated on the assumption that future yields on fixed-income investments will be available to support liabilities. If these fixed-income investments are sold, IMR requires companies to amortize the resulting capital gains that represent future interest yields needed to support policy liabilities over the remaining life of the investment.[4]

Balance Sheet. Assets

Until recently, life insurance premiums received for traditional whole life policies were far larger than the considerations received for annuities. For example, in 1955, life insurance premiums were seven times as large as annuity considerations.[5] By 1980, however, life premiums were only 1.8 times as large, and by 1989, the situation was reversed, with annuity considerations 1.6 times the size of life insurance premiums? Prior to 1980, then, life insurers received large sums of cash from whole life policyholders and had deferred, non-interest-sensitive liabilities.

The problem for life insurance regulators was to assure that a company's surplus was sufficient to absorb a decline in investment values over time. Historically, state regulators handled this problem by restricting the investments of life companies. For example, at the close of the Armstrong Committee investigations, New York amended its insurance code to limit life insurance investments to government bonds, secured corporate debt, mortgages, and policyholder loans. Investments in common stock and real estate were prohibited. Because of New York's Appleton Rule, the New York investment limitations applied to all companies, wherever domiciled, doing business in the state.

After 1980, with the growing popularity of new investment products and interest-sensitive annuities, life companies began to change their investment strategies. Data from the American Council of Life Insurance illustrate the shift in aggregate life insurer investments between 1980 and 1991.[7]

Aggregate Life Insurer Holdings — 1980

Corporate bonds	38.3%
Commercial/Residential mortgages (traditional fixed rate)	29.4%
Policy Loans	9.3%
Government Securities (including agency issues)	6.9%
Stocks (common and preferred)	6.7%
Real Estate (directly owned)	2.6%
Other	6.8%

Aggregate Life Insurer Holdings — 1991

Corporate Bonds	43.5%
Commercial/Residential mortgages (traditional fixed rate)	19.4%
Government Securities (including agency issues)	17.8%
Stocks (common and preferred)	5.0%
Policy Loans	4.9%
Real Estate (directly owned)	2.1%
Other	6.7%

An important shift in life insurer investments took place between 1980 and 1991. In 1980, 15 percent of the life companies' aggregate gross acquisitions of government and corporate bonds and mortgage-backed securities were in medium- and short-term instruments (i.e., those with maturities ≤10 years). In 1991, 62 percent of all such gross acquisitions of bonds were in medium- and short-term instruments. This shift illustrates the desire of life companies to match their assets with their newer, interest-sensitive liabilities and to increase their liquidity as consumer confidence waned in the face of some well publicized failures.[8] In recognition of the changes in life insurance products, many states relaxed their prior investment restrictions. Most states allow insurers to invest in government bonds, corporate stocks (common and preferred) and bonds, policy loans, stocks and bonds of subsidiaries, commercial and residential

mortgage loans, and real estate. Some states place percentage limitations on these investments in order to encourage portfolio diversification. No commonality exists among state investment laws, however.

In contrast to the aggregate investment figures listed above, some companies have a far greater percentage of their assets in low quality bonds and risky real estate ventures. For example, investments in junk bonds were a significant factor in the recent failure of the Executive Life Company of California. According to California regulators, approximately **$6.4** billion of the company's **$10.4** billion of assets was invested in junk bonds? In 1991, NAIC issued a model regulation restricting insurer investments in "below investment-grade bonds." Only eight states have adopted the model regulation.[10]

Similar concentrations in risky real estate loans led to the seizure of Mutual Benefit Life by New Jersey officials." The role played by risky investments in recent life insurer failures illustrates the pressing need for stricter state investment laws. NAIC is developing a model investment law that it hopes will bring greater uniformity and greater safety.

In all states, regulatory percentage limitations are disregarded for assets held in separate accounts where the policyholder participates directly in the investment risk. Investments funded by premiums received from variable life and variable annuity contracts are held in separate accounts and are segregated from all other company assets. State laws restricting insurer investments do not apply to separate accounts. Thus, the funds in a separate account may be invested in common stocks, in bonds, or in real estate, or in any combination of the three.[12] Separate accounts are used generally to handle variable life insurance, variable universal life insurance, and pension funds. The first two accounts are subject to some Securities and Exchange Commission (SEC) standards, and the pension account is subject to provisions of the ***Employee Retirement Income Security Act.***

THE ROLE OF REINSURANCE

Reinsurance use in the life insurance industry is similar to the property-casualty industry, but with some notable differences. For example, unlike the situation with the property-casualty business, the majority of life reinsurers are licensed in at least one state. Also, because every state requires life companies to compute their reserves according to a statutory formula rather than through the estimating techniques used by property-casualty insurers, underreserving is less of a problem. Finally, unlike the property-casualty business, catastrophic events (such as an earthquake or industrial accident) are rare in the life insurance business. In some cases, these differences in the life and property-casualty businesses dictate different regulatory responses. For example, overdue reinsurance balances are rare in the life insurance industry, eliminating the need for a rule requiring a reduction in surplus. Three problems with reinsurance are relevant to life companies and are considered here—transfemng business, interaffiliate reinsurance, and financial reinsurance.

Transfer of Business

The use of reinsurance to transfer blocks of business to other companies has created special problems for the life insurance industry. Sometimes called assumption reinsurance, these transfers have been used by some companies to remove an entire block of business from its balance sheet and cancel its obligations to the policyholders. This result is in contrast to the usual situation in which an insurer, who cedes indemnification to a reinsurer, remains legally liable to its policyholders. Because the reinsurer or transferee assumes the liability of the primary insurer without the consent of (and sometimes without the knowledge of) the policyholder and without regulatory oversight, the transaction is subject to abuse. Joseph M. Belth, a long-time commentator in the insurance industry, cites the following example of an abusive transfer.

> Many individuals bought single-premium deferred annuities from First Pyramid Life of **Arkansas.** A block of these annuities was transferred three times through assumption reinsurance agreements. The first transfer was to Security Benefit, and the second to Life Assurance Company of Pennsylvania. The third transfer was to Diamond Benefits Life of Arizona. Shortly thereafter Diamond Benefits was taken over by Arizona insurance regulators. . . . Life of Pennsylvania was recently taken over by Pennsylvania regulators. The affected annuitants have been unable to get at their funds for almost three years.[13]

NAIC has developed, but not adopted, a model act that would require life insurers to notify consumers of a pending assumption reinsurance transaction and given them the opportunity to remain covered by their current insurer.

Interaffiliate Reinsurance

Interaffiliate reinsurance, whereby a group of affiliated insurance companies agrees to reinsure each other's risks, has also created problems for state regulators. According to the **U.S.** General Accounting Office (GAO), "[I]n a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another. Improper support or subsidy of one affiliate at the expense of another may adversely affect the financial condition of one or more companies within the group."[14] For example, "an affiliate reinsurer may receive exorbitant premiums, or an affiliated ceding company may receive excessive commissions."[15]

Financial Reinsurance

The use of financial reinsurance (described in Chapter **3),** is widespread in the life insurance industry. For example, in 1991, the Equitable Life Assurance Society of the **U.S.** boosted its total capital by **$600** million using surplus relief reinsurance.[16] A relatively weak NAIC Model Regulation on Life Reinsurance Agreements issued in **1988** prohibits a company from taking a credit for financial reinsurance if the reinsurer does not comply with certain accounting requirements: the reinsurer must accept some risk, such as mortality or investment risk, and/or the reserve credit taken by the ceding insurer must

not be greater than the underlying reserve of the ceding company supporting the obligations transferred.

The limitations on the use of financial reinsurance in the 1988 version of the model law are weaker than the accounting rule recently issued by NAIC in connection with property-casualty insurance. In June 1992, NAIC issued a revised model rule that would require life insurers to transfer all significant **risks** on the business *ceded* to a reinsurer. Insurers who fail to do so would be denied a credit. The 1992 model rule has not been formally adopted by NAIC, but it has been adopted by California and Colorado.

STATE SOLVENCY REGULATION

Many of the problems with solvency regulation of property-casualty insurers described in Part I are relevant to life insurance companies. For example, state capital and surplus requirements for life insurers are unrelated to either the size of the company or to the riskiness of its assets. Life companies also use managing general agents (called third-party administrators) as intermediaries to negotiate reinsurance agreements. A NAIC model law imposes many of the same restrictions on third-party administrators that the managing general agent model law imposes on MGAs. Approximately 20 states have adopted the model law. Fronting appears to be less of a problem with life companies. Apparently, some of the draft model laws on fronting have included life companies, and others have not. Finally, the failure of most states to adopt meaningful investment limitations affects both industries. Multistate life insurers have created unique problems for state regulators and deserve **special** mention.

Multistate Insurance Holding Companies

The American Council of Life Insurance (ACLI) recently examined 68 life/health insurance company insolvencies that occurred between January 1985 and September 1989. Affiliate transactions were a significant factor in 69 percent of the companies.[17]

GAO found similar problems with holding companies in both the banking and insurance industries. According *to* GAO, the largest life insurer failure in history was caused by "abusive interaffiliate transactions"[18] orchestrated by the parent holding company of several insurance subsidiaries. The story of the failure of Baldwin-United is instructive, proving once again that the pyramid is not far from the tomb.

The Baldwin Phenomenon. Baldwin began as a piano company in 1862. Baldwin entered the insurance business in 1968 when it bought National Farmers Union Life and Casualty companies. From 1970 to 1980, Baldwin-United developed rapidly into a large financial conglomerate, acquiring commercial banks, savings and loan associations, mortgage banks, real estate firms, and life and property-casualty insurers around the country.[19] In 1981 and 1982, Baldwin-United was praised in financial publications as a "well-managed, diversified financial services company with an impressive growth rate and high profitability."[20] Baldwin's management also received impressive reviews: "The stock of Baldwin-United represents an interesting special situation. We do not believe its outstanding management team is being accorded a proper multiple."[21] A.M. Best Company gave the National Investors Life Insurance Company (NILIC), a Baldwin-United subsidiary, an excellent rating."

In large part, Baldwin's phenomenal growth was fueled by sales of a life insurance/investment/tax shelter product known as a single premium deferred annuity (SPDA), underwritten primarily by NILIC. The Baldwin SPDA had the following features, which made it attractive to purchasers:

- The purchaser of an SPDA paid a one-time premium deposit, eliminating the need for a recurring financial commitment.
- The SPDA was similar to a ten-year certificate of deposit in that the purchaser received interest payments from NILIC or another Baldwin subsidiary issuing the SPDAs.
- The SPDA had a death benefit and two tax advantages: (1) the capital (premium deposit) and accumulated reinvested interest were not taxed and (2) an investor could withdraw interest as a tax-free policy loan.
- The SPDA contained a guaranteed growth of principal. If Baldwin earned less than the guaranteed rate (i.e., 0.75 percent below the initial rate), the company would refund the investor's initial deposit without levying a surrender charge.[23]

Although the SPDAs were not a new product (being based loosely on the old tontine principle), Baldwin's method of selling them was new. SPDAs were sold through national securities brokerage houses, such as E.F. Hutton and Merrill Lynch.[24]

The Baldwin Failure. Even before weaknesses in Baldwin's financial empire began to surface, the company had manipulated its tax liability by shifting assets among its subsidiaries. For example, Baldwin funnelled holding company profits to subsidiaries that were in a low tax bracket and shifted paper losses to subsidiaries that were in high tax brackets. **As** its SPDA premium deposits increased, NILIC needed more regulatory surplus to support its new business. In order to increase its surplus, NILIC turned first to reinsurance, ceding business to an affiliated reinsurer, National Investors Pension Insurance Company (NIPIC).

When NILIC's need for capital and surplus outgrew this reinsurance arrangement, Baldwin exchanged securities and other assets among its affiliates and engaged in interaffiliate loan transactions to pump up the apparent net worth of NILIC and NIPIC. In summer 1982, Arkan*sas* insurance department examiners reappraised the assets of reinsurer NIPIC and lowered their value. The reevaluation rendered NIPIC statutorily insolvent.[25] Once NIPIC was found to be insolvent, the affiliated companies it reinsured could no longer claim **a** reinsurance credit for the risks ceded and had to cover the risks themselves. Without reinsurance, these ceding compan-

ies (including NILIC) were also statutorily insolvent. Baldwin reacted by reinsuring its SPDA premiums in an Arizona subsidiary because Baldwin recognized Arizona as "one of the least regulated insurance states in the Union."[26] Nevertheless, neither Arkansas as the primary domiciliary regulator of both NIPIC and NILIC, nor Indiana, as the domiciliary regulator of three other Baldwin subsidiaries underwriting **SPDAs,** took any supervisory action against the Baldwin subsidiaries until spring 1983, when state regulators petitioned their state courts for a rehabilitation order. In fall 1983, the insurance commissioners of Arkansas and Indiana imposed a moratorium until November 1987 on surrender of Baldwin SPDAs. Not until February 1988 did the holders of SPDAs of the now-bankrupt Baldwin receive their final distributions.[27]

NAIC and other commentators have listed the lessons that states should learn from the Baldwin failure. A common regulatory weakness cited was the excessive investment in affiliate securities, over $650 million in the investment portfolios of NILIC and NIPIC.[28] On several occasions, NILIC paid cash for the securities of affiliates. Yet, the value given to these securities was speculative at best. Because these shares were not publicly traded and earned no income, their value could not be verified independently.

Another regulatory weakness was the practice by NILIC of reinsuring 100 percent of its SPDA business with affiliated reinsurance companies. NAIC reacted to the Baldwin-United failure by amending the model holding company act. The amended act, which is described in Chapter 3, is one of the model acts that states must adopt in order to become certified under NAIC's accreditation program.

Executive Life of California. As the recent experience with Executive Life of California illustrates, serious problems remain with interaffiliate transactions in insurance holding company systems. In its investigation of the company just prior to the failure, the California insurance department uncovered deceptive transactions among company affiliates. For example, in one series of transactions, Executive Life transferred over $700 million of junk bonds in exchange for the securities of six newly formed affiliated partnerships. After this transaction, Executive Life reduced its mandatory securities valuation reserves and increased its surplus by $120 million.[29] On completion of its examination two years after the transaction, the California department ordered Executive Life to recalculate its **MSVR** and to disclose the substance of the junk bond transactions in its Annual Statement.

Notes

[1] Ibid., p. 555.

[2] Spencer L. Kimball and Herbert S. Denenberg, *Insurance, Government, and Social Policy: Studies in Insurance Regulation* (Homewood Illinois: Richard D. Irwin, 1969), p. 119. NAIC notes that the some problems with the net level premium method exist under both statutory and GAAP accounting.

[3] Kenneth Black, Jr., and Harold Skipper, Jr., *Life Insurance* (Englewood Cliffs, New Jersey: Prentice Hall, 1987), pp. 351-352.

[4] I am indebted to John Booth, Vice President and Chief Actuary with the American Council of Life Insurance, who provided the language of this sentence and patiently educated me during a phone conversation on July 16, 1992. Any errors are my own.

[5] Kenneth M. Wright, "The Structure, Conduct, and Regulation of the Life Insurance Industry," in Richard W. Kopcke and Richard E. Randall, eds., *The Financial Condition and Regulation of Insurance Companies,* Proceedings of a conference sponsored by the Federal Reserve Bank of Boston, June 1991, p. 80.

[6] Ibid.

[7] The data were provided to the author by Paul Reardon, Director, Investment Research, American Council of Life Insurance, phone conversation, July 14 and 27, 1992.

[8] Kenneth M. Wright, "The Structure, Conduct, and Regulation of the Life Insurance Industry"; and phone conversation with Paul Reardon, July 14 and 27, 1992.

[9] Joseph M. Belth, The *Insurance Forum,* June 1991.

[10] As noted, however, New York acted on its own to restrict so-called high yield-high risk bonds. Illinois imposed a cap on such bonds in 1990. Other states have followed.

[11] According to New Jersey regulators, Mutual Benefit had $1.1 billion of its $14 billion of assets tied up in four problem loans. Susan Pulliam, "Mutual Benefit Life Took Plenty of Risks, and Is Paying the Price," *Wall Street Journal,* July 26, 1991.

[12] Black and Skipper, *Life Insurance,* p. 557.

[13] Joseph M. Belth, ed., "The Current State of Affairs in the Life Insurance Business," *The Insurance Forum,* March 1992, p. 10.

[14] U.S. General Accounting Office (GAO), *Insurance Regulation: State Reinsurance Oversight Increased, but Problems Remain* (Washington, DC, May 1990), p. 17.

[15] Ibid.

[16] Susan Pulliam, "Insurance Regulators Mounting Attack on Controversial Financial Technique," *Wall Street Journal,* June 7, 1991.

[17] American Council of Life Insurance, "Alternatives and Enhancements to the Current Guaranty Association Mechanism," Report of the Study Group to the Legislative Committee, October, 1991, p. 17.

[18] Statement of Richard L. Fogel, Assistant Comptroller General, before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations (Washington, DC: U.S. General Accounting Office, May 22, 1991), p. 21.

[19] Report of the Conference of Insurance Legislators Task Force on Regulatory Initiative, "Risk . . . Reality . . . Reason . . . in Financial Services Deregulation, A State Legislative Perspective" (1983), p. 33.

[20] Quoted in John F. Fitzgerald, "Regulatory Lessons Learned from Baldwin-United Corporation," *Journal of Insurance Regulation* (March 1988): 284.

[21] Ibid.

[22] Ibid.

[23] Ibid.

[24] Conference of Insurance Legislators, "Risk . . . Reality . . . Reason. . ., p. 34.

[25] National Association of Insurance Commissioners, "The Baldwin-United Corporation Bankruptcy: Its Significance for Insurance Regulation."

[26] Richard L. Stem and Paul Bornstein, "What Happens When the Music Stops?," *Forbes,* December 20, 1982, p. 33; quoted in Fitzgerald, p. 303.

[27] Fitzgerald, "Regulatory Lessons Learned from Baldwin-United Corporation," pp. 294-299.

[28] Ibid., p. 300.

[29] Joseph M. Belth, "A Disastrous January for Executive Life," *The Insumnce Forum,* March 1990, pp. 91, 95.

8

Critical Issues in State Regulation of Insurance: Life Insurance Liquidation Laws and Guaranty Funds

The state laws that specify the actions that an insurance commissioner can take to protect the policyholders of a financially troubled insurance company are the same for property-casualty insurers and life insurers. Chapter 4 of this report describes state delinquency proceedings for property-casualty insurers and the two acts governing such proceedings, the Uniform Insurers Liquidation Act and the Model Act. These laws also apply to life insurers; therefore, their provisions are not described again here, nor are such other common problems as the impact of federal tax lien priorities, arbitration clauses, and the lack of uniformity among state liquidation laws.

STATE LIFE GUARANTY ASSOCIATIONS

Like property-casualty guaranty funds, state life guaranty associations protect policyholders of insolvent life insurers.[1] The structure of the two model laws is similar in several respects. For example, all insurers licensed in a state are required to be members of the state's guaranty association. When a life company becomes insolvent, the association first estimates how much will be needed to pay claims and benefits and then assesses member companies a percentage of their premium income. State annual assessment caps range from 1-4 percent, but most states have a 2 percent cap. For large insolvencies, the assessment process is repeated in subsequent years until all covered claims are paid up to the state's limit. State coverage limits range from $100,000 to $500,000 per life for individual life and annuity benefits.

Like property-casualty guaranty fund coverage limits, the differences in state life guaranty association coverage can result in inequitable treatment among similarly situated policyholders. For example, a New York resident who purchases an annuity with a cash value of $200,000 from a California company that was not licensed in New York (and therefore not eligible for coverage by the New York guaranty fund) would receive $100,000 from the California guaranty fund. In contrast, a resident of Washington with an annuity from the same company and with the same cash value would receive $200,000 from the Washington guaranty fund.[2] Some observers maintain that such differences represent legitimate public policy choices by states.

Unlike property-casualty contracts, life and annuity contracts are long term. When a life company fails, the policyholder may be in bad health and unable to find new coverage. Therefore, life guaranty associations are required to continue life, annuity, and health insurance coverage in effect, as well as pay claims. When a multistate life insurer fails, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) coordinates the activities of the state guaranty associations, all of which are members of the organization. Formed in 1983, NOLHGA also provides information on guaranty fund laws and provides others services to member guaranty associations.

Prior to the early 1980s, life insurance insolvencies were infrequent, averaging about five per year from 1975 to 1982.[3] Moreover, the failed companies were typically small; most had assets and premiums of less than $50 million. From 1975 to 1982, guaranty fund assessments totaled $50 million. Recently, life insolvencies have increased dramatically in number and size; for example,

guaranty fund assessments tripled from **$154.8** million in 1990 to an estimated **$469.7** million in **1991.**

Coverage

Virtually all life insurance policyholder claims are covered by state guaranty funds up to the typical limits of $300,000. Most guaranty associations do not, however, cover the newer, investment-type products sold by life companies to governmental agencies and pension funds. Approximately **19** state guaranty funds cover the unallocated annuity contracts of insolvent insurers, while **18** states specifically exclude such contracts: NAIC's model act defines an unallocated annuity contract as "any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by any insurer under such contract or certificate." Typically, unallocated annuity contracts are purchased by private and governmental entities (to fund their retirement plans) that are advised by professional (albeit sometimes dishonest) money managers. Coverage of such products is, of course, intimately related to the capacity of guaranty funds to cover large life company insolvencies.

One form of an unallocated annuity contract, the guaranteed investment contract or GIC, constituted a significant portion of the policy liabilities of the recently failed Executive Life Insurance Company of California. At the time of its failure in **1991,** Executive Life had over **$1.8** billion of muni-GICs outstanding. The typical Executive Life muni-GIC worked as follows:

> A municipal agency would issue bonds, which were then purchased by investors. The agency would use the proceeds of the bonds to buy a GIC from Executive Life. Because the rate of interest on the GIC was higher than the interest rate on the municipal bonds, the agency received extra money in the amount of the interest rate differential.[5]

The California conservatorship court ruled that the state's guaranty fund would have to grant the holders of Executive Life muni-GICs the same priority status as individual policyholders in the assets of the insolvent estate. This ruling will affect the capacity of state guaranty funds. Granting the holders of muni-GICs the same priority status as policyholders limits the amounts that traditional policyholders can recover from the insolvent insurer's estate, thereby increasing the amount that guaranty funds must contribute to compensate policyholders for their covered claims. The court's ruling was based on the ambiguous state of California law at the time of Executive Life's insolvency. California has since amended its law.

A recent report by NAIC describes a serious gap in life guaranty fund coverage. According to the report, a policy owner who lives in a state in which the insolvent insurer was never licensed may not be covered by any state guaranty fund. According to the model act, a state guaranty fund is required to provide coverage to nonresidents if:

1) The insolvent insurer is domiciled in the state;

2) The insurer was never licensed in the state in which a policyholder resides;

3) The state in which the policyholder resides has an association similar to the domiciliary state's association; and

4) The policy owner is not eligible for coverage by the guaranty fund in the state in which he or she resides.

Some state guaranty fund laws do not have this reciprocal provision and offer no coverage to nonresidents.[6]

Statutory Prohibitions on Guaranty Fund Disclosure

One provision in the Guaranty Fund Model Act prohibits disclosure of guaranty fund coverage. Insurers argue that disclosure would invite unscrupulous insurers to encourage consumers to shop for price rather than for price plus company stability. The argument is faulty in several respects. First, in a competitive industry, it is assumed that consumers should and will shop primarily for price. Second, in a regulated competitive industry, unsophisticated consumers have the right to assume that the primary duty of monitoring the financial solvency of insurers belongs with taxpayer-funded state departments of insurance, not with the consumer. Indeed, state departments of insurance are the best source of information for consumers on the financial health of insurers; yet state commissioners are generally precluded from or unwilling to share their information with policyholders. Third, to ensure effective state regulation, consumers must be informed of all aspects of guaranty fund coverage, including the amount of coverage, the amount of assessments, and the amount of revenue lost due to state premium tax offsets.

Who Pays the Assessments?

Few states allow property-casualty insurers to recover their guaranty fund assessments by taking a credit against state premium taxes. Rather, most property-casualty insurers recoup their assessments by increasing their policy rates or levying a surcharge on policies. In contrast, **43** states grant life insurance companies a state premium tax credit for assessments paid to the state's guaranty fund. The dissimilar treatment reflects the differences in property-casualty and life contracts. Unlike property-casualty contracts, life and annuity agreements are long term, making it difficult for life companies to recover guaranty fund assessments through policy rate increases.

The effect of state premium tax offsets is to shift the cost of life insolvencies to taxpayers. James Barrese and Jack **M.** Nelson have calculated that for life companies, approximately **79** percent of the guaranty fund assessment is borne by state taxpayers and **7** percent by federal taxpayers; **14** percent is allocated by insurers to policyholders, equity holders, and employees.'

The Capacity of Life Guaranty Funds

Table **7** lists the life/health guaranty fund assessments and capacity in **1990.** According to NOLHGA, nationwide

Table 7
Life/Health Guaranty Funds in 1990: Assessments and Capacity

State	Net Assessments	Maximum Rate	Assessable Premiums	Estimated 1990 Capacity	Assessments as a Percent of Capacity	Estimated Capacity at 2%	Assessments as a Percent of Capacity at 2%
Alabama	60,000	1.0%	2,201,405,671	22,014,057	0.3%	44,028,113	0.1%
Alaska	0	2.0	362,640,745	7,252,815	0.0	7,252,815	0.0
Arizona	46,001,000	2.0	2,186,005,402	43,720,108	105.2	43,720,108	105.2
Arkansas	165,300	2.0	1,336,408,772	26,728,175	0.6	26,728,175	0.6
California	0	2.0	17,457,965,401	349,159,308	0.0	349,159,308	0.0
Connecticut	159,300	2.0	3,455,424,390	69,108,488	0.2	69,108,488	0.2
Delaware	0	2.0	732,935,946	14,658,719	0.0	14,658,719	0.0
Florida	11,146,000	1.0	9,949,287,740	99,492,877	11.2	198,985,755	5.6
Georgia	0	2.0	4,332,929,989	86,658,600	0.0	86,658,600	0.0
Hawaii	0	2.0	646,970,256	12,939,405	0.0	12,939,405	0.0
Idaho	0	2.0	462,858,665	9,257,173	0.0	9,257,173	0.0
Illinois	(16,715,140)	2.0	10,667,609,569	213,352,191	-7.8	213,352,191	-7.8
Indiana	1,800,000	2.0	4,845,178,850	96,903,577	1.9	96,903,577	1.9
Iowa	546,840	2.0	1,820,947,754	36,418,955	1.5	36,418,955	1.5
Kansas	1,823,842	2.0	1,542,600,473	30,852,009	5.9	30,852,009	5.9
Kentucky	1,994,790	2.0	2,256,577,033	45,131,541	4.4	45,131,541	4.4
Maine	0	2 0	743,270,259	14,865,405	0.0	14,865,405	0.0
Maryland	252,122	2.0	3,079,131,342	61,582,627	0.4	61,582,627	0.4
Massachusetts	520,000	2.0	4,155,827,366	83,116,547	0.6	83,116,547	0.6
Michigan	112,585,000	2.0	6,899,225,732	137,984,515	81.6	137,984,515	81.6
Minnesota	(892,000)	2.0	2,930,613,000	58,612,260	-1.5	58,612,260	-1.5
Mississippi	5,607,450	2.0	1,254,022,731	25,080,455	22.4	25,080,455	22.4
Missouri	3,941,000	2.0	4,128,269,062	82,565,381	4.8	82,565,381	4.8
Montana	8,793,502	2.0	646,558,246	12,931,165	68.0	12,931,165	68.0
Nebraska	399,000	2.0	1,518,533,408	30,371,068	1.3	30,371,068	1.3
Nevada	1,101,250	2.0	643,805,162	12,876,103	8.6	12,876,103	8.6
New Hampshire	0	4.0	709,529,642	28,381,186	0.0	28,381,186	0.0
New Mexico	145,700	2.0	1,089,399,940	21,787,999	0.7	21,787,999	0.7
New York	0	2.0	14,347,863,722	286,957,274	0.0	286,957,274	0.0
North Carolina	(505,377)	4.0	5,054,063,658	202,162,546	-0.2	202,162,546	-0.2
North Dakota	176,500	2.0	452,751,366	9,055,027	1.9	9,055,027	1.9
Ohio	3,738,800	2.0	9,049,285,568	180,985,711	2.1	180,985,711	2.1
Oklahoma	5,513,027	2.0	1,798,375,842	35,967,517	15.3	35,967,517	15.3
Oregon	10,983,614	2.0	1,903,301,989	38,066,040	28.9	38,066,040	28.9
Pennsylvania	0	2.0	8,347,170,576	166,943,412	0.0	166,943,412	0.0
Puerto Rico	0	2.0	460,960,061	9,219,201	0.0	9,219,201	0.0
Rhode Island	2,500	3.0	551,116,917	16,533,508	0.0	16,533,508	0.0
South Carolina	0	4.0	2,088,976,303	83,559,052	0.0	83,559,052	0.0
South Dakota	0	2.0	572,575,659	11,451,513	0.0	11,451,513	0.0
Tennessee	500,000	2.0	2,998,028,666	59,960,573	0.8	59,960,573	0.8
Texas	61,852,195	1.0	12,373,281,185	123,732,812	50.0	247,465,624	25.0
Utah	343,891	2 0	981,641,206	19,632,824	1.8	19,632,824	1.8
Vermont	0	2.0	344,065,042	6,881,301	0.0	6,881,301	0.0
Virginia	194,746	2.0	4,700,909,000	94,018,180	0.2	94,018,180	0.2
Washington	45,200	2.0	2,785,953,345	55,719,067	0.1	55,719,067	0.1
West Virginia	0	2.0	1,142,211,000	22,844,220	0.0	22,844,220	0.0
Wisconsin	(6,164,538)	2.0	3,528,115,667	70,562,313	-8.7	70,562,313	-8.7
Wyoming	0	2.0	298,136,057	5,962,721	0.0	5,962,721	0.0
Total	256,115,514		165,834,735,375	3,234,017,523	7.9	3,479,257,269	7.4

Source: **NOLGHA and NAIC.**

assessment capacity for life insurance and annuities was $2.68 billion in 1990 ($1.9 billion for life insurance and $784 million for annuities).[8] Historically, net life/health assessments have been low. For example, from 1975 to 1982, those assessments averaged $6.2 million a year. Recently, however, assessments increased dramatically, tripling from $154.8 million in 1990 to $469.7 million in 1991. Although the latter figure represents only 14.4 percent of 1990 capacity, assessments made in 1991 for the Executive Life of California failure are preliminary and could reach $400 million per year over five years? Moreover, nationwide capacity figures tell only part of the story. In 1990, individual state assessment capacity ranged from $2.1 million in Vermont to $114.7 million in New York for life premiums and from $1.4 million in Wyoming to $91.3 million in Illinois for annuity considerations.[10]

As noted previously, states have at least four options to increase the capacity of the guaranty funds. First, all states could increase their assessment limits to at least 2 percent, thereby increasing the nationwide capacity of life/health guaranty funds by 7.6 percent," or beyond 2 percent. Second, states could reduce coverage, for example, by excluding coverage for unallocated annuities or restricting payments to all policyholders. For example, California's new life/health guaranty fund covers the lesser of 80 percent of the contractual obligation or $250,000 (life)/$100,000 (annuities). Third, states could adopt a prefunded guaranty fund program. Such a prefunded program would not only increase the capacity of the guaranty system but also would introduce some market discipline into the system. Under a fourth option, state guaranty funds would jointly establish a reinsurance or excess insurance mechanism.[12] The third and fourth options would involve joint action.

Notes

[1] The funds also protect policyholders of failed health insurers, a subject not included in this report.

[2] See U.S. General Accounting Office (GAO), *Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds* (Washington, DC, March, 1992, p. 27.

[3] Ibid.

[4] The remaining states have either no statutory provisions or ambiguous provisions.

[5] Summary is from Joseph M. Belth, *The Insurance Forum,* April 1990.

[6] Robert Klein, "Issues Concerning Insurance Guaranty Funds," p. 33. As of September 1990, Washington DC was the only jurisdiction that did not offer any life guaranty fund coverage. The American Council of Life Insurance notes that only five jurisdictions do not include the reciprocal provision. Letter from Edward J. Zimmerman, September 2, 1992.

[7] "Distributing the Cost of Protecting Life-Health Insurance Consumers," Statement of James Barrese and Jack M. Nelson before the U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust, Monopolies, and Business Rights, April 28, 1992.

[8] Letter from Edward J. Zimmerman, American Council of Life Insurance, September 2,1992.

[9] Klein, "Issues Concerning Insurance Guaranty Funds."

[10] GAO, *Insurer Failures,* pp. 46-47.

[11] Klein, "Issues Concerning Insurance Guaranty Funds."

[12] Ibid.

Part III

Proposed and Alternative Solutions

9

Improving State Regulation

Parts I and II of this report identified and described several areas in state solvency regulation and liquidation and guaranty fund laws that could be improved.

For state solvency regulation, these areas include:

1) *The lack of uniformity of accounting principles* for financial reporting;

2) *Accounting for reinsurance in a manner that may provide an inaccurate picture* of an insurer's true financial condition;

3) *The failure to regulate alien reinsurers effectively;*

4) *Minimum capital and surplus requirements that are too low and unrelated to the risk* assumed by a company;

5) *The use of fronting and managing general agents by property-casualty insurers* to circumvent state licensure and regulatory requirements;

6) *A significant time lag in examination of insurance companies;*

7) *The failure to initiate formal proceedings after discovery that an insurer is operating in a perilous financial condition,* thus increasing the costs to consumers and taxpayers of the eventual demise of the company;

8) *The use of uncodified accounting requirements and reporting requirements as regulatory tools in lieu of model laws and regulations* (e.g., NAIC has failed to adopt a model law restricting the use of financial reinsurance by property-casualty insurers, relying instead on accounting and reporting requirements);

9) *The failure to effectively regulate transactions between insurers and their parent and among insurers and their affiliates;*

10) *The failure to adopt meaningful investment standards for life insurance companies;* and

11) *The failure to enact effective regulation of assumption reinsurance,* whereby an insurer cedes business to a reinsurer (without the approval of the policyholder) who agrees to assume all liability for the business.

Areas in which state liquidation and guaranty fund laws could be improved include:

12) *The treatment of reinsurers under state law as players in need of special protection when a ceding insurer becomes insolvent.* The effect of this special treatment is to reduce drastically the assets available for distribution to policyholders by allowing reinsurers to:

   a) Rescind their contracts with insolvent insurers when the reinsurers can prove a material misrepresentation;

   b) Offset (without meaningful limitation) amounts due from an insolvent insurer against the amount the reinsurer owes as reimbursement for the liabilities of the insolvent insurer; and

   c) Use cut-through clauses granting some policyholders special treatment by allowing them to receive payments directly from the reinsurer without complying with state liquidation procedures.

13) *Clashes between federal and state law that diminish the amount of reinsurance proceeds available for policyholders.* The federal priority statute allows the federal government in its status as policyholder and/or tax collector to take first priority, despite state laws to the contrary, in state liquidation proceedings. The federal arbitration statute allows reinsurers to bring their disputes over coverage to a private forum outside of the state liquidation proceedings.

14) *A lack of uniformity among state liquidation laws,* leading to conflicts among states and gaps in coverage.

15) *Thefailure to introducemarket discipline intostate guaranty fund plans* by disallowing or limiting guaranty fund coverage for high-net-worth policyholders and adopting a fully or partially prefunded guaranty fund plan.

16) *Thefailure to disclose to thepublic that insurers may recover their guarantyfind assessments* by state tax offsets and/or policyholder surcharges and publicizing the effects of such recoveries on state revenues and/ or the price of insurance, respectively.

17) *Thefailure to adopt measures to mitigate the negative effects of the use of a territoriality (orhost state) concept in the administration of state guarantyfinds,* whereby responsibility for payment of claims rests with the state of residence of the policyholder or claimant. The negative effects of the use of this concept include:

  a) The existence of concurrent guaranty fund proceedings in each state in which a policyholder or claimant resides;

  b) Disagreements among state guaranty funds as to which fund must pay a particular claim;

  c) The regulatory failures of the domiciliary state (the primary regulator) being paid for by host states, reducing the incentive for domiciliary states to regulate effectively; and

  d) Multistate policyholders forum shopping by bringing their claims to the state guaranty fund that offers the broadest coverage.

18) *Thefailure to adopt measures to increase the capacity of state guarantyfinds.* Options to increase the capacity . of state guaranty funds include:

  a) All states could increase their assessment limits to at least 2 percent or beyond 2 percent, thereby increasing nationwide capacity.

  b) States could reduce guaranty fund coverage by, for example, restricting payments to all policyholders to **80** percent of state maximums, or excluding/limiting coverage for large corporations.

  c) States could adopt **a** prefunded guaranty fund program. Such a prefunded program would increase the capacity of the guaranty system and would introduce some market discipline into the system.

  d) State guaranty funds could jointly establish a reinsurance or excess insurance mechanism.

The following chapters describe and evaluate proposed solutions.

10

State Efforts to Strengthen Solvency Regulation

The National Association of Insurance Commissioners (NAIC) has a wealth of experience in working with states to increase the uniformity and efficiency of insurance regulation. NAIC has developed more than 200 model laws and regulations. Until recently, many states did not adopt the models. However, the new NAIC accreditation program, described below, makes adoption of certain model laws mandatory. The organization also collects data on insurers, updates the uniform Annual Statement on which insurers report their financial data, and monitors the financial health of companies. This chapter describes and evaluates NAIC's efforts to strengthen state solvency regulation.

NAIC'S EARLY WARNING SYSTEM

NAIC has attempted to fill the information void that arises from state-by-state regulation by conducting solvency analyses of multistate insurers and making the results available to all states. NAIC's Insurance Regulatory Information System (IRIS) uses a system of financial ratios to identify potentially troubled companies so that regulators in states where these companies do business can resolve problems before they lead to insolvency. As of March 1992, 31 states mandated insurer participation in IRIS.[1] The IRIS system uses 11 audit ratios to test the health of insurers. Insurers that fail four or more of the ratios are targeted for regulatory scrutiny. The ratios tested and the scores that result in failure for property-casualty companies are:

1. Net premium written divided by surplus (fail if the result is greater than 300 percent),
2. Change in net written premium (fail if result is greater than 33 percent or less than -33 percent),
3. Surplus aid divided by surplus (fail if result is greater than 25 percent),
4. Two-year adjusted underwriting ratio (fail if result is greater than 100 percent),
5. Net investment income divided by average invested assets (fail if result is greater than 5 percent),
6. Change in surplus ratio (fail if result is greater than -10 percent or greater than 50 percent),
7. Liabilities divided by liquid assets (fail if result is greater then 105 percent),
8. Agents' balances divided by surplus (fail if result is greater than 40 percent),
9. One-year reserve development divided by surplus (fail if result is greater than 25 percent),
10. Two-year reserve development divided by surplus (fail if result is greater than 25 percent),
11. Estimated current reserve deficiency divided by surplus (fail if result is greater than 25 percent).

NAIC sends a list of all companies that fail four or more of these tests to every state insurance regulator, along with the association's recommendation for either no action or immediate regulatory attention.

NAIC's early warning system has been sharply criticized. Observers note that the capital and surplus of many insurers is probably overstated because loss reserves are understated and because a significant amount of reinsurance receivables will never be collected. For example, the U.S. General Accounting Office (GAO) cites one industry analyst's estimate that as much as $20 billion in rein-

surance, equivalent to **17** percent of the property-casualty industry's **1988** surplus, may never be collected? James Barrese has summarized other criticisms as follows:

> . . . the problems of the IRIS ratio tests include their pass/fail nature, the fact that they are equally weighted in importance, and their dependence on surplus (which is easily manipulated). . . . If a firm is a borderline pass in all **11** tests, it may never be subject to scrutiny; it does not matter how poorly the company performed on any particular test. Moreover, the tests are internally inconsistent; if a firm's surplus increases by over 50 percent it fails one test. Since each test is equally weighted, the relative importance of failing the change in surplus test is exactly the same as having a ratio of net investment income to average invested assets of -200 percent. Yet, there is no reason to expect that the two ratios are equally correlated with financial difficulty, or that they work in the same direction. A final criticism is that there **is** a heavy dependence on surplus (seven of the **11** tests are computed using surplus), and surplus is easily manipulated within statutory accounting rules.[3]

NAIC has initiated a project to test the effectiveness of its IRIS ratios. The Solvency Surveillance Research Project will test IRIS against alternative models using statistical techniques. NAIC has set March **1993** as the due date for its final results on the property-casualty section of the research and June **1993** as the due date for its report on life/health research.

NAIC'S ACCREDITATION PROGRAM

NAIC has high hopes that its accreditation program, adopted in **1990,** will accelerate state acceptance of at least those model laws that the association deems critical to financial regulation. The purpose of the accreditation program is to establish a consistent nationwide system of solvency regulation. To become accredited, a state must comply with NAIC's financial regulation standards. **As of** September **1992, 13** states have become accredited.

An accreditation team, made up of persons knowledgeable about insurance and not associated with (nor having represented insurers in matters before) the state insurance department under review, tests compliance with NAIC's standards by reviewing a state insurance department's laws and regulations, past examination reports, and organizational and personnel policies, and assessing the department's levels of reporting and supervisory review. NAIC has identified **16** model laws and regulations that a state must adopt before becoming accredited. The accreditation team reports its findings as to state compliance to a NAIC committee of state insurance commissioners. (Appendix B contains a description of the accreditation program.)

Beginning in January **1994,** NAIC plans to ask accredited states to penalize states that do not become accredited. For example, an accredited state would not accept examination reports on insurers domiciled in nonaccredited states. It is thought that insurers in unaccredited states would find such a requirement burdensome because they would potentially be subject to examination in every state in which they did business.

Unfortunately, such a penalty may be more burdensome for states than for insurers. Most state insurance regulators complain of chronic budgetary and staffing problems that make it impossible for them to monitor even domiciliary companies on a regular basis. *An* increase in supervisory duties over nondomiciliary companies may stretch state resources to the breaking point. If, however, accredited states would share the task of examining insurers domiciled in nonaccredited states, with perhaps the largest of the accredited departments conducting most of the exams and sharing the results with all other accredited states, the penalty might be viable.

GAO criticisms of NAIC's accreditation program include the following:

1) The financial regulation standards are "general and have been interpreted permissively by accreditation review teams." For example, states with weak regulatory authorities have been accredited, and, in numerous instances, accreditation teams found apparent compliance deficiencies but certified compliance as acceptable.

2) The program has "too little focus on state insurance departments' implementation" of accreditation standards. For example, "accreditation teams are not required to assess insurance departments' use of many required legal or regulatory authorities."

3) The "review teams' documentation of their accreditation decisions did not consistently support their compliance decisions."[4]

Although the failure of regulatory agencies to comply with established formal rules is serious, it **is** not limited to state agencies. For example, GAO has on numerous *occasions* expressed similar concerns in connection with federal bank regulators. **Most** recently, GAO warned that national bank examiners were being asked to interpret national bank laws loosely to deemphasize current market conditions in evaluating real estate loans. In his recenl testimony before the House Committee on Banking, Finance, and Urban Affairs, Charles Bowsher, Comptrollei General of the United States, questioned the inconsistency between the actions **of** federal regulators and the recently passed bank reform legislation.[5]

In addition to the shortcomings noted by GAO, NAIC's accreditation program suffers from other problems in connection with the required model laws. For example, the model laws on reinsurance do not address many of the serious problems with reinsurance described in this report. Equally serious, as described in Chapter **3,** the required model law on holding company systems contains several loopholes that could allow a parent holding company to shift assets among its subsidiaries, obscuring the true net worth of insurer subsidiaries in a manner

similar to the abusive interaffiliate transactions that were implicated in the downfall of Baldwin-United and Executive Life of California. Moreover, NAIC's proposal for improving state guaranty funds does not address any of the market and regulatory disincentives in the current system. The latter issue is described in the following sections.

ANALYSIS OF PROPOSALS FOR IMPROVING STATE LIQUIDATION PROCEDURES AND GUARANTY FUNDS

State compliance with NAIC's accreditation process might soften some of the wasteful effects of state-by-state liquidation procedures and guaranty fund payments. For example, standard number 4 requires states to have a law authorizing the insurance department to order a company to take necessary corrective action or cease and desist certain hazardous practices. Standards 10, 12, and 13 compel states to prescribe minimum standards for the establishment of liabilities and reserves, require annual audits of domestic companies by independent certified public accountants, and require an actuarial opinion on the adequacy of reserves, respectively. Yet, as to guaranty funds, the NAIC program provides merely that state laws should provide for a statutory mechanism similar to NAIC's model law, which will ensure payment of policyholder obligations when a company is deemed insolvent. The standard does not designate the provisions of the model guaranty fund law that states must adopt in order to become accredited. Given the vague nature of the standards, even 100 percent compliance with NAIC's guidelines would not eliminate significant variances among state liquidation procedures and guaranty funds.

Moreover, NAIC's accreditation program does not address any of the following issues that impact state liquidation procedures and guaranty funds: reinsurance set offs, forum shopping, coverage of high net-worth insureds and products, and the market and regulatory disincentives in the current system of guaranty fund payments. The latter two issues could be addressed effectively by requiring all insurers to participate in a prefunded plan. Such a plan would alleviate concerns about the capacity of post-assessment guaranty funds to cover the increasing number of large insolvencies.

Prefunded State Guaranty Funds

Many commentators note that the exclusive reliance on post-assessment guaranty funds reduces market discipline and subsidizes the riskiest firms. Curiously, although several commentators have suggested plans for prefunded catastrophic guaranty funds, all such suggestions have been found wanting by the insurance industry. The proposals range from:

1) A state-chartered mutual reinsurance company from which all licensed insurers in a state must purchase insolvency reinsurance that would provide a backup fund to cover claims that exceeded a guaranty fund's assessment limit (Nationwide Insurance Company proposal);

2) A backup trust fund prefunded by policyholder surcharges (Hartford Insurance Company proposal);

3) A Solvency and Financial Enforcement Trust (SAFE-T) account held by an independent custodian (State Farm Insurance Companies proposal); and

4) A prefunded interstate compact.

Any of these proposals would help alleviate the guaranty fund capacity problem.

The first proposal has the added benefit of increasing insurer accountability by allowing for risk-based premiums. Although some insurers maintain that an equitable design of risk-based premiums would be nearly impossible to achieve and administer, others believe that it is possible to design such a system based on NAIC's forthcoming risk-based capital standard. In contrast, the second proposal would decrease insurer responsibility by shifting the funding to policyholders for both prefunded and post-assessment plans.

The third plan (the SAFE-T account) would require property-casualty insurers to maintain sufficient marketable securities to meet loss and loss adjustment reserves obligations determined at the end of the prior year. This plan would allow insurers to trade marketable securities in the account and to actively manage the portfolio. Withdrawals from the account would require prior approval of the insurance regulator, and insurers would be required to correct deficiencies in the account.[6] Moreover, by basing the amount of assets required to be held in a security account on the company's nationwide loss reserves, the plan mitigates some of the disincentives in the host-state concept. That is, under current state law, guaranty fund assessments are made in the states in which the policyholders of the insolvent company reside, even though these host states were not the primary regulators of the company. The host-state concept spares the domiciliary state from the full effect of the insolvency, reducing the domiciliary state's incentive to regulate effectively. The State Farm plan would moderate this effect. The fourth plan, an interstate compact, could be used to resolve many of the wasteful effects of state-by-state guaranty funds and could incorporate some of the best features of the other plans for prefunding.

Insurer objections to prefunded plans include the loss of tax offsets, fears that the funds accumulated would be appropriated by states for other purposes, and concerns that a preexisting fund would create an incentive for lax state regulation. The latter two fears do not appear to impose serious obstacles. Several proposals are designed to thwart state appropriation, and there is no reason to suspect that a prefunded plan contains any greater incentives for lax state regulation than does the present system. In fact, the primary impediments to the adoption of a prefunded plan appear to be the loss of premium tax credits and the loss of federal tax deductions for guaranty fund assessments.

As described in this report, the amount of these state and federal tax offsets is very significant. The loss of some tax offsets (only for the prefunded portion of guaranty fund

plans) should not deter states from implementing a prefunded catastrophic fund, however. The alternative to responsible state regulation is, ultimately, federal intervention and the virtual certainty of a federal prefunded plan. Under federal regulation, states would continue to collect their premium taxes, but likely would not offer insurers a premium tax offset for payments into a federal guaranty fund.

Because a prefunded guaranty fund plan (with or without risk-based premiums) would be effective only if a majority of states participated, such a plan may be implemented best through an interstate compact as described in the following chapter.

Notes

[1] American Council of Life Insurance, ***Status Report on Implementation of the Recommendations of the ACLI Task Force on Solvency Concerns,*** March **27, 1992.**

[2] U.S. General Accounting Office (GAO), ***Insurance Regulation: State Reinsurance Oversiglit Increased, but Problems Remain*** (Washington, DC, May **1990).**

[3] James Barrese, "Assessing the Financial Condition of Insurers," March **1990.**

[4] GAO, ***Insurance Regulation: The Financial Regulation Standards and Accreditation Program*** of ***the National Association*** of ***Insurance Commissioners*** (Washington, DC, April **9, 1992).**

[5] "Observations on the National Bank and Thrift Examiners' Conference," Statement of Charles **A.** Bowsher, Comptroller General of the United States before the U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs (Washington, D C U.S. General Accounting Office, January **3, 1992).**

[6] Philip **R.** O'Connor and Zack Stamp, ***The Next Step in State Solvency Regulation: The Solvency and Financial Enforcement Trust (SAFE-T) Account,*** June **1992.**

11

Cooperative State Regulation through an Interstate Compact

Two areas in which state regulation could be improved would be difficult to solve on an individual state basis: state regulation of insurance holding companies and state administration of insurer liquidations, including guaranty fund payments to policyholders and claimants. The problems could be handled by increasing either the power of the federal government or cooperation among states. Many commentators argue for the first solution, noting that the inability of states to regulate the interstate insurance market on their own compels the creation of a centralized federal agency with nationwide jurisdiction and broad preemptive powers.

Critics of centralization note that the current system of state regulation has by and large worked well, despite some recent large insolvencies. These critics cite the S&L debacle as a stunning example of the failures of centralization. In contrast to the losses from S&L failures, which current estimates place at from $200 billion to $500 billion without counting interest, losses in the insurance industry stand at less than **$15** billion during the past 10 years. On a more general level, opponents of centralization point to the need for strong, competent state governments in an increasingly complex regulatory environment and warn against turning states into "mere administrative divisions of the central government."[1]

This chapter examines cooperative administration of state liquidations and guaranty fund laws through the use of an interstate compact.

THE COMPACT CLAUSE

Article I, section 10 of the **U.S.** Constitution provides that "No state shall, without the consent of Congress. . . enter into agreement or compact with another state or with a foreign power. . . ." Little legislative history exists to explain which agreements or compacts require congressional consent or how the Congress would signify its consent if it were deemed necessary. In the years immediately following the adoption of the Constitution, states used interstate compacts primarily to settle boundary disputes. Between 1789 and 1900, states entered into 21 such compacts.[2] Typically, these boundary-dispute compacts involved only two states, and none of the early compacts created a permanent administrative agency.

In 1925, two influential legal scholars, Felix Frankfurter and James **M.** Landis, had published in the ***Yale Law Journal*** an article entitled "The Compact Clause—A Study in Interstate Adjustments," which urged the use of interstate compacts for purposes broader than boundary disputes. The authors noted that "the combined legislative powers of Congress and the several States [combined in compacts] permit a wide range of permutations and combinations for governmental action."[3] This article led other groups, such as the Chamber of Commerce of the United States, and the National Governors' Conference to advocate an expansive use of interstate compacts.[4]

As the use of interstate compacts became more commonplace, suits challenging this method of state cooperation increased. Many of the early suits involved interpretation of the phrase "agreements and compacts" and delineation of when congressional consent was needed. For example, in ***Holmes* v. *Jennison***,[5] the US. Supreme Court considered the validity of a Vermont law under which the governor sought to extradite an individual to Canada. Chief Justice Roger Taney found that the extradition statute was an unconstitutional "agreement or compact" with a foreign power. Later, the Court took a less absolutist view of the compact clause. In *Virginia* v. *Tennes-*

see,[6] the Supreme Court considered an agreement between Virginia and Tennessee that settled a boundary dispute between the two states. Justice Stephen J. Field, writing for the Court, adopted a less literal reading of the compact clause and declared that not all agreements between states were compacts within the meaning of Article 1, section 10. In *dicta,* the Court went on to note that express congressional consent was not always required, even when a true compact was involved. Instead, such consent could be inferred from subsequent congressional actions, in this case congressional assumption that the agreed-on boundary line was correct. The Court also announced the so-called "political balance" doctrine, declaring that congressional consent was required for interstate compacts only if they "increase[d] . . . the political power or influence of the states affected and thus encroached . . . upon the full and free exercise of Federal authority."[7]

Another important test of interstate compacts came in 1950 in the case of *West Virginia exrel. Dyer et al.* v. *Sirns."* *Dyer* v. *Sirns* arose out of the refusal by the West Virginia state auditor to pay the state's share of the expenses of a congressionally approved, eight-state compact to control pollution in the Ohio River system. The West Virginia Supreme Court had found that the state legislation, which delegated certain powers to an administrative agency created by the compact, was unlawful. On appeal, the U.S. Supreme Court held that a state may delegate the power to make rules and decide particular cases to an agency established by interstate compact as well as to a regular state agency. According to the Court, such a delegation is no more than a "conventional grant of legislative power.'* This case is also cited for the proposition that interstate compacts have "'super' status . . . in the hierarchy of the laws of the adopting state."" Once enacted as a valid compact, the agreement "cannot be amended, altered or repealed [by subsequent state legislation] except in accordance with the terms of the compact itself.""

The most recent Supreme Court decision construing the compact clause is a 1978 opinion upholding an interstate tax compact. One commentator has noted the close analogy between the compact upheld in *U.S. Steel* v. *Multistate Tax Commission* and proposed insurance regulation compacts.[12] U.S. Steel challenged the interstate tax compact, claiming that it was invalid because it had never received congressional approval. The compact consisted of a uniform law for apportioning the income of a multistate corporation, set up a commission to oversee the operation of that law, and provided for an audit staff to determine the tax liability of multistate corporate taxpayers. In upholding the compact, the Supreme Court elaborated on its earlier political balance doctrine by announcing a two-part test to determine when a compact must have congressional consent:

1. Does the compact authorize member states "to exercise any powers they could not exercise in its absence"?

2. Is there "any delegation of sovereign power to the Commission"?

If both of these questions are answered in the negative, the compact would not be deemed to require congressional consent. The Multistate Tax Compact met the tests because "on its face the Multistate Tax Compact contains no provisions that would enhance the political power of the member States in a way that encroaches upon the supremacy of the United States. . . . This pact does not purport to authorize the member States to exercise any powers they could not exercise in its absence. Nor is there any delegation of sovereign power to the Commission; each State retains complete freedom to adopt or reject the rules and regulations of the Commission. Moreover, . . . each State is free to withdraw at any time."[13]

A recent article published in the *Journal of Insurance Regulation* by James Jackson has sparked renewed interest in the use of the interstate compact for interstate insurance regulation. Jackson noted that an insurance regulatory compact that meets the dictates of the above two-part test would not need congressional consent, and that even if states were to delegate some "sovereign powers" to an administrative agency created by the compact, specific congressional consent may not be required. In the *McCarran-Ferguson Act,* the Congress declared that "the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that *silence* on the part of Congress *shall not* be construed to *impose any barrier* to the regulation or taxation of such business by the several States."[14] In addition to Jackson, other commentators have contended that the *McCarran-Ferguson Act* provides all the congressional consent necessary under the compact clause for the states to enter into cooperative agreements.[15]

STRENGTHS AND WEAKNESSES OF INTERSTATE COMPACTS AND CONDITIONS FOR SUCCESS

Over the years, several studies have looked at specific interstate compacts and analyzed their strengths and weaknesses. The authors of these studies have noted the following general and specific merits of the interstate compact:

1. Compacts permit the formulation of one pattern of law for a particular subject and bind the compacting states to the uniform law until changed by joint action.[16]

2. Compacts bridge jurisdictional gaps.

3. Compacts increase the capacity of the states to handle a larger share of the total task of government.[17]

4. Compacts strengthen the states and reduce expansion of power and scope of jurisdiction of the national government.'"

In contrast, critics of the interstate compact cite the following weaknesses:

1. The agencies created by compact are undemocratic and unrepresentative. This problem is made more serious by the fact that the agencies tend to be dominated by their staff.[19]

2. The compact device has been used by private enterprise groups to prevent regulations that they perceive as inimical to their interests. Thus, while the compacts ostensibly protect the authority of the states over the activities of such private enterprise groups, actual power tends to remain in the hands of private interests.[20]

3. Compacts seldom contain mechanisms for independent evaluation or audit to measure whether the administrative agency created by the compact is doing a good job.[21]

4. Compacts are difficult to amend and therefore tend to be overly rigid.[22]

Successful compacts (i.e., those that have made significant contributions to the solution of the problems they were designed to meet) are said to have the following common characteristics:

1. The compact and its administrative agency were created in the realization that the only way to handle the issues in question was to establish a compact agency to do the job.[23]

2. The compact agency was not assigned powers that threatened existing powers within the states.

3. The compact received support from various other agencies, including federal agencies.

4. The compact agency's actions were limited to those areas in which the states are individually ineffectual.[24]

THE NCOIL PROPOSAL

In November 1992, the National Conference of Insurance Legislators (NCOIL) issued its third "exposure draft" of an Interstate Insurance Protection Compact. NCOIL believes that an interstate compact would bring greater uniformity in state solvency and guaranty fund laws, thereby deflecting congressional moves for federal intervention. As envisioned by NCOIL, the compact would not require congressional consent prior to becoming effective. The compact would operate through a regulatory commission comprised of the commissioners of the compacting states (one member per state). Although created for the limited purposes of enhancing state systems for liquidating insolvent insurance companies, paying claims, and establishing uniform operating procedures for guaranty associations, the commission actually would have broad powers to:

1. Promulgate statutes and regulations relating to guaranty associations and the conservation, rehabilitation, and liquidation of insurers;

2. Act as receiver of insolvent insurers;

3. Oversee and coordinate the activities and functions of the insurance guaranty associations; and

4. Establish minimum standards for the regulation of the financial condition of insurers.

The compact classifies states as either "high premium states" (the compacting states that comprise the 30 percent of the compacting states with the greatest insurance volume), "low premium states" (the compacting states that comprise the 30 percent of compacting states with the least insurance premium volume), or "median premium states" (those compacting states that are not either high- or low-premium states). Each compacting state would be allowed one so-called member vote and an additional so-called premium vote based on its premium volume. Commission acts would become law only after an affirmative vote of a majority of both the member votes and the premium votes. Laws adopted by the commission would become binding on the compacting states at the earlier of (1) approval by a majority of the compacting states or (2) at the end of the second full legislative session of all of the compacting states. A compacting state could, however, enact legislation specifically rejecting the commission law. In that case, the commission law would not become binding on the rejecting compacting state(s).[25]

An executive committee, elected by and from the commission, would manage the affairs of the commission, oversee and evaluate the implementation and administration of commission acts, and recommend laws. The compact would be financed by commission assessments on each insurer authorized to do insurance business in a compacting state. States could withdraw from the compact by enacting a statute specifically repealing the statute by which it entered the compact into law.

Although many of the details of the compact are sketchy, having been delegated to the commission, a preliminary assessment is possible. First, although the compact gives the commission and a majority of states power to adopt binding legislation, it would allow single states to opt out of any such "binding" law. This provision may undercut the effectiveness of the compact. Second, the compact fails to distinguish between those situations in which uniformity is essential and those in which state law variances would not decrease the efficiency of liquidation procedures and guaranty fund payments. For example, some states may decide to limit guaranty fund coverage (e.g., by dollar amount and/or by a net worth test) in order to reduce the expense to their taxpayers and policyholders who ultimately bear the burden of guaranty fund payments. For similar reasons, other states may decide to limit reinsurance set offs, rescissions, and cut-through clauses in liquidations.

Third, the draft compact fails to provide for public accountability. Although the draft calls for an independent audit of the commission's functions as receiver, it requires that the auditor's report be kept from public view. Moreover, the compact makes no provisions for any public report of the activities of the commission, public access to commission data on liquidations and guaranty fund payments, or for formalized public input into commission projects. Finally, the draft contains no incentives to encourage states to join. Thus, the compact as currently drafted would appear to have some significant defects

when measured under the criteria set forth above.

Some changes that might increase the viability and accountability of the compact would include:

1. A mechanism to distinguish between those situations in which uniformity is essential and those in which state law variances would not decrease the efficiency of liquidations and guaranty fund payments;

2. The addition of guidelines for evaluating commission activities, an independent and publicly available audit of the commission's activities, and a requirement that the commission issue an annual report of its activities to state legislatures;

3. The inclusion of public representation in commission activities; and

4. The addition of an incentive to encourage states to join.[26]

One incentive that would benefit states and insurance companies would be to link NAIC's accreditation program with the compact and to allow accredited state insurance departments in compact states to do business in other accredited compact states with a single license from the domiciliary state. The use of a single license need not eliminate the ability of host states to regulate nondomiciliary insurers.

For example, the European Community provides for such a single license issued by the domiciliary country for banks operating in EC countries, while retaining certain regulatory oversight by the host country. The Second Banking Directive of the European Community prohibits a host member state from requiring an EC-licensed bank to enter its market through a separately capitalized subsidiary, but it does not ban the host state from regulating some aspects of branch activities. In particular, the host state may adopt legal rules "in the interest of the general good." The process to establish a branch within a host member state is as follows:

1. The bank that wishes to establish a branch within the territory of another member state must notify the proper authorities of its home member state and provide certain information, including the types of business envisaged and the structural organization of the branch, the address in the host member state from which documents may be obtained, and the names of the persons responsible for the management of the branch.

2. The authorities of the home member state must communicate the above information to the authorities of the host member state.

3. The host member state then indicates the conditions under which, in the interest of the general good, the branch activities may be carried on.

After the branch has been established, the host member state may require that it (along with all domestic banks) provide periodic reports on its activities and such other information as is required of domestic institutions. If the branch does not comply with the laws that the host member state has adopted "in the interest of the general good," the host member state first reports the violation to the home-state authorities, which must take "all appropriate measures" to ensure that the institution concerned ceases the offending conduct. Continuing noncompliance may lead to the host member state itself punishing the branch, including preventing the institution from initiating any further transactions within its territory.

Similar rules could be adopted for accredited states in an interstate compact. If the use of a single license is deemed too radical a departure from current practice, compact states could agree to an accelerated licensing procedure.

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[1] The phrase is from Felix Frankfurter and James M. Landis, "The Compact Clause of the Constitution — A Study in Interstate Adjustments," *Yale Law Journal* 34 (1925): 685, 687.

[2] Richard H. Leach and Redding S. Sugg, Jr., *"'lieAdministration of Interstate Compacts* (Baton Rouge: Louisiana State University Press, 1959), p. 5.

[3] Frankfurter and Landis, "The Compact Clause of the Constitution — A Study in Interstate Adjustments," pp. 685,688.

[4] Leach and Sugg, *The Administration of Interstate Compacts,* p. 10.

[5] 39 U.S. 540 (1840).

[6] 148 U.S. 503 (1893).

[7] 148 U.S. 503, 520 (1893).

[8] 341 U.S. 22 (1951).

[9] 341 U.S. 31.

[10] See, e.g., James M. Jackson, "Commerce, Compacts and Congressional Consent: Federalism and State Insurance Regulation," *Journal of Insurance Regulation* 10(1991): 23; and Dyer v. Sims, 341 U.S. at 28.

[11] Jackson, "Commerce, Compacts and Congressional Consent," p. 6.

[12] Ibid.

[13] 434 U.S. 452, 472-473 (1978).

[14] Jackson, "Commerce, Compacts and Congressional Consent."

[15] See Frederick L. Zimmerman, *The Interstate Compact* (Chicago: Council of State Governments, 1951), p. 70.

[16] Ibid.

[17] Leach and Sugg, *The Administration of Interstate Compacts,* p. 225.

[18] Weldon V. Barton, *Interstate Compacts in the Political Process* (Chapel Hill: University of North Carolina Press, 1965), p. 165.

[19] Leach and Sugg, *The Administration of Interstate Compacts,* p. 222. The National Conference of Insurance Legislators notes that this criticism could be made of any agency. Phone conversation with New York State Sen. Donald M. Halperin, August 18, 1992.

[20] Barton, *Interstate Compacts in the Political Process,* p. 164.

[21] Marian E. Ridgeway, *Interstate Compacts, A Question of Federalism* (Carbondale, Illinois: Southern Illinois University Press, 1971), p. 295.

[22] The National Conference of Insurance Legislators believes that they have solved this problem by keeping their draft inter-

state compact general. Phone conversation with New York State Sen. Donald M. Halperin, August **18, 1992.**

[23] Leach and Sugg, ***The Administration of Interstate Compacts,*** p. **213-214.**

[24] Ibid., p. **221.**

[25] The National Conference **of** Insurance Legislators notes that compact laws are not "statutes." That **is,** a governor's signature is not required.

[26] The National Conference of Insurance Legislators believes that the fact that states will be relieved of the headache of setting up liquidation and guaranty fund procedures will be a significant incentive, particularly for small states. Further NCOIL believes that the existence of the compact may cause the federal government to retreat from preemption legislation, at least for compact states. Phone conversation with New York State Sen. Donald Halperin, August **18, 1992.**

12

Proposals for Federal Oversight/Regulation

Since the mid-1800s, insurers have frequently argued for federal rather than state regulation of the industry. Bills were introduced in the Congress in 1866 and 1868 to create a national bureau of insurance, in 1869 to create the position of national commissioner of insurance, and in 1897 to declare that insurance companies doing business outside their state of incorporation were engaged in interstate commerce.' None of the bills passed, and two were never reported out of committee. These and later bills failed primarily because the Congress concluded that, given the ruling of the Supreme Court in *Paul* v. *Virginia* that insurance was not interstate commerce, it did not have the power to regulate insurance.

By 1944, when the Supreme Court changed its interpretation and acknowledged that insurance was interstate commerce, the New Deal had ushered in an era of federal activism leading the industry to favor state over federal regulation. Fearing that federal regulation would result in a loss of state premium tax revenue, states joined with the industry to lobby Congress to pass the *McCarran-Ferguson Act,* which allowed states to maintain exclusive regulatory control over insurance.

At various times since 1944, insurers have renewed their efforts to encourage Congress to enact a federal insurance regulatory scheme. The recent spate of large insurer insolvencies has led some insurers to seek federal regulation again. This chapter examines some of the current proposals, including one in the form of a report by a consulting firm, another in the form of a bill introduced in 1991 by U.S. Sen. Howard M. Metzenbaum, and a third in the form of a bill introduced by U.S. Rep. John D. Dingell. It is unlikely that Congress could preempt state authority over insurance companies that operate in only one state. Therefore, all of these proposals for federal regulation would involve a dual regulatory scheme, whereby states would regulate local insurance companies and, in some cases, the local aspects of interstate insurers (such as consumer protection laws), while the federal government would regulate the interstate activities of multistate insurers.

THE STEWART ECONOMICS PROPOSAL

In 1990, Stewart Economics issued a report describing a national system of liquidation and guarantees for property-casualty companies.' The Stewart proposal would require Congress to create a National Insurance Guaranty Corporation (NIGC). NIGC would not be a regulatory agency; its only function would be to act as rehabilitator or liquidator of companies placed in receivership by state regulators. Like current state practice, NIGC would be funded by assessments on insurance companies, but, unlike current practice, some of those assessments would be made as advance fees and used to pay for the initial operating costs in rehabilitating and liquidating companies. Membership in NIGC would be voluntary, unless mandated by states as a condition of licensure. States would not be required to turn over their insolvent member insurers to NIGC, but NIGC guarantees would only be available in liquidations conducted by NIGC. States would retain exclusive responsibility for market and solvency regulation.

The proposal suggests several incentives to encourage insurers, states, and policyholders to safeguard the financial solvency of insurers. For example, the prefunded portion of the national fund could be assessed according to the quality of insurer assets. *Also,* NIGC would have a financial analysis staff that could request a special state examination of a particular company and also have the ability to withdraw fund coverage from states that fail to take action against troubled companies.

Other incentives would encourage agents and brokers and reinsurers to be more watchful of the financial health of insurers. In the former case, agents and brokers would be given lower guaranty fund payment priority for unpaid commissions; in the latter case, reinsurers would not be permitted to offset the premiums owed them by an

insolvent ceding company against the reinsurance they owe it on losses.

The Stewart proposal has much to recommend it. For example, the plan's incentives to encourage agents, brokers, and reinsurers to watch over the financial health of insurers and to reduce the liabilities of guaranty funds are crucial ingredients to the financial health of insurers. Yet, the proposal falls short in that it fails to address the real problems that states have in regulating multistate insurers. Moreover, by divorcing the regulatory function from the liquidation and guaranty fund function and by turning over governance to the industry, the proposal sets up a very unstable situation.

It is unlikely that a national guaranty fund would continue to cover a state with strict rate regulation. Rate regulation is a sensitive issue for insurers, who maintain that it either doesn't work (i.e., studies show that rates in unregulated states are very close to those in regulated states) or that it works to keep rates artificially low (removing the flexibility of insurers to change rates with changed conditions at best and playing a role in insurer insolvencies at worst). Some consumer groups disagree, contending that rate regulation is important as long as insurers remain exempt from antitrust laws. A large state like California that regulates rates is unlikely to choose to join a national guaranty fund that is governed by insurers. Other states that do not regulate rates would likely be unwilling to give up their authority to monitor rates and intervene if they deemed it necessary. States that fall in either of these two categories would therefore likely maintain their state liquidation staff and guaranty fund provisions.

S. 1644: PROPOSAL OF SENATOR METZENBAUM

In August **1991,** Senator Metzenbaum introduced **S. 1644,** known as the "Insurance Protection Act of **1991."** The bill would create a federal insurance regulatory commission made up of five members appointed by the President. The commission would have authority to certify state insurance departments. Without such federal certification, a state could not issue a license to engage in insurance in interstate commerce. In order to become certified or accredited, a state insurance department would have to adopt certain uniform minimum federal standards in several areas, including the following: capital and surplus, accounting practices and procedures, investment regulations, liabilities and reserves, independent CPA audits, qualified actuarial analysis, restrictions ownership and transfer of owners of insurers, restrictions on transfer of policies, consumer disclosure, consumer protection, and maintenance of adequate resources by state departments of insurance, such.as a federally mandated minimum number of examiners and actuaries.

The commission would periodically examine state insurance departments to assure their enforcement of and compliance with the federal standards. States that failed to comply could lose their accreditation, forcing insurers in the state to lose their licenses to do business in interstate commerce.

In addition to the insurance regulatory commission, the Metzenbaum bill would create several new entities. A national guaranty fund would cover all insurers operating in interstate commerce. The cost of the guaranty program would be funded by pre-insolvency assessments against member companies. A national guaranty corporation would serve as the exclusive liquidator for insurers operating in interstate commerce. The bill would also create an Office of Reinsurance Regulation, which would grant or revoke licenses to reinsurers, and a Securities Valuation Office, which would value and establish quality ratings for insurer assets. Finally, the bill would create a central depository for insurance data for the purpose of studying the insurance industry.

Like the proposal by Stewart Economics, the Metzenbaum proposal has much to recommend it. In particular, the plan to conduct studies of the insurance industry, to make reports to the public, and to make annual and special reports to Congress has merit. It is hard to overstate the value of ongoing federal studies of pertinent insurance regulatory issues. Both the history of state insurance regulation and the recent flurry of activity with NAIC's accreditation program show that states cooperate to strengthen solvency regulation when pressured by the threat of federal preemption.

Other provisions may be less sound. For example, the provisions for extensive federal control of state-funded insurance departments is unprecedented in state-federal relations.

H.R. 4900: PROPOSAL OF REPRESENTATIVE DINGELL

On April **9,1992,** Representative Dingell introduced H.R. **4900,** a bill to "ensure the financial soundness and solvency of insurers." H.R. 4900 would establish an independent federal regulatory agency, the Federal Insurance Solvency Commission (the commission), made up of five members appointed by the President. The commission's duties would include establishing standards to ensure the solvency of insurers and reinsurers "in or affecting interstate or foreign commerce" and issuing federal certificates of solvency for those insurers that choose federal regulation.

A domestic insurer choosing federal regulation would be required to meet certain federal standards, including the following:

1. Minimum capital and surplus (the minimum may not exceed $500,000);
2. Appropriate standards for investments, reserves, and asset valuations;
3. Limitations on the use of and credit for reinsurance;
4. Requirements governing transactions with managing general agents;
5. Limitations on the amount of risk that may be retained on a single risk;
6. Accounting standards that would promote strong and appropriate financial monitoring of insurers;
7. Annual examinations by independent accountants;

8. Certification of loss reserves by certified actuaries; and

9. Regulation of financial transactions within holding company systems.

H.R. 4900 would establish separate standards for foreign insurers (insurers domiciled outside the United States).

Aside from listing the areas in which federally certified insurers would have to comply with federal requirements, the bill does not describe the content of the standards, leaving that duty to the commission. Because the mandated standards are vague, it is not possible to compare the federal regulatory system proposed in H.R. 4900 to the current state system. The standards in H.R. 4900 appear to be similar to the accreditation standards of the National Association of Insurance Commissioners (NAIC), however. Thus, a federal system operated by the federal government would appear to have an advantage over the existing state system only in those areas in which legislatively mandated uniformity and centralization are essential. In such areas, the needed uniformity and centralization could be achieved either through federal regulation or through an interstate compact.

Federally certified insurers designated "highly capitalized" by the commission that provide commercial insurance for a "large insurance buyer" would be exempt from all state regulation, including state laws governing unfair trade and claims practices. Because the bill would not create federal unfair claims standards, third-party claimants injured by the actions of a large commercial insurance buyer may have no avenue for redress through either a state or federal regulatory system. Other federally certified insurers would continue to be subject to state laws regulating

- Rates and policy forms;
- Unfair insurance trade practices or unfair claims settlement practices;
- Participation in an assigned risk plan or joint underwriting association;
- Filing copies of annual and quarterly financial statements;
- Payment of state premium and income taxes;
- Incorporation, organization, and corporate governance of insurance companies; and
- Registration with and designation of the state insurance regulator as its agent for service of process.

Yet, because H.R. 4900 would give the commission broad authority to preempt all state laws, the ability of states to enforce the above laws is problematic. Sections 102(7) and 206(c)(1) would grant the commission authority to determine whether a state law is preempted under the act. For example, section 206(b)(6) would authorize the commission to preempt a state law if it finds that the law would place an insurer in an unsafe or unsound financial condition. If it is unclear whether a particular state law falls within the 206(b)(6) category, the commission could issue a regulation defining the state law as one preempted by the act.

Insurers often argue that state rate regulation, a power ostensibly retained by the states under the Dingell bill, places them in an unsafe and unsound financial condition. Although some consumer groups disagree, sections 206(c)(1) and 206(b)(6) would allow the commission to eliminate state rate regulation for a federally certified insurer if the commission found that state rate regulation was detrimental to the financial condition of an insurer. In effect, these sections would give the commission power to eliminate all state rate regulation because states are unlikely to subject state-licensed insurers to rate regulation when one or more federally certified insurers are exempt.

Insurers that are part of a holding company system would be subject to dual regulation. Transactions within a holding company system that includes a federally certified insurer or reinsurer would be subject to federal requirements. Section 406 would require that such transactions be "fair and reasonable," and certain transactions involving 5 percent or more of the assets of the insurer or reinsurer would require prior approval. If the holding company system included one or more insurers that are not federally certified, the insurance commissioner of the domiciliary state could also prohibit or approve, subject to conditions, any acquisition, merger, or other transaction as provided under state law.

As to the regulation of reinsurers, the commission would have the sole power to regulate so-called professional reinsurers.) Other providers of reinsurance could apply for a federal certificate if they met certain conditions, including a minimum net-worth requirement and the establishment of a trust fund. Although one section of the bill would allow states to continue to license reinsurers other than professional reinsurers, all reinsurers would have to obey federal standards because another section would permit primary insurers to receive credit for reinsurance only if they contract with reinsurers that have a federal certificate.

In addition to the commission, H.R. 4900 would establish two private, nonprofit industry entities, the National Insurance Protection Corporation (NIPC) and the National Association of Registered Agents and Brokers (NARAB). NIPC would guarantee property-casualty (personal and commercial), life and health, and annuity insurance claims in the event of an insolvency. Claims made against certain lines of insurance, such as title insurance and surplus lines insurance, would not be guaranteed. Other limitations would cap coverage for high interest-rate life policies and annuity contracts and prohibit coverage for unallocated annuities protected under other federal programs.

The priority scheme for distribution of assets from the insolvent insurer's estate would place reinsurers claims for unpaid premiums (set offs) ahead of policyholders. Membership in NIPC would be mandatory for all federally certified insurers and voluntary for other insurers. Subject to supervision of the commission, NIPC would be prefunded by assessments on members based on their net direct written premiums.

NARAB would be authorized to regulate insurance agents and brokers. Membership in NARAB would be voluntary and would not be limited to agents and brokers engaged in interstate business. Although section 616(a) states that "all State laws, regulations, provisions, or actions purporting to regulate insurance producers shall remain in full force and effect," members of NARAB would not in fact be subject to most state laws. Section 616(b) would preempt all state laws that impose requirements on members of NARAB that differ from the uniform provisions issued by NARAB. Moreover, section 616(c) would give NARAB itself the power to preempt state laws, subject to commission review.

Like other proposed federal solutions, the Dingell bill would subject alien reinsurers to federal regulation and would set up a process for ongoing federal research on matters "that may affect the financial condition and solvency of the insurance industry in the United States." Other aspects of H.R. 4900 may create an unstable regulatory regime. For example, the system of dual regulation of insurers and reinsurers that are members of a holding company could lead to a situation in which the federal commission and one or more state regulators disagree on the permissibility of a particular merger, with the insurer caught in the middle. Moreover, the provisions for continued state regulation of rates may fall as insurers argue that state rate regulation conflicts with the commission's duty to ensure the financial health of the industry. Finally, the broad preemption authority that H.R. 4900 would grant the commission and the private industry entities created by the bill could render continued state regulation illusory.

SUMMARY: STATE v. FEDERAL REGULATION OF INSURANCE

The recent savings and loan crisis and continuing rash of bank failures serve as powerful reminders that federal oversight cannot eliminate or even moderate industry failures, whether those failures result from insufficient regulatory resources, lack of regulatory will, industry manipulation of the political process, or fraud. All were present in the recent crises in our depository institutions. For example, congressional action raising the ceiling on deposit insurance from $40,000 to $100,000 per account in 1980 is frequently cited as a significant contributing factor in the savings and loan scandals. Stories of intervention into the regulatory process by members of Congress in order to procure forbearance for favored constituents, thereby increasing the ultimate cost of insolvencies to taxpayers, have been front-page news for several years. Despite tough federal antifraud statutes and well trained federal examiners, fraud played a major role in the downfall of several savings and loan institutions. Critics, including the U.S. General Accounting Office (GAO), have warned that recent efforts by the administration to weaken bank legislation passed by Congress could lead to more bank failures.

If, as recent events illustrate, federal solvency regulation is *not intrinsically* superior to state solvency regulation, then the choice among the three regulatory systems—state, federal, or dual statelfederal—should be made by first identifying the specific regulatory successes and failures of the current system and, second, analyzing regulatory options for resolving the failures.

This report has described 18 weaknesses in the system of state regulation of insurance. Many of those weaknesses can be addressed adequately by individual state action. Indeed, several states have adopted model legislation and/or regulations issued by the National Association of Insurance Commissioners to resolve the weaknesses. The resolution of other problems in the current system may require collective state action. Effective regulation of insurance holding companies, uniform procedures for insurer liquidations and a uniform guaranty fund system fall into the latter category.

All current proposals for federal regulation of insurance advance a dual system of regulation, whereby both state and federal governments play an active role. None of the proposals provides for a true statelfederal partnership, however. In fact, a true state/federal partnership may be difficult to achieve with insurance regulation because solvency regulation (an area that some believe should be supervised by the federal government) is so intimately related to rate regulation (an area that is intrinsically local). Of course, the Congress could preempt all state rate regulation, but such an action would nullify the states' role in a dual regulatory scheme.[4]

As part of their desire to maintain authority over insurance regulation, states must not only coordinate and strengthen their laws but also adopt policies to ensure that regulators avoid the appearance of impropriety in their dealings with industry representatives. A recent article in the *Washington* Post described the "tradition" of NAIC meeting host states to solicit funds from the industry for the purpose of providing entertainment and conference receptions and dinners.[5]

Other conference traditions include the distribution of gifts to commissioners and hospitality suites in the conference hotel. Official NAIC policy regarding the propriety of such industry involvement in meetings has evolved over the years. Recently, the organization has taken several steps to assure that the level of industry participation is appropriate. For example, in response to concern expressed by some interested consumer groups that the cost of travel to NAIC meetings was too great for some consumer organizations to bear, NAIC established a unique fund to underwrite the travel expenses of consumer representatives. In addition, NAIC members voted recently to have the commissioners' dinner (held at each NAIC meeting) paid for by NAIC rather than by the industry.

State policies regarding the acceptance of such gifts range from no policy to a requirement that all gifts received from the regulated industry be disclosed to a designated state official (the so-called legislative model) to a prohibition against acceptance of gifts and benefits. The official policy of the Texas Department of Insurance is an example of the latter. The policy prohibits the commissioner, state board of insurance officials, and employees from "accepting any benefit, gift, traditional holiday gifts

and foods, favor, service, or operations or activities that are provided to, or regulated by, the agency." In connection with NAIC meetings, this policy requires Texas regulators to pay their own way to special events, receptions, and hospitality suites sponsored by industry groups, pay for their meals unless included in the registration fee, and decline to attend industry-sponsored meals. Texas Insurance Board member Allene Evans believes that regulators have no business accepting gifts from industry representatives. According to Ms. Evans, the Texas ethical guidelines, along with an open door policy, strikes the proper balance by ensuring that industry representatives gave input into regulatory policy but in a business rather than a social setting. Ms. Evans believes that NAIC could eliminate the appearance of impropriety at its meetings by refusing to sanction industry cash donations, receptions, and dinners, as well as by discouraging sponsorship of unofficial events and gift giving.[6]

Although federal intervention into insurance regulation may be premature, Congress should continue to play a role in state regulation of insurance. Many of the most important reforms instituted by the states were a direct result of congressional investigations, which exposed state regulatory deficiencies. Over the years, federal oversight, in the form of periodic congressional investigations and agency studies, has proved to be an effective stimulus to state action.

CONCLUSION

It is commonly presumed that decisions involving economic regulation (such as the decision whether to regulate insurance rates) should be vested in the political jurisdiction whose constituents directly reap the benefits and bear the costs of those decisions. The presumption suggests that regulatory authority over insurance should remain in state hands. The results of a recent ACIR Gallup Poll of public opinion indicate that there is significant public support for this proposition. When asked whether the federal government or each state government should regulate companies that sell life, fire, property, casualty, and automobile insurance, 51 percent voted for state regulation and 37.4 percent favored federal regulation.' Recently, however, calls for federal intervention in insurance regulation have increased dramatically. Those urging federal regulation cite the growing number and size of insolvencies as evidence of the inability of states to regulate the interstate and international aspects of insurance. Thus, the continuing role of states as sole regulators of property-casualty and life insurance is in doubt today.

This report has described the system of state regulation and identified areas for improvement. Most of the weaknesses identified could be resolved by the states. Indeed, some states have adopted effective corrective measures. Two of those weaknesses may require federal intervention, however, and four may require coordinated state action. Congress could strengthen state regulation by passing legislation exempting state insurance liquidations from the effects of the federal priority and federal arbitration statutes. These two federal statutes sharply curtail the ability of state liquidators to collect and distribute assets of the insolvent insurer's estate in an orderly manner.

The four areas that would benefit from coordinated state action are (1) the regulation of insurance holding company systems, (2) the need for uniformity in state liquidation procedures, (3) the need to coordinate the administration of state guaranty fund programs, and (4) the need to impose market discipline on those programs through prefunding and coverage limitations.

Both the states and the federal government have proposed solutions to the current regulatory problems. NAIC has recently established a program to accredit state insurance departments that have adopted certain model solvency-related laws and to establish through this program a nationwide system of regulation. To date, 13 states have become accredited. The recent actions of NAIC to strengthen state insurance regulation and the responsiveness of many state legislatures are impressive. Yet, the accreditation program may not be sufficient to resolve the serious problems in the areas in which coordinated state action is essential—holding company regulation, liquidation procedures, and guaranty fund laws.

Although several proposals for a federal system of regulation exist, none of them appears likely to become law in the near future. Estimates of the cost of the recent S&L crisis range from over $200 billion to $500 billion, without counting interest. These figures and the recent rash of bank failures are sober reminders that federal regulation is not a panacea for the problems in the regulation of financial industries. In fact, many of the more serious problems that GAO has identified in connection with state regulation apply also to federal regulation. In particular, GAO has criticized the failure of federal bank regulators to comply with existing statutes and regulations. Moreover, the states and NAIC have extensive experience in regulating insurance. Many of the current federal proposals recognize that experience by either providing for retention of state regulation (with the addition of federal mandates and oversight) or adopting NAIC's accreditation standards.

In their current form, neither the bill introduced by Senator Metzenbaum nor the bill introduced by Representative Dingell provides for a real federal-state partnership. The Metzenbaum bill would transform state regulators into administrators of a federal program. The Dingell bill would appear to allow states to continue to regulate some aspects of insurance, but the broad preemption power granted the federal agency and private industry entities may signal the end of state regulation.

A promising proposal for strengthening administration of state liquidation and guaranty fund procedures is the interstate compact. Through a compact administered by a commission with limited rulemaking authority delegated to it by state legislatures, states could centralize the liquidation of insolvent insurers and guaranty funds. In order to ensure its success, such a compact should provide for accountability through an independent audit of the commission's activities and contain incentives to encourage participation. A legislature-based compact would be in a position to work with and exploit the wealth of experience possessed by NAIC.

The use of a compact would have another important benefit. During the 1970s and 1980s, the prior bright lines

separating insurance from banking and from securities activities began to blur. The distinctions among these financial industries will almost certainly continue to blur in the foreseeable future. A realistic assessment of state-federal relations would compel the conclusion that federal regulators faced with regulating the interstate and international aspects of the financial industries will preempt state regulation of insurance rather than attempt to deal with 51 different insurance regulators and regulatory systems. But if states can put in place a structure for coordinated regulation of some of the interstate aspects of insurance, they will have the ability to enter into a regulatory partnership with the federal government, rather than becoming mere administrative divisions of the central government.

The history of state regulation of insurance demonstrates that states have strengthened and coordinated their regulatory procedures when forced to do so during periods of congressional activity, such as federal investigations and threats of preemption. The other side of the coin is, of course, the tendency for states to relax their efforts at coordination when the congressional spotlight shines elsewhere. Given this history, it may be time to authorize a federal agency to conduct research and issue studies of the property-casualty and life insurance industries to ensure continual federal scrutiny of state regulatory efforts.

Some examples of studies that could increase the effectiveness of state insurance regulation include: the size and effect of reinsurance offsets on state tax revenues and insurer solvency, a state-by-state examination of the percentage of policyholders that reside in the state of domicile of their insurers, the effect of guaranty fund assessments on state tax revenues, the effect of the federal priority statute on the capacity of state guaranty funds, analyses of workplace and product safety, and analyses of highway safety issues. In conducting insurance studies, a federal agency could review trends that are wider than single states.

Notes

[1] A complete list of the bills is set forth in U.S. v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 592, n. 15.

[2] Stewart Economics, Inc., *Insurance Insolvency Guarantees* (Chapel Hill, North Carolina, 1990).

[3] A company is classified as "professional" if the majority of its business is reinsurance.

[4] Few states actually regulate insurance rates today, but most states have laws granting them the power to do so. The history of state insurance regulation shows that states have alternately favored/disfavored rate setting as a regulatory tool.

[5] Thomas Heath and Albert B. Crenshaw, "Insurance Firms Pick Up Tab for Regulators' Events, *Washington Post,* December 14, 1992.

[6] Phone interview with Allene, member, Texas Insurance Board, December 15, 1992.

[7] U.S. Advisory Commission on Intergovernmental Relations, *Changing Public Attitudes on Governments and Tares 1992* (Washington, DC, 1992). The question posed was: "Should the federal government regulate companies that sell life, fire, property, casualty, and automobile insurance throughout the country, or should each state government regulate the companies that sell these types of insurance in its state?"

Appendix A

State Requirements: Minimum Capital and Surplus Required of Insurers

National Association of Insurance Commissioners
September 17,1992
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ALABAMA §§ 27-3-7 to 27-3-9

		Capital	Surplus
1.	Life	800,000	150%/ 100%
2.	Disability	500,000	150%/ 100%
3.	Life and Disability	800,000	150%/ 100%
4.	New Domestic Stock Life Insurers	1,000,000	1,000,000
5.	Property	300,000	150%/ 100%
6.	Casualty	400,000	150%/ 100%
7.	Marine	300,000	150%/ 100%
8.	Surety	350,000	150%/ 100%
9.	Title	200,000	150%/ 100%
10.	Multiple Lines	500,000	150%/ 100%

Alabama has a 5 year seasoning requirement; if an insurer has not transacted business for 5 years, then is required to maintain surplus of 150% of capital; otherwise, 100% of capital is to be maintained as surplus.

ALASKA §§ 21.09.270, 27.09.080

		Basic Capital or Basic Guarantee Surplus	Add'l Surplus When First Authorized	Additional Maintained Surplus
1.	Life	1,000,000	1,000,000	750,000
2.	Disability	1,000,000	1,000,000	750,000
3.	Life and Disability	1,250,000	1,250,000	1,000,000
4.	Property	1,000,000	1,000,000	750,000
5.	Casualty, excluding vehicle	1,000,000	1,000,000	750,000
6.	Marine and Transportation	1,000,000	1,000,000	750,000
7.	Surety	1,000,000	1,000,000	750,000
8.	Title	500,000	500,000	250,000
9.	Vehicle	1,000,000	1,000,000	750,000
10.	Any three or more of numbers 2, 4-7, and 9	3,000,000	3,000,000	2,250,000
11.	Legal Expenses	1,000,000	1,000,000	750,000
12.	Mortgage Guarantee	1,000,000	1,000,000	750,000

ARIZONA §§ 20-210 to 20-212

		Capital	Surplus
1.	Life+	300,000	150,000
2.	Disability	300,000	150,000
3.	Life and Disability+	400,000	200,000
4.	Property	600,000	300,000
5.	Casualty	600,000	300,000
6.	Marine and Transportation	600,000	300,000
7.	Surety	1,000,000	500,000
8.	Title*+	500,000	250,000
9.	Vehicle	600,000	300,000
10.	Multiple Lines (any two or more numbers 4 through 7	1,000,000	*500,000*

* Does not apply to mutual insurers + Does not apply to reciprocal insurers
Director may require additional capital based on type, volume and nature of business conducted.

Except for life and disability combination and title, any insurer may be authorized to transact lawful combination with additional capital of $200,000 per kind over the largest amount required.

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ARKANSAS §§ 23-63-205, 23-63-207

		Capital	Surplus
1.	Life	500,000	500,000
2.	Disability	500,000	500,000
3.	Life and Disability	500,000	500,000
4.	Property	250,000	250,000
5.	Casualty	500,000	500,000
6.	Surety	500,000	500,000
7.	Marine	250,000	250,000
8.	Title	100,000	100,000
9.	Title and Abstractor's Professional Liability	125,000	125,000
10.	Property, Casualty & Marine	750,000	750,000
11.	Multiple Lines	sum of the minimum as set forth	sum of the minimum as set forth

Commissioner may require insurer to possess and maintain additional capital and surplus in addition to that required above based on the types, volume or nature of the business transacted by the insurer.

CALIFORNIA §§ 700.01 to 700.05, 10510, 15011, 12359

		Capital	Surplus
1.	Life	2,250,000	100% of capital
2.	Life and Disability	2,500,000	100% of capital
3.	Title	250,000	100% of capital
4.	Fire	350,000	100% of capital
5.	Marine	350,000	100% of capital
6.	Surety	350,000	100% of capital
7.	Disability	250,000	100% of capital
8.	Plate Glass	100,000	100% of capital
9.	Liability)	(for any or all	100% of capital
10.	Workers' Compensation)	(of these	
11.	Common Carrier Liability)	(300,000	
12.	Life and any of above 3 lines	2,550,000 for any or all of them	100% of capital
13.	Boiler and Machinery	100,000	100% of capital
14.	Burglary	100,000	100% of capital
15.	Credit	100,000	100% of capital
16.	Sprinkler	100,000	100% of capital
17.	Team and Vehicle	100,000	100% of capital
18.	Automobile	200,000	100% of capital plus $200,000
19.	Aircraft	100,000	100% of capital
20.	Miscellaneous	100,000	100% of capital
21.	Mortgage	250,000	100% of capital
22.	Mortgage Guaranty	1,000,000	100% of capital

Insurers transacting multiple lines shall have $2,600,000 or the aggregate as set forth above, whichever is lower.

Incorporated insurers not transacting life lines, fire, marine or surety shall have excess capital of $300,000 over the aggregate amount set forth above.

For admission, no incorporated insurer shall have less than $1,000,000 nor more than $2,600,000 capital.

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COLORADO § 10-3-201

Certificate of Authority issued prior to 5/6/63: (but see below)	Capital	Surplus
1. Life	100,000	50,000
2. Fire	200,000	100,000
3. Fire (territory limited to Colorado)	50,000	25,000
4. Casualty (including fidelity and surety)	250,000	125,000
5. Casualty (excluding fidelity and surety)	100,000	50,000
6. Casualty (including fidelity and surety and territory limited to Colorado)	50,000	25,000
7. Multiple Line	400,000	350,000

Certificate of Authority issued On or After 5/6/63: (but see below)	Capital	Surplus
1. Life	200,000	100,000
2. Fire	200,000	100,000
3. Fire (territory limited to Colorado)	100,000	50,000
4. Casualty (including fidelity and surety)	250,000	125,000
5. Casualty (excluding fidelity and surety)	200,000	100,000
6. Casualty (excluding fidelity and surety and territory limited to Colorado)	100,000	50,000
7. Multiple Line	400,000	350,000
8. Title	200,000	100,000
9. Title (territory limited to Colorado)	100,000	50,000

Certificate of Authority issued On or After 7/1/79: (but see below)	Capital	Surplus
1. Life	400,000	200,000
2. Fire	400,000	200,000
3. Fire (territory limited to Colorado)	200,000	100,000
4. Casualty (including fidelity and surety)	500,000	250,000
5. Casualty (excluding fidelity and surety)	400,000	200,000
6. Casualty (excluding fidelity and surety and territory limited to Colorado)	200,000	100,000
7. Multiple Line	1,250,000	750,000
8. Title	400,000	200,000
9. Title (territory limited to Colorado)	200,000	100,000

Certificate of Authority Issued
On or After 7/1/91:
Companies licensed prior to July 1, 1991 shall have until 12/31/92 to increase their total capital and surplus to the amounts marked with asterisks.

	Capital and Surplus
1. Life	*780,000
2. Fire	*780,000
3. Casualty	*900,000
4. Multiple Line	*2,000,000
5. Title	*630,000

Colorado continued on next page

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COLORADO (cont.)

	Capital and Surplus
Certificate of Authority Issued On or After 7/1/92:	
1. Life	960,000
2. Fire	960,000
3. Casualty	1,050,000
4. Multiple Line	2,000,000
5. Title	690,000
Certificate of Authority Issued On or After 7/1/93:	
1. Life	1,140,000
2. Fire	1,140,000
3. Casualty	1,200,000
4. Multiple Line	2,000,000
5. Title	690,000
Certificate of Authority Issued On or After 7/1/94:	
1. Life	1,320,000
2. Fire	1,320,000
3. Casualty	1,350,000
4. Multiple Line	2,000,000
5. Title Insurance	720,000
Certificate of Authority Issued On or After 7/1/95:	
1. Life	1,500,000
2. Fire	1,500,000
3. Casualty	1,500,000
4. Multiple Line	2,000,000
5. Title Insurance	750,000

CONNECTICUT § 38a-72

	Capital	surplus	Mutual surplus
1. Life	1,000,000	2,000,000	3,000,000
2. Mortgage Guaranty	2,000,000	2,000,000	4,000,000
3. Health	500,000	500,000	1,000,000
4. Marine	500,000	250,000	750,000
5. Fidelity and Surety	500,000	500,000	1,000,000
6. Title	500,000	500,000	1,000,000
7. Worker's Compensation	500,000	500,000	1,000,000
8. Liability	500,000	500,000	1,000,000
9. Property	500,000	250,000	750,000
10. Life & Health	1,000,000	2,000,000	3,000,000
11. All Lines-Max. Required.	2,000,000	2,000,000	4,000,000

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DELAWARE tit. 18 § 511

	Capital	Surplus
1. Life	300,000	150,000
2. Health	300,000	150,000
3. Life and Health	350,000	200,000
4. Property	300,000	150,000
5. casualty	400,000	200,000
6. Marine & Transportation	350,000	175,000
7. Surety	300,000	150,000
8. Title	250,000	125,000
9. Multiple	500,000	250,000

DISTRICT OF COLUMBIA §§ 35-608, 35-701, 35-1516

	Capital	Surplus
Life Companies		
Capital Stock Company	1,000,000	50% of capital stock
Mutual Company	N/A	1,500,000
Fire and Casualty Companies		
Capital Stock Company	300,000	300,000
Domestic Mutual Company	N/A	300,000
Foreign and Alien Mutual Company	N/A	400,000

FLORIDA §§ 624.407.624.408, 628.161

Stock Companies

To receive authority: capital and surplus of $2,500,000
To maintain certificate of authority:
Insurers licensed prior to 1989 must maintain at least:
Until Dec. 31, 1992 $1,300,000
Thereafter 1,500,000
or alternative calculation based on liabilities.

Mutuals	Initial Surplus	Maintenance Level Surplus
1. Health	300,000	200,000
2. Property	200,000	150,000
3. Casualty	300,000	200,000
4. Any Combination 1,2,3	400,000	250,000
5. Life	2,500,000	1,500,000

GEORGIA §§ 33-3-6 and 33-3-7

	Capital	Surplus
1. For companies newly admitted 1/1/91 and thereafter and for all companies on 7/1/92 and thereafter:	1,500,000	1,500,000 or 50% cap.
2. Until July 1, 1992 for companies admitted prior to 1/1/91:	1,500,000	400,000 or 50% cap.

Commissioner may, at his discretion, grant a company 2 extra years to meet these requirements.

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HAWAII §§ 431:3-205 to 431:3-207

		Capital (Stock) or Unimpaired Surplus (Mutual)	Surplus Additional amount required of all insurers after 7/1/93
1.	Life	600,000	50% capital
2.	Disability	450,000	50% capital
3.	Property	750,000	50% capital
4.	Marine and Transportation	1,000,000	50% capital
5.	Vehicle	1,000,000	50% capital
6.	General Casualty	1,500,000	50% capital
7.	Surety	1,000,000	50% capital
8.	Title	400,000	50% capital

9. Combination of Classes: Amount equal to the sum required of each individual class of insurance, total not exceed $2.5 million.

IDAHO § 41-313

		Paid-Up Capital Stock or Basic Surplus	Additional Surplus
1.	Life	400,000	400,000
2.	Disability	400,000	400,000
3.	Life and Disability	506,000	500,000
4.	Property	400,000	400,000
5.	General Casualty	500,000	500,000
6.	Marine and Transportation	450,000	450,000
7.	Vehicle	400,000	400,000
8.	Surety	500,000	500,000
9.	Title	100,000	100,000
10.	Multiple Lines (all but life and title)	650,000	650,000
11.	Any 2 of Property, Marine & Transportation, General Casualty, Vehicle, Surety, Disability	550,000	550,000

ILLINOIS I.C. § 4, 13, 43

CLASS 1: Life. Accident and Health

a. Life
b. Accident and Health
c. Legal Expense

CLASS 2: Casualty. Fidelity and Surety

a. Accident and Health
b. Vehicle
c. Liability
d. Workers' Compensation
e. Burglary and Forgery
f. Glass
g. Fidelity and Surety
h. Miscellaneous
i. Other Casualty Risks
j. Contingent Losses
k. Livestock and Domestic Animals
l. Legal Expense

CLASS 3: Fire and Marine, etc.

a. Fire
b. Elements
c. War, Riot and Explosion
d. Marine and Transportation
e. Vehicle
f. Property Damage, Sprinkler Leakage and Crop
g. Other Fire and Marine Risks
h. Contingent Losses
i. Legal Expense

Illinois continued on next page

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ILLINOIS (cont.)

Stock Insurers	Capital	Initial Surplus	Surplus to be Maintained* 1991-1995
1. Class 1a, b and/or c	1,000,000	1,000,000	500,000
2. Class 2a, b, c, d, g, g, i, and or j	1,000,000	1,000,000	500,000
3. Class 2e, f, i, l and/or Class 3 (any, all of or combination of)	400,000	600,000	300,000
4. Class 2 - any and all clauses except e, f, k, l and Class 3 - any and all clauses	1,000,000	1,000,000	500,000
5. Class 2 - for k only**	100,000	150,000	50,000

Mutual Insurers	Initial Surplus	Surplus to be Maintained* 1991-1995
1. Class 1a, b and/or c	2,000,000	1,500,000
2. Class 2a, b, c, d, g, h, i, and/o j	2,000,000	1,500,000
3. Class 2e, f, k, l and/or Class 3 (any, all of or combination of)	1,000,000	700,000
4. Class 2 - any and all clauses except e, f, k, l and Class 3 - any and all clauses	2,000,000	1,500,000
5. Class 2 - for k only	250,000	150,000

*In addition to minimum original capital.
** Provided company shall not expose itself to any loss on any one risk in an amount exceeding $5,000.

INDIANA §§ 27-1-5-1, 27-1-6-14, 27-1-6-15

CLASS 1:
a. Life and Annuities
b. Accident and Health

CLASS 2:
a. Accident, Health and Disability
b. Employers Liability, Workers' Comp.
c. Burglary and Theft
d. Glass
e. Boiler and Machinery
f. Motor Vehicle Liability
g. Water Damage
h. Liability
i. Credit
j. Title
k. Fidelity and Surety
l. Other Casualty
m. Legal Expense

CLASS 3:
a. Fire, Wind, Hail, Loot, Riot
b. Crop
c. Water and Fire Extinguisher Damage
d. Marine and Transportation

Indiana continued on next page

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INDIANA (cont.)

Stock:

		Paid-In Capital	Surplus
	Organized Prior to 3/7/67:		
1.	One or More Kind of Class 1	200,000	1,000,000/250,000#
2.	Any One Kind of Class 2 except k	200,000	1,000,000/250,000#
3.	Any 2 Kinds of Class 2 except k	300,000	1,000,000/250,000#
4.	3 or More Kinds of Class 2 except k	400,000	1,000,000/250,000#
5.	One or More Kind Class 3	400,000	1,000,000/250,000#
6.	One or More Kinds under Class 2 and Class 3	750,000	1,000,000/250,000#
7.	One or more Kinds of Class 2 including k	750,000	1,000,000/250,000#
	Organized after 3/6/67 and prior to 7/1/77:		
1.	One or More Kind of Class 1	400,000	1,000,000/250,000#
2.	Any One Kind of Class 2 except k	400,000	1,000,000/250,000#
3.	One or More Kind Class 3	400,000	1,000,000/250,000#
4.	One or More Kinds under Class 2 and Class 3	750,000	1,000,000/250,000#
5.	One or more Kinds of Class 2 including k	750,000	1,000,000/250,000#
	Organized after 6/30/77:	1,000,000	1,000,000/250,000#

Mutual:

		Minimum Surplus	
	Organized prior to 7/1/77:	250,000	
1.	One or More Kinds under Class 2 or Class 1 and Class 3, excluding 2k	750,000	
2.	One or More Kinds of Class 2 including k	1,000,000	
3.	One or More Kinds under Class 2 and Class 3, including 2k	1,000,000	
	Organized after 6/30/77:		2,000,000/1,250,000#

#First amount is initial requirement/Second amount is that to be constantly maintained

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IOWA §§ 508.5, 515.8, 515.10

		Capital	Surplus
1.	Life	2,500,000	2,500,000
2.	Other Than Life	2,500,000	2,500,000

KANSAS §§ 40-401, 40-402, 40-901, 40-1102, 40-1103, 40-1104

		Capital	Surplus
1.	Life	600,000	600,000
2.	Single Line (Property or Casualty)	450,000	300,000
3.	Multiple Line (Property or Casualty)	900,000	600,000

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KENTUCKY § 304.3-120

		Capital	Surplus
1.	Stock Insurers	1,000,000	2,000,000
2.	Foreign Mutual, Reciprocal and Lloyd's Insurers	1,000,000	2,000,000

LOUISIANA §§ 22:71 to 22:71.2, 22:121.2

Paid-In capital and surplus requirements for companies admitted prior to 9/1/89:

		Capital	Surplus
1.	Life	100,000	200,000
2.	Health and Accident	100,000	200,000
3.	Life, Accident and Health	100,000	200,000
4.	Vehicle Physical Damage	100,000	150,000
5.	Title		
	- licensed prior to 9/1/85	50,000	25,000
	- licensed on or after 9/1/85	100,000	200,000
6.	Industrial Fire	200,000	100,000
7.	Workers' Comp. Only (licensed as of 7/27/66)	100,000	50,000
8.	Crop and Livestock Only (licensed as of 7/27/66)	100,000	150,000
9.	Vehicle	650,000	350,000
10.	Liability	650,000	350,000
11.	Burglary and Forgery	650,000	350,000
12.	Workers' Compensation	650,000	350,000
13.	Glass	650,000	350,000
14.	Fidelity and Surety	650,000	350,000
15.	Fire and Extended Coverage	650,000	350,000
16.	Steam Boiler and Sprinkler Leakage	650,000	350,000
17.	Crop and Livestock	650,000	350,000
18.	Marine and Transportation	650,000	350,000
19.	Miscellaneous	650,000	350,000
20.	All Lines, except Life and Title	1,000,000	

Capital and surplus requirements for companies admitted on or after 9/1/89:

		Paid-In Capital	. .	Operating Surplus
1.	Life	100,000	1,900,000	1,000,000
2.	Health and Accident	100,000	1,900,000	1,000,000
3.	Life, Accident and Health	100,000	1,900,000	1,000,000
4.	Vehicle Physical Damage	100,000	1,150,000	1,000,000
5.	Title	100,000	400,000	500,000
6.	Industrial Fire	200,000	800,000	1,000,000
7.	Vehicle	650,000	1,350,000	1,000,000
8.	Liability	650,000	1,350,000	1,000,000
9.	Workers' Compensation	650,000	1,350,000	1,000,000
10.	Burglary and Forgery	650,000	1,350,000	1,000,000
11.	Glass	650,000	1,350,000	1,000,000
12.	Fidelity and Surety	650,000	1,350,000	1,000,000
13.	Fire and Extended Coverage	650,000	1,350,000	1,000,000

Louisiana continued on next page

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LOUISIANA (cont.)

		Paid-In Capital	Minimum Surplus	Operating Surplus
14.	Steam Boiler and Sprinkler	650,000	1,350,000	1,000,000
15.	Crop and Livestock	650,000	1,350,000	1,000,000
16.	Marine and Transportation	650,000	1,350,000	1,000,000
17.	Miscellaneous	650,000	1,350,000	1,000,000
18.	All Lines, except Life and Title	650,000	1,350,000	1,000,000

The commissioner may require additional capital and surplus based on type, volume, and nature of business transacted.

MAINE 24-A §§ 410,411

		Paid-In Capital (Stock) or Basic Surplus (Mutual)	Initial Free Surplus
1.	Life*	1,500,000	1,500,000
2.	Health	1,000,000	1,000,000
3.	Life and Health*	2,500,000	2,500,000
4.	Casualty	1,500,000	1,500,000
5.	Marine and Transportation	1,500,000	1,500,000
6.	Property	1,000,000	1,000,000
7.	Surety	1,500,000	1,500,000
8.	Title	500,000	500,000
9.	Multiple Line	2,500,000	2,500,000
10.	All lines (life and one or more lines except health)	5,000,000	5,000,000
11.	Legal services (in addition to above)	500,000	
12.	Financial Guaranty (monoline)	2,500,000	47,500,000

*Does not apply to reciprocal insurers.

A domestic mutual insurer holding a certificate of authority prior to January 1, 1989 may continue to write a business if it maintains the following basic surplus:

1.	Life	1,000,000
2.	Health	500,000
3.	Life and Health	1,250,000
4.	Casualty	750,000
5.	Marine and Transportation	1,000,000
6.	Property	500,000
7.	Surety	1,000,000
8.	Title	350,000
9.	Multiple Line	2,500,000

MARYLAND 48A §§ 47 to 49

		Capital	Surplus
Commencing Business Prior to 7/1/65:			
1.	Life, including annuities and health	200,000	#
2.	Health	100,000	#
3.	Property and Marine, excluding #5	250,000	#
4.	Title	250,000	#
5.	Wet Marine and Transportation	250,000	#
6.	Casualty, excluding #7 and #8	250,000	#

Maryland continued on next page

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MARYLAND (cont.)

	Capital	Surplus
7. Vehicle Liability	250,000	#*
8. Workers' Compensation	250,000	#
9. Surety	250,000	#
10. 2 or more of these listed lines	lesser of $500,000 or sum total	

Commencing Business On or After 7/1/65 and Before 7/1/91	Capital	Surplus
1. Life, including annuities and health	500,000	#
2. Health	250,000	#
3. Property and Marine, excluding #5	250,000	#
4. Title	250,000	#
5. Wet Marine and Transportation	250,000	#
6. Casualty, excluding #7 and #8	250,000	#
7. Vehicle Liability	250,000	#
8. Workers' Compensation	250,000	#
9. Surety	250,000	#
10. 2 or more of these listed lines	500.000	#

Commencing Business On or After 7/1/91:	Capital	Surplus
1. Life, including annuities	1,500,000	#
2 Health	750,000	#
3. Property and Marine, excluding #5	750,000	#
4. Title	750,000	#
5. Wet Marine and Transportation	750,000	#
6. Casualty, excluding #7 and #8	750,000	#
7. Vehicle Liability	750,000	#
8. Workers' Compensation	750,000	#
9. Surety	750,000	#
10. 2 or more of these listed lines	1,500,000	#

On or after 7/1/2001 any insurer which qualified to engage in business before 7/1/91 shall possess and maintain paid-in capital in an amount not less than 150% of that required of insurers commencing business on 6/30/91.

#Minimum Surplus Required: (1) new insurers need minimum surplus of 150% of minimum capital stock; (2) insurer which commenced business on or after 7/1/66 shall maintain surplus in an amount not less than 100% of minimum capital required; (3) an insurer which commenced business before 7/1/66 shall maintain surplus in an amount not less than 50% of minimum capital required.

***Vehicle Liability insurers which commenced business prior to 7/1/66 must also maintain $300,000 additional surplus.**

MASSACHUSETTS 175 §§ 47 to 48, 51

	Paid-Up Capital	Paid-Surplus	Mutual in Surplus
1. Fire	200,000	400,000	600,000
2 Ocean Marine, Inland Navigation	300,000	600,000	900,000
a. 1 + Ocean marine	400,000	800,000	1,200,000
b. 1 - ocean marine	300,000	600,000	900,000
3. Surety and Fidelity	200,000	400,000	600,000
4. Boiler and Machinery	200,000	400,000	600,000

Massachusetts continued on next page

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MASSACHUSETTS (cont.)

		Paid Up Capital	Paid-Surplus	Mutual in Surplus
5.	Accident and Health, Liability and Property Damage, Automobile Workers' Compensation	400,000	800,000	1,200,000
	- Accident and Health Only	100,000	200,000	300,000
6.	Glass	100,000	200,000	300,000
7.	Water Damage and Sprinkler Leakage	200,000		
8.	Elevator and Aircraft Property Damage	200,000	400,000	600,000
9.	Credit Insurance	200,000	400,000	600,000
10.	Title	100,000	200,000	300,000
11.	Mortgage	200,000	400,000	600,000
12.	Burglary, Forgery and Larceny	200,000	400,000	600,000
13.	Livestock	100,000	200,000	300,000
15.	Reinsurance	500,000	1,000,000	1,500,000
16.	Life	400,000	800.000	1,200,000
17.	Repair and Replacement (when combined with one or more of classes 1, 2 and 8)	400,000	800,000	1,200,000
19.	Legal Services	100,000	200,000	300,000
	Classes 6 & 16	800,000	800,000	
	Classes 1 & 8	200,000		
	Classes 1 & 2 except ocean marine	300,000		
	Classes 1 & 2	400,000		
	Classes 1 & 17	400,000		
	Classes 1, 2, 8, 17	400,000		

Any 2 or more in Classes 4, 5, 6, 7, 8, 9, 10, 12, 13 - Largest amount plus 1/2 requirement for each additional line. Surplus is twice that amount.

MICHIGAN §500.410

Applies to insurers admitted after 7/1/65.

		Capital	Surplus
1.	Life	1,000,000	500,000
2.	Life and Disability	1,000,000	500,000
3.	Disability	1,000,000	500,000
4.	Property and Marine	1,000,000	500,000
5.	Automobile	1,000,000	500,000
6.	Casualty	1,000,000	500,000
7.	Surety and Fidelity	1,000,000	500,000
8.	Surety and Fidelity, Casualty	1,000,000	500,000
9.	Multiple Lines	1,000,000	500,000

1. $1,500,000 is the minimum amount of capital and surplus required for an initial COA. Dept. has authority to require additional surplus. After licensure, $1,000,000 must remain unimpaired.

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MINNESOTA §§ 60A.06, 60A.07

		Capital	Surplus#
Stock Insurers			
1.	Fire	350,000	350,000/175,000
2.	Marine and Transportation	350,000	350,000/175,000
3.	Boiler and Machinery	200,000	200,000/100,000
4.	Life	1,000,000	2,000,000/500,000
5a.	Accident and Sickness	500,000	1,000,000/500,000
	Mutual insurers		1,500,000/1,000,000
5b.	Workers' Compensation	500,000	1,000,000/500,000
6.	Fidelity and Surety	500,000	500,000/250,000
7.	Title	500,000	500,000/250,000
8.	Glass	200,000	200,000/100,000
9.	Burglary, Theft and Forgery	200,000	200,000/100,000
10.	Livestock	200,000	200,000/100,000
11.	Credit	350,000	700,000/350,000
12.	Vehicle	500,000	1,000,000/500,000
13.	Liability	500,000	1,000,000/500,000
14.	Elevator	200,000	200,000/100,000
15.	Legal Expense	350,000	350,000/175,000
16.	Multiple Lines	1,000,000	1,000,000/500,000
	Mutual Insurers		2,000,000/1,500,000

#First amount is initial requirement/second amount is that to be constantly maintained
Mutual insurers must meet same surplus requirements except where otherwise specified.

MISSISSIPPI $83-19-31

		Capital	Surplus
1.	Glass, Fire, Windstorm, Related Coverages, Wet Marine or Inland Marine	400,000	600,000
2.	Fidelity, Casualty, Surety or Guaranty	400,000	600,000
3.	Sprinkler Leakage	400,000	600,000
4.	Vehicle, Bicycles, Aircraft and Elevator	400,000	600,000
5.	Life or Accident and Health	400,000	600,000
5a.	Life, Accident and Health	400,000	600,000
6.	Industrial Life	100,000	50,000
7.	Multiple Lines	600,000	900,000

MISSOURI §§ 376.280, 379.010, 379.525

	Capital	Surplus
Licensed after 7/1/87:		
Stock Insurers:		
Life and Accident	600,000	600,000
Property or Liability or Fidelity and Surety or Accident and Health	800,000	800,000
More than one of above P/C classes	1,200,000	1,200,000

Missouri continued on next page

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MISSOURI (cont.)

P/C insurers licensed prior to 7/11/87, have until December 31, 1992 to meet requirements, in graduated steps:

	Capital	Surplus
One line by 12/31/91 surplus of	700,000	700,000
More than one line by 12/31/91 surplus of	1,100,000	1,100,000
Mutual Insurers:		
More than one line		2,400,000
Single line mutuals		1,600,000

Mutuals licensed prior to 7/1/87 have until 12/31/92 to increase surplus to these amounts in graduated steps:

One line by 12/31/91 surplus of	1,400,000
More than one line by 12/31/91 surplus of	2,200,000

MONTANA §§ 33-2-109, 33-3-204

		Capital	Surplus
1.	Life	200,000	200,000
2.	Disability	200,000	200,000
3.	Life and Disability	300,000	300,000
4.	Credit Life and Disability	50,000	50,000
5.	Property	400,000	400,000
6.	Marine	400,000	400,000
7a.	Casualty, except Workers' Compensation	400,000	400,000
7b.	Casualty with Workers' Compensation	600,000	600,000
8.	Surety	500,000	500,000
9.	Title	200,000	200,000
10.	Multiple Lines	800,000	800,000

NEBRASKA §§ 44-201, 44-214, 44-219, 22-243

	Initial Capital and Surplus (Stock) or Surplus (Mutual)	Maintained Surplus
Life and Variable Life without Variable Annuities and/or Accident and Sickness, or any one line P/C	1,000,000	1,000,000
All Lines including variable annuities	2,000,000	2,000,000

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NEVADA § 680A.120

Effective 10-1-91 for a certificate of authority must have:

	Paid-In Capital (Stock) or Basic Surplus (Mutual)	Initia ree Surplus
Life, health, property, casualty, surety, marine and transportation, and multiple line	500.000	1,000,000
Title	500,000	750,000
Financial Guarantee	10,000,000	40,000,000

Insurers licensed prior to effective date may continue to meet the requirements below until 1/1/94.

1.	Life	200,000	500,000
2.	Health	200,000	500,000
3.	Life and Health	300,000	750,000
4.	Property	300,000	750,000
5.	Casualty	300,000	750,000
6.	Casualty and Health	400,000	1,000,000
7.	Surety	500,000	1,000,000
8.	Marine and Transportation	300,000	750,000
9.	Multiple Line	500,000	1,000,000
10.	Title	100,000	250,000

NEW HAMPSHIRE §§ 401:4, 402:13, 402:14, 405:2, 405:4, 411:1, 416-A:5

		Capital	Paid-In Capital	Surplus
1.	All Stock Insurers	800,000	200,000	1,000,000
2.	All Mutual Insurers	500,000		800,000
3.	Multiple Lines		400,000	400,000
4.	Life Stock Insurers	600,000	150,000	750,000
5.	Title Insurers	200,000	100,000	300,000

NEW JERSEY §§ 17B:18-35, 17:17-1, 17:46B-7, 17:17-6, 17:17-7

		Stock Insurers		Mutuals
		Capital	Surplus	Net Cash Assets
a.	Fire and Casualty	200,000	100,000	
b.	Marine and Transportation	200,000	100,000	
c.	Life and Health	800,000	1,700,000	600,000
d.	Liability	400,000	600,000	300,000
e.	Workers' Compensation			300,000
f.	Boiler and Machinery			
g.	Fidelity and Surety	250,000	50% capital	375,000
h.	Title	500,000	250,000	
i.	Credit			
j.	Burglary and Theft			
k.	Glass			
l.	Water Damage and Sprinkler Leakage	200,000	100,000	
m.	Livestock			
n.	Smoke and Smudge			

New Jersey continued on next page

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NEW JERSEY (cont.)

	Stock Insurers		Mutuals
	Capital	Surplus	Net Cash Assets
o. All Lines but Life and Health	2,000,000	1,000,000	
p. Life and Annuity	1,000,000	2,100,000	
q. Life, Health, Annuity	1,500,000	2,850,000	
r. Health	500,000	750,000	

Stock Insurers: minimum capital $200,000 with additional $100,000 for each additional line; minimum surplus *50%* of capital.
Mutual Insurers: minimum $50,000 net cash assets required for each line authorized to transact.

NEW MEXICO § 59A-5-16

	Capital	Surplus
1. Life andlor Health	600,000	400,000
2. General Casualty and/or Surety	500,000	500,000
3. Property and/or Marine and Transportation	500,000	500,000
4. Vehicle	500,000	500,000
5. Title	500,000	500,000
6. Multiple Lines, except life and/or health and title, per each additional line transacted	100,000	100,000

Aggregate Requirements Related to Premium Volume (earned or received):

	$5 to $10 Million	$10 to $25 Million	Over $25 Million
1. Life and/or Health	700,000	800,000	900,000
2. General Casualty and/or Surety	800,000	900,000	1,000,000
3. Property and/or Marine and Transportation	800,000	900,000	1,000,000
4. Vehicle	800,000	900,000	1,000,000
5. Title	800,000	900,000	1,000,000

NEW YO= §§ 1113,4103,4202,4208,4107

	Domestic Stock Capital	Companies Surplus
Group A:		
1. Life	2,000,000	4,000,000
2. Annuities (initial surplus)	150,000	100,000
3a. Accident and Sickness	100,000	50,000
3b. Disability	100,000	50,000
5. Miscellaneous Property[a]		
6. Water Damage[a,c]	100,000	50,000
*7. Burglary and Theft	300,000	150,000
*8. Glass	100,000	50,000
*9. Boiler and Machinery	100,000	50,000
*10. Elevator	100,000	50,000
*11. Animal	100,000	50,000
12. Collision[b,c,d]	100,000	50,000
*13. Personal Injury Liability	500,000	250,000
*14. Property Damage Liability	100,000	50,000

New York continued on next page

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NEW YORK (cont.)

		Domestic Stock Capital	Companies Surplus
*15.	Workers' Compensation/Employer Liability	500,000	250,000
*16.	Fidelity and Surety	900,000	450,000
*17.	Credit	400,000	200,000
18.	Title		
19.	Motor Vehicle and Aircraft Physical Damage[c,d]		
21.	Marine Protection and Indemnity[d]		
22.	Residual Value	2,000,000	1,000,000
23.	Mortgage Guaranty		
24.	Credit Unemployment	400,000	200,000
	* Basic Additional Amount Required to Write Any One or More of These Lines	100,000	50,000
Group B:			
4.	Fire[c]	500,000	500,000
20.	Marine and Inland Marine[d]	500,000	500,000

Multiple Lines: Domestic Stock Property/Casualty Insurers

If licensed to write one or more of the lines in Group A and having minimum capital of $1,000,000 may be licensed to write any other kind of insurance in Group A upon having an initial surplus equal to the aggregate of capital and surplus specified and shall maintain a surplus of the greater of $1,000,000 or aggregate capital specified.

If licensed to write any kind of insurance in Group A, must have minimum capital of $1,000,000 and an initial surplus equal to the aggregate of capital and surplus specified before being additionally authorized to transact any insurance of Group B. Insurer shall maintain a surplus of the greater of $1,000,000 or aggregate capital specified.

Insurers reinsuring lines of business and transacting business outside the U.S. for which they are not licensed to write directly, must maintain a minimum surplus to policyholders of $35,000,000 and a deposit of $3,000,000 (included in surplus of policyholders).

[a] if licensed to write fire (4), additional capital and surplus is not required

[b] if licensed to write fire (4) or marine and inland marine (20), additional capital and surplus is not required

[c] if licensed to write fire (4), no additional capital and surplus is required to write miscellaneous property (5), water damage (6), collision (12), motor vehicle and aircraft physical damage (19) or inland marine only (20)

[d] if licensed to write marine and inland marine (20), no additional capital and surplus is required to write collision (12), motor vehicle and aircraft physical damage (19) or marine protection and indemnity (21)

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NEW YORK (cont.)

TABLE TWO

		Initial Surplus	Minimum Surplus to be Maintained
Fire	4 [also 5,6, 12,19 and 20 inland][a,b,e]	300,000	200,000
Burglary	7	300,000	200,000
Glass	8	150,000	100,000
Boiler	9	300,000	200,000
Elevator	10	150,000	100,000
Animal	11	150,000	100,000
Liab. - P.I	13 [also 6,12 and 14][c,e]	500,000	400,000
Workers' Comp.	15[f]	500,000	400,000
Fidelity/Surety	16	1,500,000	1,000,000
Credit	17	750,000	500,000
Marine	20 [also 12.19 and 21][b,d,e]	1,000,000	500,000
Marine P.&I.	21b	500,000	500,000

If licensed to write any kind of insurance specified in TABLE TWO, a mutual property/casualty company may write any one or more of the kinds of insurance specified in TABLE THREE - Group A and Group B.

If licensed to write any kind of insurance specified in TABLE THREE - Group A, it may write any one or more of the kinds of insurance specified in TABLE THREE - Group C.

TABLE THREE

		Initial Surplus	Minimum Surplus to be Maintained
	Group A		
Burglary	7	100,000	100,000
Glass	8	50,000	50,000
Boiler	9	100,000	100,000
Elevator	10	50,000	50,000
Animal	11	50,000	50,000
Liab. - P.I.	13[c,e]	300,000	300,000
Workers' Comp.	15	300,000	300,000
Fidelity/Surety	16	900,000	900,000
Credit	17	300,000	300,000
	Group B		
Fire	4 [also 5,6,12,19 and 20 inland]	300,000	200,000
Marine	20 [also 12,19 and 21][b,d,e]	1,000,000	500,000
Accident & Health	3(i)	100,000	100,000
Accident & Health	3(ii)	100,000	100,000
Water Damage	6[a,c,g]	50,000	50,000
Collision	12[a,c,h]	50,000	50,000
Liab. P.D.	14[c,e]	50,000	50,000
Residual Value	22	3,000,000	2,000,000

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NEW YORK (cont.)

A mutual property/casualty insurance company may be licensed to write any one kind of insurance as specified in TABLE TWO [except as provided for in b], subject to the following:

a. If licensed to write paragraph 4, no additional surplus required for 5,6,12,19 and 20 (inland marine).
b. If organized to write paragraphs 4, 20 or 21, the initial and minimum surplus required for paragraphs 7, 8, 9, 10, 11, 13, 15, 16, or 17 to be taken from TABLE TWO for the line with the highest initial surplus.
c. If licensed to write paragraph 13, no additional surplus required for paragraphs, 6, 12 and 14.
d. If licensed to write paragraph 20, no additional surplus required for paragraphs, 12, 19 and 21.
e. If licensed to write paragraphs 13, 14 and 19, must maintain a surplus of $600,000.
f. If licensed to write paragraph 15, no additional surplus required for paragraph 3(i) if licensed for the purpose of Article 9 of the workers' compensation law.
g. If licensed to write paragraph 4 or 13, no additional surplus required.
h. If licensed to write paragraphs 4, 13 or 20, no additional surplus required.

....

NORTH CAROLINA §§ 58-7-75.58-7-15

	Paid In Capital	Surplus
Stock Insurers:		
1. Life	600,000	900,000/150,000#
2. Accident and Health (cancellable)	400,000	600,000/100,000
3. Accident and Health (cancellable and noncancelable)	600,000	900,000/150,000
4. One or more of the following lines: Fire, Misc. Property, Water Damage, Burglary and Theft, Animal, Collision, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity or Miscellaneous	800,000	1,200,000/200,000
5. One or more of the following lines: Accident and Health, Water Damage, Burglary and Theft, Glass Boiler and Machinery, Elevator, Animal, Collision, Personal Injury Liability, Property Damage Liability, Workers' Compensation and Employers Liability, Fidelity and Surety, Credit, Title, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity or Miscellaneous.	1,000,000	1,500,000/250,000

#First amount is initial requirement/second amount is that to be constantly maintained

	Initial Surplus	Constantly Maintained Surplus
Mutual:		
1. Limited Assessable: Fire, Misc. Property, Water Damage, Burglary and Theft, Glass, Boiler and Machinery, Animal, Collision, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity and/or Miscellaneous lines	300,000	300,000

North Carolina continued on next page

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NORTH CAROLINA (cont.)

2. Assessable:	
A. Fire, Misc. Property and/or Water Damage	twice the net retained liability under the largest policy of insurance; never less than $60,000
B. Burglary and Theft, Glass, Animal, Collision, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity and/or Miscellaneous lines	60,000 constantly maintained
C. Multiple Lines	400,000 constantly maintained
3. Nonassessable:	
A. Fire, Misc. Property, Water Damage, Burglary and Theft, Glass, Boiler and Machinery, Animal, Collision, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity and/or Miscellaneous lines	800,000 constantly maintained
B. Accident and Health, Water Damage, Burglary and Theft, Glass, Boiler and Machinery, Elevator, Animal, Collision, Personal Injury Liability, Property Damage Liability, Workers' Compensation and Employers Liability, Fidelity and Surety, Credit, Title, Motor Vehicle and Aircraft, Marine, Marine Protection and Indemnity, and/or Miscellaneous	1,000,000 constantly maintained
C. Multiple Lines (A and B above)	1,800,000 constantly maintained
D. Life	200,000/100,000#
E. Accidental Death and Personal Injury	200,000/100,000#
F. Life, Accidental Death and Personal Injury	400,000/200,000#
G. Disability	500,000/300,000#
H. Multiple Lines	1,000,000 constantly maintained

#First amount is initial requirement/second amount is that to be constantly maintained

---

NORTH DAKOTA §§ 26.1-05-04, 26.1-12-08, 26.1-12-10

	Capital	Surplus
1. All Stock Insurers	500,000	500,000
2. All Mutual Companies		1,000,000

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OHIO §§ 3907.05, 3909.02, 3925.12, 3929.011

Stock insurers other than life or title:

For a new or renewal certificate of authority issued after 8/8/91, domestic and foreign insurers writing the lines in each list must have:

	Total Maintained Capital and Surplus	At Least Capital	At Least Surplus
1. List A	2,500,000	1,000,000	1,000,000
2. List B	5,000,000	2,000,000	2,000,000
3. List C	10,000,000	4,500,000	4,500,000
4. Assumes reinsurance and writes from List A or B	10,000,000	4,500,000	4,500,000

Mutual insurers other than life or title:

For a new or renewal certificate of authority issued after 8/8/91, insurers writing any of the lines listed in each list shall have:

	Total Maintained Surplus
1. List A	2,500,000
2. List B	5,000,000
3. List C	10,000,000
4. Assumes reinsurance and writes from List A or B	10,000,000

A
fire, allied lines, farmowners multiple peril, homeowners multiple peril, ocean marine, inland marine, earthquake, group accident and health, credit accident and health, auto liability, auto physical damage, aircraft, glass, burglary and theft, boiler and machinery, and credit.
B
commercial multiple peril, financial guaranty, medical malpractice, workers compensation, other liability, fidelity, surety, any other risk other than life insurance.
C
reinsurance only.

Title insurers

$120,000 capital and $180,000 surplus.

Life insurers:

Stock:
$2,500,000 capital and surplus with at least $1,000,000 each in capital and surplus.

Mutual:
$1,000,000 surplus.

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OKLAHOMA tit. 36 §§ 610 to 612.2

		Capital and Surplus	Additional Expendable Surplus
1.	Life and/or Accident and Health	500,000	50% of min. surplus
2.	Property	500,000	50% of min. surplus
3.	Marine	500,000	50% of min. surplus
4.	Casualty	500,000	50% of min. surplus
5.	Vehicle	500,000	50% of min. surplus
6.	Surety	500,000	50% of min. surplus
7.	Alien-Surety	500,000	50% of min. surplus
8.	Title	500,000	50% of min. surplus
9.	All Insurance Except Life, Surety and Title	500,000	50% of min. surplus
10.	All Insurance Except Life and Title	500,000	50% of min. surplus
11.	Workers' Compensation	5,000,000	
12.	Guaranteed Renewable A&H	2,000,000 (if licensed after 10/1/84); 1,000,000, if licensed before that date	50% of min. surplus
13.	Additional Lines, per line	100,000	

Vehicle and Accident and Health may be combined with Casualty without additional funds.

OREGON §§ 731.554, 731.558, 731.562, 750.045

		Capital and Surplus
1.	All insurers not defined below:	1,000,000
	Additional when first authorized for any Certificate of Authority:	500,000
2.	Workers' Compensation	3,000,000
3.	Mortgage	4,000,000
4.	Home Protection	10% aggregate premiums, not less than 40,000 nor more than 1,000,000
5.	Title	500,000
6.	Health Care Service Contractors	250,000 min. 500,000 min.

PENNSYLVANIA §§ 40-5-106, 40-37-101, 40-59-102, 40-61-105

		Capital	Surplus	Total
I.	Property/Casualty Companies			
(a)	Class of Business			
	(1) Life, Variable Life, Variable Annuities	1,000,000	50% of capital	1,500,000
	(2) Life, Variable Life, Variable Annuities, Health and Disability	1,100,000	50% of capital	1,650,000
	Total (a) Authority	2,100,000	1,050,000	3,150,000

Pennsylvania continued on next page

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	Capital	Surplus	Total
(b) Class of Business			
(1) Fire, Allied Lines	100,000	50,000	150,000
(2) Inland Marine, Auto Physical Damage	100,000	50,000	150,000
(3) Ocean Marine	200,000	100,000	300,000
Total (b) Authority	400,000	200,000	600,000

Minimum capital and surplus for any one (c) authority is at least **$750,000** and **$375,000,** respectively. For any two or more classes of insurance, the capital must equal the greater of $750,000 or the sum of total reauired for each class; surplus must equal or exceed 50% of the minimum required capital.

	Capital	Surplus	Total
(c) Class of Business			
(1) Fidelity & Surety	200,000	100,000	300,000
(2) Accident and Health	50,000	25,000	75,000
(3) Glass	50,000	25.000	75,000
(4) Other Liability including: professional liability, medical malpractice, etc.	50,000	25,000	75,000
(5) Boiler & Machinery	50,000	25,000	75,000
(6) Burglary & Theft	50,000	25,000	75,000
(7) Credit	100,000	50,000	150,000
(8) Water Damage	50,000	25,000	75,000
(9) Elevator	50,000	25,000	75,000
(10) Livestock	50,000	25,000	75,000
(11) Auto Liability	500,000	250,000	750,000
(12) Mine	50,000	25,000	75,000
(13) Personal Property Floater	50,000	25,000	75,000
(14) Workers' Compensation	750,000	375,000	1,125,000
Total (c) Authority	1,950,000	975,000	2,925,000
Total (a), (b) & (c) Authority	4,450,000	2,225,000	6,675,000

Mutual insurers issuing non-assessable policies must possess surplus equal to the capital required for stock insurers.

II. Title Companies

Must possess capital of at least $250,000 and surplus of at least $125,000.

III. Life Insurers	Capital	Surplus	Total
Life and Annuities	1,000,000	500,000	1,500,000
Accident and Health	100,000	50,000	150,000
Total	1,100,000	550,000	1,650,000

Mutual life insurers must have a guarantee capital, before commencing business, of not less than $500,000, and shall maintain unimpaired a policyholders surplus of $250,000 out of guarantee capital, surplus, or any combination thereof. Mutual life insurers authorized to issue variable annuity contracts, in addition to life and annuity contracts, must have a policyholders surplus of not less than **$1,500,000.**

No additional amounts are required by stock life insurers for variable life and variable annuity authority; however, separate authorization must be sought for variable authority as contained in PA Code, Title 31, Chapters 82 and 85.

Pennsylvania continued on next page

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PENNSYLVANIA (cont.)

NOTE: The above capital and surplus amounts are statutory minimums. The Insurance Commissioner has the discretion to require additional amounts. Because Section 503 of the Insurance Department Act requires insurers to maintain the minimum required capital and surplus unimpaired at all times, the Insurance Commissioner will require newly-incorporated insurers to demonstrate possession of surplus over the statutory minimum amount. The exact amount of additional surplus will be dependent upon the financial forecasts included in the insurer's business plan.

—TO RICO 26 §§ 309,310,312

		Capital	Surplus
1.	Life*	500,000	50% of capital
2.	Disability*	300,000	50% of capital
3.	Life and Disability*	800,000	50% of capital
4.	Property	500,000	50% of capital
5.	Agricultural Only	must qualify for property	must qualify for property
6.	Marine and Transport	500,000	50% of capital
7.	Casualty	600,000	50% of capital
8.	Vehicle Only	500,000	50% of capital
9.	Surety and Fidelity	750,000	50% of capital
10.	Title*	500,000	50% of capital
11.	Mortgage Loans*	1,000,000	50% of capital
12.	All Lines but Life and Mortgage Loans	1,000,000	50% of capital

*For lawful combinations, add $200,000 for each additional kind of insurance to the amount required above.

RHODE ISLAND §§ 27-2-5, 27-1-37

		Stock		Mutuals
		Paid-In Capital	Surplus	Assets Over Liabilities
1.	Domestic Insurers	1,000,000	2,000,000	3,000,000
2.	Foreign Insurers	1,000,000	2,000,000	3,000,000
3.	Monoline Companies	2,000,000	capital and surplus	

SOUTH CAROLINA §§ 38-9-10, 38-9-20, 38-6-30

Stock:

		Capital	nitial Surplus	Maintained Surplus
1.	Life	600,000	600,000	25% initial amount
2.	Accident and Health	600,000	600,000	25% initial amount
3.	Life, Accident and Health	1,200,000	1,200,000	25% initial amount
4.	Property	1,200,000	1,200,000	25% initial amount
5.	Casualty	1,200,000	1,200,000	25% initial amount
6.	Surety	1,200,000	1,200,000	25% initial amount
7.	Marine	1,200,000	1,200,000	25% initial amount
8.	Title	600,000	600,000	25% initial amount
9.	Multiple Lines	1,500,000	1,500,000	25% initial amount

The Commissioner may require additional initial capital and surplus based on the type or nature of business transacted.

Insurers licensed prior to 7/1/91 which do not meet the minimum requirements shown, must maintain at least the capital shown on 1990 annual statement and surplus in an amount of at least 25% of that amount.

South Carolina continued on next page

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SOUTH CAROLINA (cont.)

Mutual Insurers:	Initial Surplus
1. Life	1,200,000
2. Accident and Health	1,200,000
3. Life, Accident and Health	2,400,000
4. Property	2,400,000
5. Casualty	2,400,000
6. Surety	2,400,000
7. Marine	2,400,000
8. Title	1,200,000
9. Multiple Lines	3,000,000

Mutual insurers maintained surplus must be equal to the sum of capital and maintained surplus of a licensed stock insurer.

The Commissioner may require additional initial surplus based on the type or nature of business transacted.

Insurers licensed prior to 7/1/91 which do not meet the minimum requirements shown, must maintain at least the capital shown on 1990 annual statement and surplus in an amount of at least 25% of that amount.

SOUTH DAKOTA §§ 58-6-23, 58-6-25

	Capital	Surplus
1. Life		
Domestic	200,000	300,000
Foreign	300,000	350,000
2. Health		
Domestic	200,000	300,000
Foreign	300,000	350,000
3. Life and Health		
Domestic	400,000	400,000
Foreign	400,000	425,000
4. Property	200,000	300,000
5. Casualty with Workers' Compensation	300,000	350,000
without Workers' Compensation	200,000	300,000
6. Marine and Transportation	200,000	300,000
7. Surety	200,000	300,000
8. Title	200,000	300,000
9. Multiple Lines	400,000	400,000

If within 3 years after initial certificate of authority is issued, the insurer applies to transact additional line(s), it must possess capital and surplus in the aggregate as shown above.

TENNESSEE §§ 56-2-114, 56-2-115

	Capital	Surplus
1. All Insurers	1,000,000	1,000,000
2. Reinsurance Only - Credit Life and/or Accident and Health	150,000	50% of capital

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TEXAS Arts. 2.02, 3.02, 3.22, 15.04, 21.43, 21.44

		Capital	Surplus
1.	Companies Other Than Life, Accident or Health	1,000,000	1,000,000
2.	Life and/or Accident and/or Health	700,000	700,000
3.	Foreign Mutual - Cyclone, Tornado, Hail and Storm Insurance		2,000,000

By 12/31/92, company's capital must be increased by at least 10% of the difference between the minimum capital level required for a newly incorporated company and the company's capital on December 31, 1991.

By 12/31/93, company's capital must be increased by at least 20% of the difference between the minimum capital level required by a newly incorporated company and the company's capital on December 31, 1991.

By 12/31/94, increase by at least 30%.
By 12/31/95, increase by at least 40%.
By 12/31/96, increase by at least 50%.
By 12/31/97, increase by at least 60%.
By 12/31/98, increase by at least 70%.
By 12/31/99, increase by at least 80%.
By 12/31/2000, increase by at least 90%.
By 12/31/2001, same as for new company.

The board may adopt rules, regulations and guidelines requiring any company incorporated under this article and any admitted alien or foreign insurer to maintain capital and surplus levels in excess of the statutory levels required by this article based upon nature, type and volume of risks, company's portfolio, and company's reserves.

UTAH §§ 31A-5-211, 31A-17-302, 31A-6-204, 31A-7-201, 31A-9-209, 31A-14-205

		Capital (Stock) or Surplus (Mutual)	Compulsory Surplus
1.	Life, Annuity, Disability or and combination	400,000	(See note #)
*2.	Property	200,000	
*3.	Surety	300,000	
*4.	Bail Bonds Only	100,000	
*5.	Marine and Transportation	200,000	
*6.	Vehicle Liability	400,000	
*7.	Liability	600,000	
*8.	Workers' Compensation	300,000	
9.	Title	200,000	
10.	Professional Liability, excluding Medical Malpractice	700,000	
11.	Professional Liability, including Medical Malpractice	1,000,000	
12.	Multiple Lines, except life, annuity or title	2,000,000	

*Subject to an aggregate of $1,000,000 capital for more than one of these lines.

Assessable Mutuals: shall not issue life or annuities; need not have a permanent surplus if policyholder assessment liability is unlimited; compulsory surplus is equal to that required of an insurer in compliance with the code.

Utah continued on next page

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UTAH (cont.)

Compulsory Surplus: the greater of

a. 75% minimum capital; or

b. net total of $SO per $1,000 life insurance amount at risk, plus 10% disability premiums earned, plus 3 1/2% annuity reserves, plus 15% net workers' compensation and other liability premiums earned, plus 20% medical malpractice premiums earned, plus 10% net premiums earned on lines of insurance not set forth, plus 5% admitted value of common stocks and real estate, plus 2% admitted value of all other invested assets (some exclusions apply), less any mandatory security valuation reserve being maintained, and less minimum required capital (or permanent surplus) required.

"Phase-In Standards" apply to insurers who do not meet the above compulsory surplus requirements as of 12/31/86.

VERMONT tit. 8 §§ 3301, 3304, 3309; Bulletin 43

	Capital	Surplus
Stock Insurers:		
All Insurers Seeking to Commence Business After 7/1/91	2,000,000	3,000,000
Prior to 7/1/91	250,000	150,000
	Basic Surplus	**Free Surplus**
Mutual Insurers:		
Commencing Business After 7/1/91	2,000,000	3,000,000
Prior to 7/1/91	250,000	150,000

Commissioner may prescribe additional capital or surplus for all insurers based upon the type, volume, and nature of insurance transacted.

VIRGIN ISLANDS tit. 22 §§ 451, 462, 466

Initial Requirements:	Capital	Surplus
1. Life	100,000	50,000
2. Disability	100,000	25,000
3. Life and Disability	125,000	75,000
4. Property	200,000	50,000
5. Marine and Transportation	250,000	150,000
6. Vehicle Only	200,000	100,000
7. General Casualty	300,000	150,000
8. Surety	100,000	400,000
9. Bail Bonds Only	25,000	25,000
10. All Lines but Life and Title	450,000	250,000

Virgin Islands continued on next page

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		Capital	Surplus
	Additional Capital Requirements:		
A.	Authorized for Disability:		
	Property	150,000	
	Vehicle	150,000	
	General Casualty	200,000	
	Marine and Transportation	250,000	
	Surety	250,000	
	Bail Bond	50,000	
	Fidelity	50,000	
B.	Authorized for Property:		
	Disability	50,000	
	Vehicle	100,000	
	General Casualty	150,000	
	Marine and Transportation	100,000	
	Surety	150,000	
	Bail Bond	50,000	
	Fidelity	50,000	
C.	Authorized for Vehicle:		
	Disability	50,000	
	Property	100,000	
	General Casualty	100,000	
	Marine and Transportation	100,000	
	Surety	150,000	
	Bail Bond	50,000	
	Fidelity	50,000	
D.	Authorized for General Casualty:		
	Disability	none	
	Property	50,000	
	Vehicle	none	
	Marine and Transportation	50,000	
	Surety	50,000	
	Bail Bond	25,000	
	Fidelity	none	
E.	Authorized for Marine and Transportation:		
	Disability	50,000	
	Property	50,000	
	Vehicle	50,000	
	General Casualty	100,000	
	Surety	100,000	
	Bail Bond	25,000	
	Fidelity	50,000	
F.	Authorized for Surety:		
	Disability	50,000	
	Property	50,000	
	Vehicle	50,000	
	General Casualty	50,000	
	Marine and Transportation	50,000	
	Bail Bond	none	
	Fidelity	none	

Virgin Islands continued on next page

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VIRGIN ISLANDS (cont.)

	Capital	Surplus
G. Authorized for Bail Bond:		
Disability	100,000	
Property	200,000	
Vehicle	200,000	
General Casualty	275,000	
Marine and Transportation	225,000	
Surety	250,000	
Fidelity	50,000	

Special Surplus:

A. Vehicle, General Casualty (except disability and fidelity), Marine and Transportation, or Surety (except bail bond and fidelity), shall be $100,000.

B. All Lines but Life, Title and Disability: $250,000.

VIRGINIA §§ 38.2-1037, 38.2-1028, 38.2-1029, 38.2-1030

	Capital	Surplus
New Insurers:		
1. All Stock Insurers	1,000,000	3,000,000
2. Assessable Mutual Insurers		1,600,000
3. Nonassessable Mutual Insurers		2,000,000
4. Nonassessable Mutual Insurers Authorized After 6/30/91		4,000,000

Insurers licensed to transact business prior to 6/30/91 have until 7/1/94 to attain the above levels.

WASHINGTON §§ 48.05.340, 48.05.360

	Paid-In (Stock) or Basic Surplus (Mutual)	Capital Additional Surplus
Authorized Before 7/1/91:		
1. Life	1,000,000	1,000,000
2. Disability	1,000,000	1,000,000
3. Life and Disability	1,200,000	1,200,000
4. Property	1,000,000	1,000,000
5. Marine and Transportation	1,000,000	1,000,000
6. General Casualty	1,200,000	1,200,000
7. Vehicle	1,000,000	1,000,000
8. Surety	1,000,000	1,000,000
9. Any Two of the Following: Property, Marine and Transportation, General Casualty, Vehicle, Surety, or Disability	1,500,000	1,500,000
10. Multiple Lines (all but Life and Title)	1,500,000	1,500,000

Washington continued on next page

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WASHINGTON (cont.)

	Paid-In (Stock) or Basic Surplus (Mutual)	Capital Additional Surplus
Authorized On or After 7/1/91:		
1. Life	2,000,000	2,000,000
2. Disability	2,000,000	2,000,000
3. Life and Disability	2,400,000	2,400,000
4. Property	2,000,000	2,000,000
5. Marine and Transportation	2,000,000	2,000,000
6. General Casualty	2,400,000	2,400,000
7. Vehicle	2,000,000	2,000,000
8. Surety	2,000,000	2,000,000
9. Any Two of the Following: Property, Marine and Transportation, General Casualty, Vehicle, Surety, or Disability	3,000,000	3,000,000
10. Multiple Lines (all but Life and Title)	3,000,000	3,000,000

WEST VIRGINIA §§ 33-3-5a, 33-3-5b, 33-24-10

	Minimum Capital (stock insurer) or Surplus (mutual insurer)	Additional Surplus
Authorized prior to 3/10/90:		
1. Life	750,000	2,000,000
2. Accident and Sickness	750,000	2,000,000
3. Life, Accident and Sickness	1,000,000	2,000,000
4. Fire and Marine	250,000	2,000,000
5. Casualty	250,000	2,000,000
6. Surety	600,000	2,000,000
7. Accident and Sickness with: Fire and Marine and/or Casualty	450,000	2,000,000
8. Fire and Marine and Casualty	500,000	2,000,000
9. Surety with Accident and Sickness, Fire and Marine, and/or Casualty	750,000	2,000,000

Insurers authorized under prior law have until 1/1/93 to meet requirements below.

	Capital	Surplus	Mutual Surplus
Authorized On or After 3/10/90:	1,000,000	1,000,000	2,000,000

WISCONSIN § 611.19

	Minimum Capital (stock insurer) or Surplus (mutual insurer)	Additional Surplus
1. All Stock and Nonassessable Mutual Insurers	2,000,000	50% of minimum
2. Assessable Mutuals:		
Initial Minimum	100,000	
Assessment Unlimited	none	
Assessment Limited	reduced to reasonable amount	

Commissioner may reduce the required amounts.

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WYOMING §§ 26-3-108 to 26-3-110, 26-24-109

	Stock Insurers			Reciprocals and Foreign Domestic
			Mutuals	Mutuals
	Capital	Surplus	Surplus	Surplus
1. Life	1,000,000	500,000	1,500,000	150,000
2. Disability	1,000,000	500,000	1,500,000	150,000
3. Life and Disability	1,000,000	1,000,000	2,000,000	
4. Property	1,000,000	1,000,000	2,000,000	200,000
5. Casualty without Surety or W.C.	1,000,000	1,000,000	2,000,000	200,000
6. Casualty with Surety and W.C.	*1,000,000*	*1,500,000*	*2,500,000*	*250,000*
7. Marine and Transportation	1,000,000	1,000,000	2,000,000	
8. Multiple Line (property and any additional kind)	2,000,000	2,000,000	4,000,000	
9. Title	500,000	250,000		

The commissioner may require additional capital and surplus based on types, volume, and nature of insurance business transacted.

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Every attempt has been made to provide correct and complete information. The reader should consult the statutes of the specific states to ascertain all applicable requirements.

NAIC
9/17/92

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Appendix B

Financial Regulation Standards and Accreditation Program

National Association of Insurance Commissioners
June 19,1992
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INTRODUCTION

A system of effective solvency regulation has certain basic components. It requires that regulators have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs. It requires that regulators have the necessary resources to carry out that authority. Finally, it requires that insurance departments have in place organizational and personnel practices designed for effective regulation.

To guide state legislatures and state insurance departments in the development of effective solvency regulation, the NAIC began, in **1988,** the process which led to the adoption of the NAIC Financial Regulation Standards in June **1989.** These standards, discussed in greater detail below, establish minimum requirements for an effective regulatory system in each state.

In order to provide guidance to the states regarding the minimum standards and an incentive to put them in place, the NAIC adopted in June **1990** a formal certification program. Under this plan, each state's insurance department will be reviewed by an independent review team whose job it is to assess that department's compliance with the NAIC Financial Regulation Standards. Departments meeting the NAIC Standards will be publicly acknowledged, while departments not in compliance will be given guidance by the NAIC to bring the department into compliance. Furthermore, beginning in January **1994,** accredited states will not accept reports of zone examinations from unaccredited states except under limited circumstances, providing further impetus for states to adopt the minimum standards. It is likely that states will pass similar provisions to act as incentives for state insurance departments to become accredited. For example, a state may decide not to license a company domiciled in a non-accredited state.

To help states assess their compliance with the standards, the NAIC has performed a review of each state's laws and regulations addressing insurer insolvency, in order to alert states to differences between the NAIC models that are a part of the Financial Regulation Standards and each state's statutes and regulations.

Thirteen states—Colorado, Florida, Illinois, Iowa, Kansas, Minnesota, New York, North Carolina, North Dakota, Ohio, South Carolina, Virginia, and Wisconsin—have undergone the formal certification process and have been accredited as being in compliance with the Financial Regulation Standards. Additional states will be reviewed in the second half of **1992.**

HOW THE ACCREDITATION PROGRAM WORKS

The NAIC accreditation program establishes minimum requirements under which a state insurance department may seek initial accreditation. Additionally, the Program establishes guidelines for states already accredited to maintain that accreditation over time.

Initial Accreditation Review

1. State requests an accreditation review by contacting the Support and Services Office **(SSO)** of the NAIC.
2. NAIC/SSO **confirms** with the state that the Financial Regulation Standards Self-Evaluation Guide on file at the **SSO** is current and complete or requests the state to submit an updated Self- Evaluation Guide.
3. NAIC/SSO notifies the Financial Regulation Standards and Accreditation Committee (FRSAC) that the state has requested an accreditation review and provides FRSAC with a list of qualified Review Team candidates, comprised of experts in insurance regulation with no present ties to either the industry or an insurance department.
4. FRSAC selects the Review Team **and** the Review Team Leader from the qualified list. The Review Team consists of three to **six** individuals, depending on the size of the state. At least one of the Review Team members is required to be a disinterested former executive level regulator.
5. NAIC/SSO notifies the state of the Review Team selected by the FRSAC.
6. NAIC/SSO notifies the Review Team members. The Review Team members are paid by the NAIC/SSO at a set hourly rate for the time plus reasonable actual expenses incurred.
7. NAIC/SSO works with the state to schedule the site visit and notifies the Review Team of the timing. Generally, a site visit takes three to five days, depending on the size of the state.
8. NAIC/SSO sends copies of the state's completed Financial Regulation Standards Self-Evaluation Guide plus any applicable supporting documentation and the NAIC/SSO staff's synopsis of the Self-Evaluation Guide and detailed review of the Laws and Regulations section including any concerns and potential problems to each Review Team member to enable the Review Team to plan and prepare for the site visit.
9. NAIC/SSO notifies the state of the data, other information, and interview needs of the Review Team for their on-site review.
10. Review Team performs the on-site review following a general outline of procedures to be performed to allow for uniformity among the site visits at the different states. In addition, an NAIC/SSO representative is an observer on each site visit to help ensure uniformity and consistency in each on-site review. Before the on-site review, there is an initial meeting of the team members to discuss comments and concerns from review of the Financial Standards Self-Evaluation Guide and supporting documentation and the NAIC staff's synopsis of the Self- Evaluation Guide.
11. The on-site review consists of the following:
    a. Interviews with department personnel.
    b. Review of laws and regulations.
    c. Review of prior examination reports and supporting work papers and analytical reviews.

d. Inspection of regulatory files for selected companies.

e. Review of organizational and personnel policies.

f. Walk-through of the department to gain an understanding of document and communication flows.

g. Meeting of the team members to discuss comments and findings from the review.

h. Closing conference with the state to discuss findings.

12. As a result of the site visit, a report is prepared by the Review Team and submitted to the FRSAC by the Team Leader. The report summarizes the scope of the procedures performed during the site visit, documents the findings on an exception basis, highlights major recommendations as a result of the review, and concludes with an opinion of the Review Team as to whether the Team believes that the state should be accredited by the FRSAC.

13. FRSAC meets to discuss the Review Team's report. FRSAC also has copies of the state's Financial Regulation Standards Self-Evaluation Guide and supporting documentation available. In addition, the Review Team and/or the Team Leader is present at the meeting as needed. The NAIC/SSO representative who served as an observer on the on-site review also attends the meeting.

14. As a result of this meeting, the FRSAC makes a decision whether or not the state should be accredited. Except in unusual circumstances, the recommendations of the review team will be adopted by the FRSAC.

15. FRSAC informs the state of its decision. If the decision is favorable, the state receives an accreditation award at the next scheduled NAIC national meeting, and a press release acknowledging the accreditation will be issued. If the decision is unfavorable, the state has three options: withdraw the request for accreditation; ask FRSAC to hold its decision in abeyance pending legislative or other corrective action to bring the state into compliance with the standards; or ask the FRSAC to reconsider the decision.

16. If the state requests reconsideration, FRSAC meets to hear the state's appeal. As a result of this meeting, FRSAC makes a final decision regarding whether to accredit the state and inform the state of the decision.

17. Accreditation is for a five-year period, subject to annual reviews of the state's Financial Regulation Standards Self-Evaluation Guide. If information comes to the attention of the FRSAC which suggests that a state may no longer meet the standards, a special review may be conducted.

18. If FRSAC concludes that the state should not be accredited, the specific reasons are documented in a report to the state.

Interim Annual Reviews

1. Annually, on the first four anniversaries of the state's accreditation, the state shall submit updated Financial Regulation Standards Self-Evaluation Guides along with a report which summarizes the changes from the prior year to the NAIC/SSO.
2. The state's report in the first interim year after accreditation shall also respond to all recommendations made in the Review Team's report which was prepared during the accreditation process.
3. NAIC/SSO will review the documentation submitted by the state and summarize for presentation to FRSAC.
4. After hearing the report from the NAIC/SSO, FRSAC will determine whether the state still complies with the financial regulation standards. (FRSAC can request that a representative of the state be present to answer questions, if desired.)
5. If FRSAC finds the state to be in non-compliance with the financial regulation standards, the specific reasons would be documented in a letter to the state and the accreditation would be revoked.
6. On the fifth anniversary of the state's accreditation, the state would be subject to a full accreditation review following the steps outlined for an initial accreditation review above.

A CLOSER LOOK AT THE MINIMUM STANDARDS

The financial regulation standards have been divided into three major categories: laws and regulations; regulatory practices and procedures; and organizational and personnel practices.

Laws and Regulations

1. Examination Authority

The department should have authority to examine companies whenever it is deemed necessary. Such authority should include complete access to the company's books and records and, if necessary, the records of any affiliated company, agent, and/or managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees, and agents of the company under oath when deemed necessary with respect to transactions directly or indirectly related to the company under examination.

2. Capital and Surplus Requirement

The department should have the ability to require that insurers have and maintain a minimum level of capital and surplus to transact business. The department should have the authority to require additional capital and surplus based upon the type, volume, and nature of insurance business transacted.

3. NAIC Accounting Practices and Procedures

The department should require that all companies report-

ing to the department file the appropriate NAIC annual statement blank which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the NAIC's Accounting Practices and Procedures Manual.

4. Corrective Action

State law should contain the NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in a Hazardous Condition or a substantially similar provision which authorizes the department to order a company to take necessary corrective action or cease and desist certain practices which, if not corrected, could place the company in a hazardous financial condition.

5. Valuation of Investments

The department should require that securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC's Valuation of Securities Office. Other invested assets should be required to be valued in accordance with the procedures promulgated by the NAIC's Financial Condition (EX4) Subcommittee.

6. Holding Company Systems

State law should contain the NAIC Model Holding Company Systems Act or an Act substantially similar, and the department should have adopted the NAIC's model regulation relating to this law.

7. Risk Limitation

State law should prescribe the maximum net amount of risk to be retained by a property and liability company for an individual risk based on the company's capital and surplus which should be no larger than 10% of the company's capital and surplus.

8. Investment Regulations

State statute should require a diversified investment portfolio for all domestic insurers both as to type and issue and include a requirement for liquidity.

9. Admitted Assets

State statute should describe those assets which may be admitted, authorized, or allowed as assets in the statutory financial statement of insurers.

10. Liabilities and Reserves

State statute should prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an insurer; including, life reserves, active life reserves, and unearned premium reserves and liabilities for claims and losses unpaid and incurred but not reported claims.

11. Reinsurance Ceded

State law should contain the NAIC Model Law on Credit for Reinsurance and the Model Regulation for Life Reinsurance Agreements or substantially similar laws.

12. CPA Audits

State Statute or regulation should contain a requirement for annual audits of domestic insurance companies by independent certified public accountants, such as contained in the NAIC's Model Requiring Annual Audited Financial Reports.

13. Actuarial Opinion

State statute or regulation should contain a requirement for an opinion on life and health policy and claim reserves and property and liability loss and loss adjustment expense reserves by a qualified actuary or specialist on an annual basis for all domestic insurance companies.

14. Receivership

State law should set forth a receivership scheme for the administration, by the insurance commissioner, of insurance companies found to be insolvent as set forth in the NAIC's Model Law on Supervision, Conservation, Rehabilitation, and Liquidation.

15. Guaranty Funds

State law should provide for a statutory mechanism, such as that contained in the NAIC's model acts on the subject, to ensure the payment of policyholders' obligations subject to appropriate restrictions and limitations when a company is deemed insolvent.

16. Other

i) State Statute should contain a provision similar to the NAIC Model Act requiring domestic insurance companies to participate in the NAIC Insurance Regulatory Information System (IRIS).

ii) State law should contain a provision similar to the NAIC's Model Risk Retention Act for the regulation of risk retention groups and purchasing groups.

iii) State statute should contain the NAIC's Model Law for Business Transacted with Producer Controlled Property/Casualty Insurer Act or a similar provision. This Model was amended in June 1991 and will not be required for accreditation until June 1993.

17. Recent Additions to the Standards

In December 1990, the NAIC added to the original list of Financial Regulation Standards three additional standards:

i) Managing General Agents

State law should contain the NAIC Managing General Agents Act or an Act substantially similar.

ii) Reinsurance Intermediaries

State law should contain the NAIC Reinsurance Intermediaries Act or an Act substantially similar.

iii) Examinations

State law should contain the NAIC Model Law on Examination or an Act substantially similar.

States will have two years from the date of adoption by the NAIC to comply with these new standards (see "Evolving Standards: The Impact of Changes in the Fi-

nancial Regulation Standards," page 11, for procedures for revising standards).

Regulatory Practices and Procedures

1. Financial Analysis

i) Department should have a sufficient staff of financial analysts with the capacity to effectively review the financial statements as well as other information and data to discern potential and actual financial problems of domestic insurance companies.

ii) Department should have an intra-department communication and reporting system that assures that all relevant information and data received by the department which may assist in the financial analysis process is directed to the financial analysis staff.

iii) The internal financial analysis process should provide for levels of review and reporting.

iv) The financial analysis procedure should be priority based to ensure that potential problem companies are reviewed promptly. Such a prioritization scheme should utilize the NAIC's Insurance Regulator Information System and/or a state's own system.

2. Financial Examinations

i) The department should have the resources to examine all domestic companies on a periodic basis which is commensurate with the financial strengths and position of the insurer.

ii) The department's examination staff should consist of a variety of specialists with training and/or experience in the following areas or otherwise available qualified specialists which will permit the department to effectively examine any insurer: computer audit specialist, reinsurance specialist, life and health company examiners, property and liability examiners, life and health actuarial examiners, property and liability actuarial examiners, and property and liability claims examiners.

iii) The department's procedures for examinations shall provide for supervisory review within the department of examination work papers and reports to ensure that the examination procedures and findings are appropriate and complete and that the examination was conducted in an efficient and timely manner.

iv) The department's policy and procedures for examinations should follow those that are set forth in the NAIC's Examiners Handbook.

v) In scheduling financial examinations, the department should follow those procedures set forth in the NAIC's Examiners Handbook. The schedule should provide for the periodic examination of all domestic companies on a timely basis. This system should accord priority to companies which are having adverse financial trends or otherwise demonstrate a need for examination such as determinations of the NAIC IRIS Examiner Team.

vi) The department's procedures require that all examination reports which contain material adverse findings be promptly presented to the Commissioner or his or her designee for determination and implementation of appropriate regulatory action.

vii) The department's reports of examination should be prepared in accordance with the format adopted by the NAIC and should be sent to other states in which the company transacts business in a timely fashion.

3. Other

The department should generally follow and observe the procedures set forth in the NAIC's Troubled Insurance Company Handbook regarding domestic insurance companies identified as troubled, including communication to the insurance departments in jurisdictions in which the carrier transacts business.

Organizational and Personnel Practices

1. Professional Development

The department should have a policy which requires the professional development of staff through job-related college courses, professional programs, and/or other training programs which are funded by the department.

2. Organization

All financial regulation and surveillance activities are the responsibility of an individual who shall report to the Commissioner or his or her designee.

3. Evaluation of Staff

The department's staff and contractual staff involved in financial regulation and surveillance should all be periodically evaluated by the department to ensure that job duties and responsibilities are being discharged in a satisfactory manner.

4. Minimum Educational and Experience Requirements

The department should establish minimum educational and experience requirements for all professional employees and contractual staff positions in the financial surveillance and regulation area which are commensurate with the duties and responsibilities of the position.

5. Pay Structure

The department's pay structure for those positions involved with financial surveillance and regulation should be competitively based to attract and retain qualified personnel.

6. Funding

The department's funding should be sufficient to allow for the financial surveillance and regulation staff's participation as appropriate in the meetings and training sessions of the NAIC and meetings relating to the review, coordination, and the development and implementation of action for troubled insurers.

Evolving Standards: The Impact of Changes in the Financial Regulation Standards

As insurance industry practices evolve, *so* must solvency regulation. In recognition of this, the NAIC **has** anticipated that the original Financial Regulation Standards, outlined above, would not be static, but would be changed from time to time. The Accreditation Program reflects this concept by allowing for additional minimum standards. In the event additional standards are established by the NAIC, state insurance departments seeking to acquire or retain accreditation will have two years from the date of the NAIC established the new standards to implement them.

In December 1991, the NAIC adopted formal procedures to encourage input from public officials, consumers, academics, and industry representatives in the process when making changes in the NAIC's Financial Regulation Standards and Accreditation Program.

The procedures identify four ways in which the solvency standards may be modified:

1. The development of new models;
2. Amendments to existing models already included in the standards;
3. Addition of more or more specific requirements in any part of the standards; or
4. Modification of current requirements already generically included in the standards, such as modification of the Annual Statement Blank required to be filed by all companies.

The procedures for the development of a new model that the Executive Committee foresees will be considered for incorporation into the standards and amendments to models already included in the standards are much the same. In both cases, the Executive Committee, either upon request or of its own initiative, will make note of the potential impact on the standards in its charge to the panel responsible for the development of the model. The panel will then give notice to all insurance regulators, the National Conference of State Legislatures (NCSL), National Governors' Association (NGA), National Conference of Insurance Legislators (NCOIL), and others, both of the potential change in standards and of meeting times and places.

Once the new or amended model is received by the Executive Committee, it will be referred to the Financial Regulation Standards and Accreditation Committee (FRSAC) for a recommendation on whether the model is appropriate for inclusion in the standards.

Should any member of the NAIC or FRSAC propose additional requirements in parts **A,** B, or C of these standards, initial review of that proposal will be conducted by FRSAC, and the procedure for notice to and participation by public officials and members of the public shall be the same as for other changes in the standards.

WHAT THE FUTURE HOLDS: A STRONG SYSTEM OF SOLVENCY REGULATION

In its present state, the regulation of the insurance industry for solvency stands as a unique example of how a national regulatory system can be built with its foundation at the state, not federal, level. The strength of that system resides in the interdependence of independent state regulators, each responsible to his or her own constituency, yet jointly responsible for the financial health of an entire industry.

State insurance regulators, not content to rest on historic success of the current regime, have devised, in the Financial Regulation Standards Accreditation Program, a powerful means of achieving the necessary degree of uniformity among states without sacrificing the multi-state diversity that has been instrumental to that success. **At** this writing, state legislatures and insurance departments across the nation are moving at an unprecedented pace to bring their respective solvency regulation into compliance with the NAIC's standards. In fact, in 1991 alone, **42** states adopted legislative packages designed to bring their departments of insurance into compliance with the Financial Regulation Standards. Four other states and the District of Columbia considered similar packages.

This flurry of legislative and administrative activity runs counter to the prediction of some critics of the Accreditation Program that the incentives for compliance with the standards would prove to be inadequate to motivate legislatures and insurance departments to upgrade their solvency regulation approach. **As** can be seen from this activity, the blend of peer pressure among state regulators, political support from multi-state domestic insurers, the sanction imposed by the new Model Law on Examination (see discussion at Page 1), and the likelihood of the future adoption of even more severe incentives, has proven to be a potent force in encouraging legislators and regulators to strive to attain the NAIC's standards.

Other ACIR Publications

Federal Statutory Preemption of State and Local Authority: History, Inventory, and Issues. A.121. 1992 ... $10.00
Changing Public Attitudes on Governments and Taxes—1992, S.21. 1992 ... $10.00
Significant Features of Fiscal Federalism. 1992 Edition. Volume I. M.180. 1992 ... $20.00
Volume II, M-180-II, 1992 ... $22.50
Toward a Federal Infrastructure Strategy: Issues and Options. A.120. 1992 ... $10.00
Medicaid: Intergovernmental Trends and Options. A.119. 1992 ... $10.00
Local Boundary Commissions: Status and Roles in Forming. Adjusting and Dissolving Local Government Boundaries. M.183. 1992 ... $8.00
Characteristics of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded FY 1991. M.182. 1992 ... $10.00
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Local Revenue Diversification:
Rural Economies. SR-13, 1990 ... $8.00
Local Sales Taxes. SR.12. 1989 ... $8.00
Local Income Taxes. SR.IO. 1988 ... $5.00
User Charges. SR.6. 1987 ... $5.00
State Taxation of Banks: Issues and Options. M.168.1989 ... $10.00
State Regulation of Banks in an Era of Deregulation. A-110, 1988 ... $10.00
State Constitutions in the Federal System: Selected Issues and Opportunities for State Initiatives. A.113. 1989 ... $15.00
Residential Community Associations:
Private Governments in the Intergovernmental System? A.112. 1989 ... $10.00
Questions and Answers for Public Officials. M-166, 1989 ... $5.00
Disability Rights Mandates: Federal and State Compliance with Employment Protections and Architectural Barrier Removal. A-111, 1989 ... $10.00
Assisting the Homeless: State and Local Responses in an Era of Limited Resources. M.161. 1988 ... $10.00
Devolution of Federal Aid Highway Programs: Cases in State-Local Relations and Issues in State Law. M-160, 1988 ... $5.00
Devolving Selected Federal-Aid Highway Programs and Revenue Bases: A Critical Appraisal. A-108, 1987 ... $10.00
The Organization of Local Public Economies. A-109, 1987 ... $5.00

What Is ACIR

The **U.S. Advisory Commission on Intergovernmental Relations** (ACIR) was created by the Congress in 1959 to monitor the operation of the American federal system and to recommend improvements. ACIR is an independent, bipartisan commission composed of 26 members—nine representing the federal government, 14 representing state and local government, and three representing the general public.

The President appoints 20 members—three private citizens and three federal executive officials directly, and four governors, three state legislators, four mayors, and three elected county officials from slates nominated by the National Governors' Association, the National Conference of State Legislatures, the National League of Cities, U.S. Conference of Mayors, and the National Association of Counties. The three Senators are chosen by the President of the Senate and the three Representatives by the Speaker of the House of Representatives.

Each Commission member serves a two-year term and may be reappointed.

As a continuing body, the Commission addresses specific issues and problems the resolution of which would produce improved cooperation among federal, state, and local governments and more effective functioning of the federal system. In addition to examining important functional and policy relationships among the various governments, the Commission extensively studies critical governmental finance issues. One of the long-range efforts of the Commission has been to seek ways to improve federal, state, and local governmental practices and policies to achieve equitable allocation of resources, increased efficiency and equity, and better coordination and cooperation.

In selecting items for research, the Commission considers the relative importance and urgency of the problem, its manageability from the point of view of finances and staff available to ACIR, and the extent to which the Commission can make a fruitful contribution toward the solution of the problem.

After selecting intergovernmental issues for investigation, ACIR follows a multistep procedure that assures review and comment by representatives of all points of view, all affected governments, technical experts, and interested groups. The Commission then debates each issue and formulates its policy position. Commission findings and recommendations are published and draft bills and executive orders developed to assist in implementing ACIR policy recommendations.