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REGULATION OF INSURANCE COMPANIES AND THE ROLE OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

HEARING

BEFORE THE

SUBCOMMITTEE ON
POLICY RESEARCH AND INSURANCE

OF THE

COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

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MONDAY, JULY 29, 1991

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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REGULATION OF INSURANCE COMPANIES AND THE ROLE OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MONDAY, JULY 29, 1991

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON POLICY RESEARCH AND INSURANCE,
COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 2 p.m., in room 2222, Rayburn House Office Building, Hon. Ben Erdreich [chairman of the subcommittee] presiding.

Present: Chairman Erdreich, Representatives Kanjorkski, Bereuter, Roth, and Nussle.

Chairman ERDREICH. We call this hearing to order. The subcommittee has called this hearing to consider the effectiveness of the current regulatory structure of the insurance industry. Individuals, workers, and retirees, as well as commercial enterprises and financial institutions, depend on the safety and soundness of the insurance industry. We all are concerned about any erosion of the industry's financial health, and I have called this hearing to determine what must be done to reverse the trend.

The number of insurance failures has increased alarmingly over the last several years. During the 1970's, there were 108 property/casualty insolvencies; during the 1980's there were 226 insolvencies, with a significant increase beginning in 1984. During the first half of the 1980's, there were 20 life/health company insolvencies; during the last half there were 65 insolvencies, with 26 in 1989 and 13 in 1990. In this year alone, we have witnessed the failures of some of the industry's largest companies, such as Executive Life and Mutual Benefit.

Over the last 2 years, the subcommittee has held hearings on solvency issues for property and casualty insurers relating to earthquake risks and pollution liability. In those hearings we learned of the interrelationships between the insurance industry and other types of financial intermediaries. In particular, we learned that significant insolvencies in the insurance industry may have impacts throughout the financial markets, including impacts on federally insured banks and thrifts.

The subcommittee has also issued a report on the insurance industry, with particular focus on their role as financial intermediaries and competitors with banks and thrifts for limited funds from investors and retirees. Increased competition among banks and insurers suggests the need for similar regulatory policies for bank

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and insurer regulators to avoid creating unintended consequences in the marketplace.

Many of the market forces that influenced investment decisions by failed banks and thrifts have also been at work in the insurance industry, and lax regulatory supervision and inadequate regulatory response gives rise to larger problems in the future. Just as increased failures in the banking and thrift industries has required Congress to review regulatory activities and capital standards of these financial institutions, increased insurance company failures require increased scrutiny.

To begin the subcommittee's inquiry into insurance regulation, I have invited testimony from the National Association of Insurance Commissioners. I have no preconceived ideas about the effectiveness of State regulation or about the potential need of the Federal Government in the regulation of insurance companies, but the number of recent insolvencies and their causes suggest at the very least a need for increased diligence and oversight by regulators. It is clear that the current regulatory oversight of the insurance industry must be enhanced and strengthened.

The NAIC has engaged in a program of strengthening regulatory standards and reserve requirements. This includes an accreditation program for States in an effort to impose uniform regulatory guidelines and standards. With this hearing I hope to determine whether these steps are enough to address the problems, or whether the private, voluntary structure of the NAIC is inadequate to force States to adopt real, uniform guidelines and standards.

The subcommittee intends to conduct several hearings on insurance regulation and the impact of insurer insolvencies on the economy and financial markets. Ultimately, Congress must decide what role, if any, the Federal Government must play in the regulation of the industry.

[The prepared statement of the Hon. Ben Erdreich can be found in the appendix.]

Chairman ERDREICH. Mr. Roth, do you have any opening statement or comments?

Mr. ROTH. Thank you, Mr. Chairman.

First of all, I want to compliment you for having this hearing today. We do have an excellent panel. I am a member of a board of an insurance company. They are meeting today, but I could not be there because of this meeting and also because of votes on the floor.

This is a very important topic. We know the insurance industry is the back bone of our country and it is so vital to all our financial institutions. I must compliment you, Mr. Chairman, also on the panel that you have selected to be here today to give us their views on how we can improve things. I think McCarran-Ferguson has worked well. I hope we will use a rational approach in the restructuring and reengineering and not go off as Congress has done many times in a tangent and a panic.

I know under your leadership, Mr. Chairman, that we will utilize a rational approach to review some of the regulations that we do work under. I do have another hearing so I probably will not be here for the entire hearing here but I am looking at this testimony with very much interest in what our panelists tell us.

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Chairman ERDREICH. Thank you.

I want to welcome the first panel, William McCartney, Director of Insurance of the State of Nebraska and Vice President, National Association of Insurance Commissioners; Ms. Constance Foster, Commissioner, State of Pennsylvania; and Mike Weaver, Commissioner, State of Alabama.

Without objection, your full statements are part of our record and my full opening statement will be made a part of our record.

We will start with Mr. McCartney. Thank you for being here. You may summarize your statement since it is in the record.

STATEMENT OF WILLIAM McCARTNEY, DIRECTOR OF INSURANCE, STATE OF NEBRASKA; VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. MCCARTNEY. Thank you, Mr. Chairman. I am Bill McCartney and I am Director of Insurance in the State of Nebraska. I appear before this subcommittee today on behalf of the National Association of Insurance Commissioners [NAIC], as the vice president of that organization.

Those of us who regulate the business of insurance have chosen to be in this arena at a most interesting time. Public officials, both State and Federal, are at an important point of choice, between viewing troubles in the industry as a looming disaster, or as a time of opportunity to reaffirm our basic common responsibility—to provide American consumers with a valuable financial product upon which they can rely to protect against disaster and achieve their dreams. State regulators have selected to follow this second choice, to provide American consumers with a valuable financial product.

A clear-eyed approach to effective regulation begins with a realistic, choice-based analysis of the strengths of State regulation, as compared with the alternative. First, State regulators, unlike their Federal counterparts, responded to the changed financial environment in the 1980's with stronger, not weaker, regulation. Despite financial pressures on State budgets, State insurance regulators continued to see enhancements in their regulatory efforts. The NAIC's involvement in solvency regulation dates back to its formation 120 years ago. In fact, the NAIC was created specifically to address a spate of insurance company insolvencies in the late 1860's and early 1870's. Since then, this Nation's State regulators have worked together, through the NAIC, to protect the American consumer from the financial and personal loss that can be the result of the insolvency of an insurance company. The resulting system of insurance regulation provides a high degree of uniformity in the supervision of interstate companies, yet is sufficiently decentralized to provide responsiveness to insurance consumers and a sensitivity to the regulatory needs of a diverse nation.

In 1875, the NAIC adopted the predecessor to the Annual Statement Blank which, since then, has served as the uniform financial reporting form for all insurance companies. Thirty-four years later, in 1909, when changing, and sometimes fraudulent, investment practices by insurers threatened the stability of the industry, the NAIC established the Securities Valuation Office, SVO, to provide uniform valuations of insurers' securities.

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In the 1930's and 1940's, multi-State insurance companies became more prevalent. The NAIC responded, first by establishing the "zone examination system" for the regional examination of multi-State companies, then by publishing the NAIC Examiners Handbook to standardize zone examination procedures.

During the 1960's and 1970's, as the business of insurance continued to grow more complex, the NAIC responded with a host of improvements in solvency regulation. These enhancements included the adoption of model guaranty association acts and the institution of a centralized data base and early warning system to help identify and prioritize troubled companies. This system was later expanded to become what is now known as the Insurance Regulatory Information System, IRIS.

History no doubt will view 1988 as a watershed year in solvency regulation. That year, 50 insurers become insolvent or were the subject of formal regulatory action because of significant financial impairment, one of the largest numbers in years. Far more disturbing was the upheaval in other financial services institutions, primarily regulated by the Federal Government. The number of bank failures continued to climb, from 184 in 1987 to 200 in 1988. That year the 223 failed thrifts totaled nearly four times the failures in the previous year.

In this environment, in which troubles in the federally-regulated financial institutions has shaken consumer confidence in all financial institutions, the NAIC has moved aggressively to enhance what has long been a sound system of insurance regulation by beginning the process which led to the 1989 adoption of the Financial Regulation Standards. These minimum standards establish bottom line requirements for State solvency regulation in three key areas: one, laws and regulation; two, regulatory practices and procedures; and three, organizational and personnel practices.

In order to provide guidance to the States regarding the minimum standards and an incentive to put them in place, the NAIC adopted a formal certification program in June 1990. 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's Financial Regulation Standards. Departments meeting the NAIC standards will be publicly acknowledged, while departments not in compliance will be given guidance by the NAIC on how to bring the department into compliance. Furthermore, beginning in January 1994, accredited States will not accept reports of examination from nonaccredited States, providing further impetus for States to adopt the minimum standards. We expect that, as the standards are enhanced and more States enact them, greater pressure will be placed on other States to become accredited.

So far, four States, Florida, New York, South Carolina, and Illinois, have been accredited under this nascent program, and other States will be reviewed for accreditation in 1991. This audit process is less than a year old. The conduct of these first audits has served two primary functions. They have verified the capabilities of these four departments and have provided the NAIC with much information on how to improve the audit procedures necessary to obtain a thorough, credible assessment of solvency regulatory resources. Im-

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provements to the procedures are being incorporated into upcoming audits.

Some critics of State regulation have questioned whether the States will respond to the NAIC's call for enhanced solvency regulation through passage of the statutes and regulations required for NAIC certification. We are here to report to you that the response in these first few months of the program has been very encouraging. Earlier this year, the National Conference of State legislatures adopted a resolution calling on the States to adopt the NAIC's standards in every State, and the National Governors' Association passed a similar resolution endorsing the NAIC's Solvency Policing Agenda and reaffirming the organization's opposition to Federal preemption of State solvency regulation.

In the State legislatures, it appears that the joint call of regulators, legislators, and Governors for enhanced solvency regulation is being heard. Across the Nation, State legislatures are moving aggressively toward the implementation of legislation called for by the NAIC Financial Regulation Standards. So far, 33 States have adopted legislative packages designed to bring the departments of insurance into compliance with the Financial Regulation Standards, with similar packages working their way through 12 other State legislatures. With every passing week, it becomes increasingly clear that 1991 will see the passage of more proconsumer solvency legislation than in any previous year in our history.

No matter how important the standards and accreditation process is to State insurance regulation, it is only one component of a broad agenda to enhance solvency regulation. While the agenda covers a wide array of topics, such as reinsurance, guaranty funds, and the refinement of insurance accounting principles, a central component of that agenda addresses better supervision of insurer investments. For example, in June 1991, the NAIC adopted a Model Act to place a cap on the amount of junk bonds which could be held by an insurer. Furthermore, last month the NAIC began exploration of a proposal to replace the Mandatory Securities Valuation Reserve, MSVR, system for life companies, currently limited to securities, with a reserving system which covers all assets held by insurers. Additionally, the NAIC is conducting a survey of insurers to determine the extent of investment in real estate and real estate-related assets in order to develop a monitoring mechanism to detect emerging problems for those insurers with a high level of investments in this area. The results of that survey should be available in September 1991.

On another front, two NAIC panels continue their work on what will ultimately be one of the more significant changes in insurance regulation to have been devised in recent years: the development of risk-based capital requirements. Draft Model Acts are expected to be ready for exposure in late 1991 or early 1992.

Creative approaches sometimes require a willingness to break from historic patterns of behavior and belief. For years, State regulation has steadfastly and nearly uniformly resisted intervention by the Federal Government in the regulation of insurance. We have done this, not out of a sense that our "turf" must be preserved, but because of our frequent experience that, more often

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than not, such involvement hinders the resolution of the very problems the Federal involvement is intended to solve.

However, State insurance regulators are basically pragmatic, and we base our evaluation about the prospect of Federal involvement in State insurance regulation on a case-by-case analysis. On the issue of fraud in insurance, we have found that existing Federal and State laws addressing the recurring problem of deceptive financial reporting and outright theft in the insurance business do not provide the American consumer with adequate protection.

To respond to this failing, the NAIC this year proposed a Federal bill to make certain types of insurance fraud a Federal offense.

Earlier this month, the U.S. Senate agreed and passed, as an amendment to its version of the crime bill, a bill based upon the NAIC proposal. We anticipate and hope that the proposal will receive substantial support in the House when it is considered this fall. I strongly urge you to join us in support of this important proposal.

The NAIC is also showing flexibility with respect to addressing our growing concerns about regulatory problems posed by the fact that a substantial amount of reinsurance and, for that matter, surplus lines insurance, is written by companies based in other nations. In response to this concern, the NAIC has adopted in concept and is currently developing specific provisions for a Federal act to empower the NAIC to regulate all non-U.S. insurers.

At the State and NAIC levels, the enhancement of insurance regulation is proceeding on a wide rage of fronts. We are in the midst of a broad-based effort to upgrade the examination process, including:

One, enhancements in the system by which regulators are warned in a timely fashion that an examination of a particular company is called for, allowing for a targeted allocation of examination resources,

Two, improvements in the financial reporting system upon which regulators can place substantial reliance,

Three, the creation of a system of on-site examinations that are more timely and targeted toward those companies most in need of examination, and

Finally, we are taking steps to raise the overall quality of financial examinations.

We are also looking at the NAIC model act on guarantee funds. We have created a working group, specifically looking at the issue of guarantee funds and the liquidations of interstate insurance carriers. Two hearings have been held so far with the third scheduled for September. During those hearings, we have not just taken testimony from interested parties, but we have listened. No one attending those hearings could conclude that we began the process with a decision about the final product already made.

Yet there are those who claim that the States, in spite of our efforts, cannot effectively regulate the insurance industry. We have seen this analysis echoed by the U.S. General Accounting Office. This agency, which has built a formidable reputation on its ability to objectively weigh alternatives in arriving at a solution to a wide range of problems, has turned its back on its own legacy and fol-

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lowed much the same, nonchoice path as have some editorial writers.

In its May 22 testimony before Chairman Dingel's subcommittee, the GAO unleashed an indictment of the current, State-based system of insurance regulation with no reference to any alternative systems. This is, in our opinion, a glaring failure of analysis, made more glaring by the fact that the GAO has analyzed and reanalyzed the regulation, Federal and State, of thrifts and banks. In other words, an agency that possesses all the resources they would need to compare State regulation of insurance to various regulatory structures of other financial institutions declined to do so.

Unfortunately, this flawed analysis does more to obscure than illuminate the important public policy issues involved in insurance regulation. No, solutions are products of creativity, and creativity is not served by forcing reality to fit slogans like "patchwork system of regulation" or "inadequate regulatory resources."

Mr. Chairman, State insurance regulators and the NAIC have made our choice—to look clearly at the problems and the strengths, and to address the problems while building on the strengths. We have made this choice, not because we inherently make better decisions than those who approach these issues with closed minds but because, as the regulators of the industry, we have to live with the consequences of our choices.

Holding firmly to beliefs that just don't wash leads us down blind alleys. Creating solutions out of the strengths of what exists leads us to a better system of regulation.

With me on the panel is Commissioner Connie Foster from Pennsylvania and Commissioner Mike Weaver from Alabama. They will give you further details of efforts in their States to bring them more into compliance with NAIC's financial standards package.

Thank you.

Chairman ERDREICH. Thank you.

[The prepared statement of Mr. McCartney can be found in the appendix.]

Chairman ERDREICH. Next, Constance Foster, Commissioner, State of Pennsylvania. Welcome. Your full statement is part of the record. If you would summarize, we will appreciate it.

STATEMENT OF CONSTANCE FOSTER, COMMISSIONER, STATE OF PENNSYLVANIA

Ms. FOSTER. I am, of course, the Insurance Commissioner of Pennsylvania, and I have held that office since January 1987. I will not repeat anything Bill covered, but I will talk about what has gone on in Pennsylvania.

I think Pennsylvania got a jump on the solvency issue. In 1987, the legislature granted us a specific allocation directed to the question of solvency. With that money, we hired Arthur Andersen, who conducted a comprehensive study of what Pennsylvania was doing in 1988. They came out with a series of recommendations and a plan. The purpose of that was to both update, integrate and coordinate all aspects of the Insurance Department into the solvency issue.

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It is only too easy to look at solvency as just a question of numbers and, in particular, numbers on financial statements. But as we have heard, sometimes in the hard way, there are other areas, rates, the consumer service area where there are signs and symptoms that must be listened to.

Since that study was completed many of the recommendations have been incorporated in Pennsylvania. NAIC has developed IRIS ratios.

In Pennsylvania we have come up with 20 benchmarks which are run on all 1,500 companies licensed to do business in Pennsylvania. Out of those ratios and out of a scorecard they are rated high, medium or low priority in terms of solvency concerns.

For those that are high priority we use our resources. We target them for target examinations. We have implemented the Troubled Company Procedures that are recommended by the NAIC. We have established within the department an intra-agency policy directive committee which meets on a regular basis to discuss specific financial and solvency-related issues wherever they come up, when it is in the context of a specific examination, when it is in the context of the NAIC.

Finally and perhaps most important is the integration. The financial analysis unit has been integrated with our examination so that field examiners have access to all of the research that has come from throughout all of the departments before they go out in the field. With the establishment of NAIC minimum standards Pennsylvania added to its efforts already under way a comprehensive review of its legislative and regulatory provisions.

I think everyone is aware that the legislation, if passed, will not prevent insolvency. Nothing can prevent insolvency, and perhaps nothing should because we are still talking about a market economy. But it will allow for earlier detection, monitoring, stricter controls over frontline transactions and control some investment problems.

All the legislation needed in Pennsylvania was sent to our General Assembly in May 1991. It is already out of committee in our Senate. Our House Insurance Committee has conducted extensive hearings across Pennsylvania. Those hearings will conclude in September, and we anticipate a bill on the governor's desk to be signed by the end of this year. All the regulations are in draft. We anticipate that we will be seeking accreditation from NAIC by January 1, 1992. I am confident that that date is going to be met.

I think that summarizes what Pennsylvania has been doing, as I said, going all the way back to 1987.

Chairman ERDREICH. Thank you.

[The prepared statement of Ms. Foster can be found in the appendix.]

Chairman ERDREICH. Mike Weaver, welcome again. It is good to have you up here. You may summarize your oral statement.

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STATEMENT OF MIKE WEAVER, COMMISSIONER, STATE OF ALABAMA

Mr. WEAVER. I am Mike Weaver, Commissioner for Insurance in the State of Alabama. We oversee the insurance industry in our State.

One of the things we look at in the regulatory process that consumers may tend to lose sight of, the basic premise of the consumer generally is price and quality of the product. What we have to look at is the soundness of the insurance company and their capability to pay claims.

In Alabama, the insurance industry is a $6 billion a year premium industry. We have approximately 1,200 companies licensed there. So we have a very broad and complex responsibility.

Along those lines, we feel that we have an effective financial surveillance and regulation structure in the State. We examine every domestic insurance company at least once every 3 years. If need be, we have the statutory capability to examine them more often than that.

We are constantly striving to upgrade and change where change is necessary, to do a better job to protect the insurance companies and the citizens of our State. I call the changing on the continuing basis that we are halfway home, and we still have a long way to go.

We are experiencing severe change both in the regulatory arena and in the corporate arena as far as the insurance industry goes. We in the governmental sector, as you are well aware in dealing with what you have to deal with, are sometimes limited with the resources available to do it with. We would like to be all things to all people, but sometimes we have to make choices and sometimes they are very difficult choices as to what to do with resources. We are doing quite well with what we have been given to deal with it in the State of Alabama.

Other States depend on us because we are individual and regulate State by State. We have a story to tell along those lines also.

Within the last couple of years, we have gone head to head with another State with an insurance company domiciled there. It was formerly domiciled in our State. We were familiar with the company. One thing led to another. One of the constants in this particular case was consumer complaints. Consumer complaints don't lie. If you are getting them fast and ferocious from other areas, you can bank on it that something is not right.

In this case, some people in the Louisiana Insurance Department, which was the State that we went up against, were subsequently indicted, and a lot of them are currently serving jail terms, and some of them will in the future.

That is the case in point that individual State regulations do work, and it continues to because where one State was a little lax because of the situation another State that had a vested interest came forward and did what it was supposed to do which proved the insurance regulation works and the judicial system works.

As Connie said, we probably will not be able to stop insolvency and, certainly, the criminal activities involved with this. We have to make sure we get it brought to our attention as soon as possible

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to use the resources we have available and constantly strive to upgrade them.

The insolvency in question where we went head to head was $180 million. If we had not done what we did, a lot more Alabama and Louisiana policyholders would have been harmed. That, to me, is a prime example of State regulation properly functioning versus the cumbersome Federal bureaucracy that could develop.

Another consumer issue is: During the first 6 months of this year, we have recovered more money for consumers in the State of Alabama than we did in the whole year of 1988. Last year we received over 40,000 consumer phone calls in the Insurance Department of Alabama. We are a relatively small State, but consumer attitudes and confidence play a roll in solvency almost as much, if not as much, as the financial situation.

A very recent example of that would be the Mutual Benefit situation where over $1 billion was withdrawn over a 2-week period of time. There are not many insurance companies nationwide that can withstand that thrust. The public has to have confidence in what is going on out there in all financial institutions, insurance being one of the major ones.

In Alabama, we were one of the first States to pass the model long-term care and model Medigap regulation. Just because you are small doesn't mean you cannot act.

In a recent report from the GAO, the ratio of Alabama's Insurance Department's budget versus the premium tax collected, we were 47th out of 50 States. But as far as regulatory actions against agencies and agents we were in the top 20.

Again, I say you don't have to be big to be better. We are trying to keep pace with the complex industry that we regulate. As you are well aware, it is a very difficult proposition under even the best of circumstances.

In Alabama over the past 3 years, with the support of the Governor and our State legislature, the Insurance Department budget has more than doubled. So we are making strides. There is a great effort out there among all the people involved with government, a lot of pressure put on by the consumers in the State to mandate that we have a strong Insurance Department. So that makes it a lot easier to deliver when you do have a mandate of everybody concerned.

We have been very fortunate in that we have had very few insolvencies in the State of Alabama. That I look at in two ways, the strength of the companies that are domiciled there and the strength of the regulation and the regulatory process that is there.

We are currently in the process of, and well down the road assembling a package of solvency bills to help us in our accreditation process. They are going to the legislature, and we have received broad support from legislators and consumer groups.

With the publicity going on, a lot of which is not very good, a lot of things can come out of that to make it easier to pass the solvency regulations and move forward; which we intend to do.

Essentially, that is a brief synopsis of Alabama's story. We are trying to do the best we can with what we have.

It is a very difficult proposition, but with the help of a lot of good concerned people, and government officials, and Insurance Depart-

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ments from other States in the NAIC, it is quite an undertaking that we look forward to achieving.

Thank you.

[The prepared statement of Mr. Weaver can be found in the appendix.]

Chairman ERDREICH. Thank you.

I thought I heard you say that Alabama has some 1,200 insurance companies doing business that you oversee.

Mr. WEAVER. That is correct.

Chairman ERDREICH. Pennsylvania?

Ms. FOSTER. Fifteen hundred.

Chairman ERDREICH. Nebraska?

Mr. MCCARTNEY. Around 1,500.

Mr. WEAVER. We are tough on them, Mr. Chairman, that is why we have less.

Chairman ERDREICH. When Executive Life ran into its difficulties, a lady from home contacted me. Her husband purchased an annuity. I had not heard of Executive Life until the problem started.

It was a couple hundred thousand dollar annuity. We wanted to know what was happening.

In last week's *Newsweek* an article by Jane Bryant Quinn had a headline, "Is your Insurance Company Really Safe?" It turned out the California-based Executive Life is paying 70 cents on the dollar at this point but Executive Life of New York is paying in full.

I understand we have 50 States and these are separate companies or affiliates of a larger parent company. But I would like to know how does that happen?

As it happens I have a constituent in Alabama who is getting 70 cents on a dollar at this point. But if it is Executive Life in New York, they would be receiving 100 cents on a dollar. Why the difference?

Mr. McCartney.

Mr. MCCARTNEY. The real difference in this case, I think, is the financial situation is different at the two companies. New York regulators had stricter standards, to be perfectly frank.

New York adopted one of the first models limiting investments in junk bonds and put some stronger financial requirements on the New York company than were put on the California company.

The 70 percent versus 100 percent is a reflection of where the regulators evaluate the current financial structure of the two companies.

Chairman ERDREICH. The model act proposed by NAIC and the accreditation program will provide uniformity in the separate States with the affiliates of the single company?

Mr. MCCARTNEY. If we had the financial regulatory standards in place 10 years ago, I believe you would not be seeing the problems such as we are seeing today.

Chairman ERDREICH. You were very bullish, I will say, optimistic about the number of States that will be in the program by 1994.

Mr. Weaver from Alabama, and certainly Ms. Foster, made it clear Pennsylvania is almost there, and Alabama will be moving as I understand it, Nebraska as well. So you see most of the States by 1994 meeting the accreditation program NAIC has set forth?

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Mr. McCARTNEY. As I have said before other congressional committees, if we don't see a substantial majority of the States in position to be accredited by the end of 1994, then that ought to be an indication to the Congress that the States don't have the will or lack the resources to regulate this industry for financial solvency.

Chairman ERDREICH. Of course, individuals who put funds into commercial banks have the FDIC insurance behind it, with $100,000 protected.

However, if I purchase an annuity with a life insurance company, is there a similar guarantee, so to speak, not by the Federal Government, but by a guarantee from your State, or your State, or your State?

Mr. McCARTNEY. There is a similar guarantee. Most are modeled after a NAIC guarantee.

There are two: One is for the property and casualty sector. All the jurisdictions have those, and there is one for the life and health sector. With the adoption of the life and health model in New Jersey, every jurisdiction save for the DC has a life and health guarantee act.

Nebraska is typical. We cover policies up to $100,000 and annuity benefits up to $100,000 and we cover death benefits in a life insurance policy up to $300,000. The cost of that is borne by the insurance industry and State taxpayers.

In some States there is a premium tax offset to fund the guaranty funds. In other States there is no such device.

Chairman ERDREICH. Pennsylvania is identical?

Ms. FOSTER. They are not identical, but Pennsylvania is very, very similar to what Bill has just described in that it was evolved of the NAIC model act and we provide $100,000 and $300,000 coverage.

Chairman ERDREICH. If the States are not identical, should they be?

Mr. McCARTNEY. One of the things that NAIC is doing is holding the hearings looking at the funds. They have been working very well for over 20 years. That doesn't mean that maybe there are not some improvements that could be made to them.

I think we will try to find a way to make those improvements, to do a better job of multi-State liquidation and try to incorporate improvements in the liquidation process into the guarantee funds.

Ms. FOSTER. The biggest problem in the guarantee funds used to be the holes created by certain States not having the protection. With all 50 States but for Washington, DC, the single biggest thing has been done.

Chairman ERDREICH. Is it clearly shown and explained to the consumer, just like the logo at the bank that says "Insured By," or do you find out after the fact that you are lucky, your State has a guaranty fund?

Mr. McCARTNEY. One of the provisions in the model act works to the opposite. It says companies are not to advertise the policy is covered by the guarantee fund because it is not to be viewed as giving them competitive advantage.

Ms. FOSTER. In Pennsylvania we require disclosure of companies that do not have it, surplus lines writers, risk retention groups.

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Most of the publicity that is done is done to warn people that there is no coverage in place.

Chairman ERDREICH. Using Executive Life as an example, the policy then, of course, came from the domicile corporation in California but the policyholder lives in Alabama.

I assume the Alabama guaranty fund does not provide aid; it is the fund in California, the domiciliary that steps in?

Ms. FOSTER. Pennsylvania has a guarantee fund that pays all policy holders in all States if a Pennsylvania company becomes insolvent on the life, accident, and health side. We are changing that. The new law requires that it covers only Pennsylvania residents.

Pennsylvania residents are double protected because we pay everywhere.

There are a number of funds that pay residents only. In the case of Executive Life in Pennsylvania, and Alabama, our residents would be paid by our guaranty fund.

Chairman ERDREICH. Would the California fund pay?

Ms. FOSTER. No, they are residents only. California will pay only California.

Chairman ERDREICH. Mr. Nussle.

Mr. NUSSLE. Thank you, Mr. Chairman.

I have tried to do some reading on this particular topic. We just got done with the banking bill so it is not that we don't understand what a crisis is.

It is just that there may be a difference between this crisis and the one we dealt with. I have read newspaper articles that said, reporting on an IDS report, that talked about if there was a severe recession the entire industry could suffer 20 percent loss or 20 percent of the companies could be in trouble.

It is everything from banking, poor management, the recession, prolonged downturn from real estate. There is somebody from Mutual Benefit Life who said he can think of eight or nine companies in serious trouble.

You are on the frontlines; what is going on? Why are we facing this crisis of confidence, if you will?

Let's start there.

Would you just identify the problem for my purpose?

Mr. MCCARTNEY. In my mind, I think part of the problem has been that when you look at the financial services industry, it is like a three-legged stool—banks, savings and loans, and the insurance industry. We have had such severe problems with two of those—thrifts and banks—the news media and others are saying, well, gee, there must be problems with the insurance industry as well. We are seeing a real crisis in confidence.

That, in my mind, is probably the worst thing that could happen. There is not a company in the country that can stand runs that Commissioner Weaver was talking about, where people ask for $1 billion in policy loans and surrenders in a 2-week period. Something like that happened with Executive Life and Mutual Benefit. Even the strongest cannot respond to those claims.

People will say, there were problems in the other two and there must be problems with the insurance part as well.

Mr. NUSSLE. Do you think it is more psychological or media driven than it is factual?

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Mr. McCartney. For the most part, I do. There are problems, and I have seen them, Executive Life, Mutual Benefit. But the industry is very solid. Its investments are diversified.

Part of the problem with Mutual Benefit was an over-reliance on real estate, and First Capital Life, an over-reliance on junk bonds. But the insurance industry has less than 6 percent of its assets in junk bonds.

It is when certain companies in the past have gotten into problems on the assets side that we have seen the problems with near insolvencies.

Ms. Foster. I would say that we cannot ignore that there has been a recession and that that recession has affected the industry as it has other industries. I think, under any circumstances, there would have been a number of failures.

This is a market economy. As in any other arena, there will be people entering and people leaving. What is different is the crisis in public confidence. We would have had some failures in the country as we have had from time to time.

But at Mutual Benefit that was going along fine when that crisis occurred, and you get the $1 billion call; then it becomes the fourth domino. It was Executive Life, First Capital, Monarch in Massachusetts, and now Mutual Benefit. It becomes a self-fulfilling prophecy. It is a domino effect.

I think, before the S&Ls and the public lack of confidence in Mutual Benefit as a whole, we would not be in the situation as it is. There are problems with management and there are problems with investments. But the crisis that has resulted from those things, I would agree, is a question of public reaction.

Mr. Weaver. As I stated in my testimony earlier, there has to be a public confidence, because no financial institution, insurance company or otherwise, could withstand what some of these companies were asked to withstand. Until that public confidence is restored, there will be other situations that will be similar to what we have just experienced.

What it takes to do that, I don't know. I don't think we should have an adverse media blitz. I don't think we should say the entire industry is unhealthy, because it is not. But there has to be a restoration of the public confidence in the financial institutions of this country, or we are all going to be in deep problems.

Mr. Nussle. The topic of today's hearing is State Regulation of the Insurance Industry. As a question to follow up on your comments, what could you do, what can we do in order to support that confidence or bring that confidence back up, and do it in a way that is constructive, that will not hurt some of these; or address some of these areas that you don't think need to be addressed—in other words, not overregulate, but properly regulate? What can we do on the State side?

There are a couple of questions—early warning detection, what can you do or what can we do to put that into the systems? Is it there already?

Mr. Weaver. A lot of it is there. A lot is being addressed in the current accreditation through NAIC. It is a matter of doing it and acting.

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You say, what can you do versus what can we do. We need to be a team versus an adversarial relationship.

Mr. NUSSLE. How would you do this? Do we need to do this at the Federal level? Do we leave it at the State? Or do we make this a Federal issue?

What do you suggest?

Mr. WEAVER. I would say, leave it at the State level, but support it from the Federal level.

Mr. NUSSLE. How would you do that?

Mr. WEAVER. We are working together on multi-employer trusts and purchasing groups that were created by the Federal Government and kind of left in limbo as far as who was to regulate this. There have been a lot of abuses in this system. We have worked closely with the FBI, the Justice Department, some Senate committees, and others. A lot of investigations are going on throughout most, if not all, States with a lot of these different organizations.

So a teamwork situation, given the role of the Federal versus the role of the States, in my opinion, it is just that, that the States can regulate the insurance industry better than the Federal Government can regulate it, but there is a role for everybody to play.

Ms. FOSTER. If I could expand, I think so much of the discussion has been on the question of Federal versus State regulation. I think the most productive discussion has gone on when we have looked at things issue by issue, for example, the issue of fraud, which is a very serious problem.

If you look at the role of reinsurance and the offshore and foreign reinsurance and the ability of the States to handle that, interstate liquidations, as Bill mentioned, I think what we have to do is get away from the State versus Federal and start focusing in on very specific aspects. I think, if we sat down together, we could agree on four or five topics.

Solvency is not a topic, but everything that goes into it is—liquidations, frauds—and look at them on a topic by topic basis.

Mr. NUSSLE. Thank you. We may do that.

Chairman ERDREICH. Mr. Kanjorski.

Mr. KANJORSKI. Thank you.

Welcome to the subcommittee, Mrs. Foster. Those of us from Pennsylvania have a great deal of confidence in your ability as Insurance Commissioner. That was evidenced by the Governor's reappointment of you to a second term.

You talked about your process in handling the domestic insurance firms in Pennsylvania, I know you do an excellent job. The other insurance firms that do business in Pennsylvania, how are you able to do a hard-core investigation of their assets and their reliability?

Ms. FOSTER. What we do is what our solvency network is involved in that we developed with Arthur Andersen. Every company that is licensed to do business in Pennsylvania is put through that analysis, all 20 ratios are run against that company. If we have concerns, if it would turn out to be a high priority, we would call that company to meet with us, contact the State of Domicile.

We typically do not use our examination powers on other States, but that does not mean we close an eye.

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Mr. KANJORSKI. You have powers to go to another State and make an examination?

Ms. FOSTER. Yes, as part of our admissions.

Mr. KANJORSKI. The basis for that methodology of checking relies on two basic sources. The professional accounting firms tell us they are doing a better job in the insurance industry than they did in the S&L industry, and that you have the capacity to get within these companies and the disclosures that they make or the laws or the commissioners of the State in which they are involved have the same feeling that you have.

The experience we had in S&L business was that through political ideology, State licensed S&Ls were to a large extent the beginning of the entire crisis. That is because those in charge, the State thrift regulators, become economic development boosters, using the licensing laws and regulations to let anyone into the business, particularly in California, and in Texas.

I was interested in hearing my colleague from the other side of the aisle when he talked about this problem of micro and macroappearance in the industry. I recall recently an insurance executive, by using approximately $1,000 of his own funds amassed $70 million in loans from two insurance companies it controlled and was able to become a big player in the S&L industry.

That is an example of, perhaps, micro confidence problems. We see an individual who for all intents and purposes abuses his relationship to that degree for personal gain.

When you move to the macroside, going to the testimony of all of you that this may be, to a large extent, a crisis in confidence, isn't there good reason for the American people to have a crisis in confidence, not only in the insurance industry, but also the S&L industry after the debacles that we have seen?

We have seen Mr. Greenspan, who is eminently qualified in the country as a financial expert, pass on 18 of the largest S&L cases in the country. Within months of passing on them and finding them healthy organizations, they failed.

Then we discussed hundreds of misstatements of assets by our leading accounting firms in the country, leading some of us to believe that certified statements are no longer reliable in business as they always were.

Worst of all, Mr. Darman has now indicated that our deficit will be at least $358 billion this year without counting the money from the Social Security funds. If we were to add that in and the tapping of other funds, you would find the deficit in the United States today would exceed about $450 billion, which is 50 percent of the total debt in the United States—exceeds 50 percent.

With all these factors, when you have seen the crime and corruption in the S&L industry, the junk bond industry, and the stock market—with some big people in prison now—the insurance firms are using fiduciary relationship funds to buy other funds to make personal wealth—when you see political personalities as high as the President of the United States—one claiming it didn't start until after the recession, another says it happened before, another says the recession is over—do you think the American people are making a mistake about having confidence in the banks or S&Ls they are putting their money in.

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Or for that matter, the leadership, there is no evidence in the country over the last decade, not only for S&Ls and financial services, but also every area of American society we have looked at, and I have gone over—I can't think of anything compelling to say we ought to have confidence in—our leadership, business, political, or the commentators, even to the fact that the people who run this camera have been able to successfully promote this industry in such a way as to promote their credibility.

Ms. FOSTER. That is a lot to respond to.

Mr. KANJORSKI. How about 25 words or less?

Ms. FOSTER. That is fair. I believe there are problems in the insurance industry. There are some problems with fraud that we have seen in Pennsylvania. There are some problems clearly on the asset side. In fact, all the problems we are looking at today, I hope I am not overstating it, is on the asset side of the balance sheet.

Five years ago it was all understating the losses. Today it is the real estate investments. There is not a day that something does not go past my desk where somebody is not writing something down whether it is a Pennsylvania company or who else. When you look at the losses projected and tallied today and the losses projected and real in the banks, the insurance industry even when all its losses are tallied up, is not going to be even in the same ball park.

Unfortunately, the consumer does not understand the difference. The consumers' confidence, despite the triple hit, they think their economy is collapsing around them, therefore, they respond very quickly to what they feel is bad news.

I would say yes there are problems but the issue is one of magnitude. To the extent that there is perceived a crisis, I believe that it comes out of the confidence side rather than the actual financial statements of the industry as a whole.

Mr. KANJORSKI. Thank you, Mr. Chairman.

Chairman ERDREICH. Mr. Bereuter.

Mr. BEREUTER. Thank you, Mr. Chairman. I want to thank the witnesses for their testimony. I apologize for the fact that I could not be here at first.

Mr. McCartney, I want to recognize you and welcome you especially from my home State. I ask unanimous consent that my opening statement be made a part of the record.

Chairman ERDREICH. Without objection.

[The information referred to can be found in the appendix.]

Mr. BEREUTER. I made some remarks in that about NAIC's efforts to establish uniform guidelines for the industry by the States' insurance agencies. I would welcome any kind of remarks from you about your method for attempting to have some assurance to the public that we are not going to have if not uniform at least adequate measures on the subject.

Those are the macrosubjects my colleague from Pennsylvania mentioned. We share those. That is the primary focus of our thoughts here today. Mr. McCartney in our own home State there has been much discussion about the problems of Executive Life and the impact on their several subsidiaries in Nebraska.

I want to ask you what the impact has been on your regulatory responsibilities. What the impact is as you understand it on Ne-

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braskans who have obtained coverage through those subsidiaries of Executive Life as to the safeness and soundness of the firm.

Mr. McCartney. There is no indication that I have of those three companies being insolvent. Recently within the past week we finished a preliminary draft of the examination report of the most significant of those companies which would indicate that it is all right. The problem with those as any of the companies that is part of that group is a run on the bank. Those companies are in sufficient shape to pay normal claims.

People in Nebraska and other States where those companies are licensed can expect them to continue paying claims. However, if everybody who is a policyholder decided to take out the money in the form of policy loans or surrenders, none of the companies is in a position to do that.

We are engaged in discussions with the ownership of the company. There are others outside the company which have expressed a willingness perhaps to make investments in those. If those investments are made and come to fruition the company will be again restored to the proper level where it can be a going concern.

We fully expect that to happen.

Mr. Bereuter. That is something I may want to ask a few additional questions on. I would like the opportunity to submit a couple of questions to you on an informal basis if I may.

Of course, we are concerned primarily about the safety and soundness of the industry. This panel I think also has some responsibility to be sure the insurance sector is regulating insurance companies so as to protect the consumer. One of the concerns Congress has had over a period of time to get to a sort of micro issue, here but an important one, is the subject of Medigap policy. Medicare supplemental insurance policies have been sold to a large number of Americans. I find from our own case work that sometimes people I deal with have three, four, and five, believe it or not, Medicare supplemental insurance policies and collectively they provide nothing to the people because they are duplicative in large part to part B and part A.

These people often are the ones who can least afford to pay those additional premiums. So the Congress passed legislation which will be implemented in the next 3 months which will require certain disclosures and actions on the part of the insurance agents selling medical insurance policies.

Whether or not that works well really depends to a major extent, it seems to me, on the State insurance agencies and whether or not you are having an impact on the insurance agencies domiciled in your State and people doing business there.

What can you tell me about this subject and perhaps NAIC's position or program, a task force on this effort?

Mr. McCartney. Congressman Bereuter, I am delighted you asked this question. Medicare supplement has been an area where the Federal Government and the State have worked in partnership for about a decade.

Sometime ago when Congress adopted some Medicare legislation Congress delegated to the NAIC to set up minimum standards for Medicare supplement insurance.

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The NAIC has done that. The standards have been around for about 10 years. There was a period of time over the course of the last 3 years where we had to change those standards every year.

First we got some in place. They really were pretty good standards and then Congress enacted the catastrophic bill and we had to rework them to bring them into compliance with the catastrophic bill. Then the next year the catastrophic bill was repealed.

Last year Congress made major changes again. We are holding a telephone plenary session of the NAIC to act on the minimum standards for Medicare supplement policies. We have darn good standards.

Mr. BEREUTER. You mean the State or NAIC?

Mr. MCCARTNEY. The NAIC as well as individual States have very good standards. they are in place in most of the States if not all of the States. The States view this as a high priority. We hear the horror stories but for the most part this is a heavily regulated aspect of health insurance.

With the adoption of consumer protection measures going into place tomorrow you will see additional enhancements in that business.

Mr. BEREUTER. I like those words. I can tell you the existing regulations are not protecting consumers because too many people are wasting too much money as in the past. The problem is not really in the State companies that you regulate, for which you have the primary people, It is these benevolent people from the TV and movie industry who are on TV advertising these policies which have almost no benefit and are in fact in the parlance "a rip off". It does argue for some sort of national thrust or attempt to regulate unless you can effectively deal with it among the 50 States. I would solicit comments from the others on the panel as well if you have any.

Mr. MCCARTNEY. What we have done through the delegation of authority from the Congress has been to establish a national standard. If it is not in effect in every State the Federal Government will regulate the policies.

Ms. FOSTER. We face this in Pennsylvania, too. It is not so much a standard but the agent conduct. It is illegal in Pennsylvania for the agent to sell a second Medigap policy if he knows one is already in place.

I think it has to do with our going into companies, seeing if there is a company that sold a second or third policy. When we find that we fine the company. I think it is enforcement as well as a standards issue.

Mr. BEREUTER. Another microarea is flood insurance. We just had a devastating flood as Mr. McCartney knows, the community of Howells. That was a flood prone community. It is anecdotal but it comes to me in large numbers that insurance companies in our State, and I don't think we are unique, that are not well motivate, well informed or interested to sell flood insurance.

If you do not sell flood insurance and make it known, our programs are not going to work. What would you say about this subject?

Mr. MCCARTNEY. You are looking at me, Congressman.

Mr. BEREUTER. You are elected.

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Mr. McCARTNEY. For the most part the flood insurance program is a Federal program. It is not regulated by the States for the most part.

Mr. BEREUTER. Indeed it is a Federal program but the agents operating in your States, I am curious how you can motivate them to know there is a private insurance program to be sold. We rely on them to sell it.

Mr. McCARTNEY. Most of the motivations come from lending institutions. If they know they are lending on a property on a flood plain they make sure the purchaser purchases that insurance.

I agree with you that it is incumbent on the agent to offer it. But you can lead a horse to water but you can't make him drink. I would not know without hearing some of the stories you heard whether the agents offered them or the people declined to buy them because of the cost or they were unaware of the program.

Mr. BEREUTER. I think the members of this program would agree that the primary key fact has been the lending institution and their failure to require flood insurance on mortgages they hold. If they did, you would have more businesses in that community and elsewhere who would somehow have found the flood insurance by the private entities even if they were not interested in selling them.

Thank you, Mr. Chairman.

Chairman ERDREICH. The bill we moved out of the House which is now waiting in the Senate on flood insurance requires lenders to escrow and attempts to get more folks to participate. I want to ask one more question because GAO is coming up next.

I want to answer something they raised in their testimony. It follows up what Mr. Nussle raised, an area I wanted to get at. That is early intervention, the ability to know when there is a problem out there and how soon you individually as State commissioners intervene.

We wrestled with this in the banking bill that is seeking to move through the Congress. GAO in its study found that in 71 percent of the cases of failed insurance companies regulators did not take action until after the failure occurred.

I don't have a similar figure for the banking field. My point is that if that is the mark then we would have questions about the current system. How good a job do you do on identifying problem companies and early intervention?

Mr. McCARTNEY. I would like to talk about what we do with respect to this but before I do let me talk briefly about the GAO report. In our opinion the GAO report is from a survey of the State insurance departments that was fundamentally flawed from the outset. The survey questionnaire was shared with the NAIC staff in Kansas City. A number of suggestions were made for improvements, none of which were incorporated in the survey document when it went out. That survey talks about formal actions an insurance department takes. Insurance departments take a number of informal actions once they become aware that there could be a problem at the company.

We don't wait to put it under supervision. As soon as we hear there is a problem we do something but the document did not ask

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that. At what time were there problems in the company where you took formal action? We had a problem with that.

There is the early warning systems the NAIC does. It has the largest insurance financial data base in the world. We used the financial information from the financial statements to run a series of ratios from the financial reports of the companies.

Commissioner Foster told you they do something similar to that just in Pennsylvania. As a result of that ratio we bring in a team of experienced examiners from the States to review the ratios and kind of put these things in piles as Commissioner Foster talked about, which ones need immediate attention, which ones need attention but not immediate and which ones need no attention at all.

Then that is referred to the States. The individual commissioners are put on the line. We are asked, hey, we have serious reservations about the ratios here and what is going on with this company. We want a report from you. The individual department reports back to this working group of experienced people from NAIC and individual departments. If the working group does not like the response it gets from the State, if the response is inadequate or the State chooses not to respond at all, additional follow up is done. If at the end of the day the working group is not satisfied the States are instructed that there is probably a severe problem with this company and the State of domicile ought to take action.

There are steps to identify the companies and there are steps taken to take remedial action once that identification has been made.

Chairman ERDREICH. Last Friday, the *Wall Street Journal* article stated that Moody dropped its rating on six big companies. Would NAIC or your informational system have been aware of the problems of those six assuming you concur? You may have a different view of what Moody came up with. How rapidly would your awareness be communicated?

How speedily would the information move from your systems?

Mr. MCCARTNEY. We obtained on diskette the financial statements from the company and it is updated quarterly. Moody's did not say they were insolvent. They downgraded them from A-plus to A.

Chairman ERDREICH. Would you routinely pick that up and move it through your system?

Mr. MCCARTNEY. Yes. Not cnly is this done in each State as Connie and I do but NAIC has a staff here in Washington, DC who do this on an individual company by company basis and make those claims constantly.

Chairman ERDREICH. Mr. Nussle, do you have an additional question?

Mr. NUSSLE. No, thank you.

Chairman ERDREICH. Our next panel is Richard Fogel, Assistant Comptroller General, General Government Issues, U.S. General Accounting Office; Craig Simmons, Director, Financial Institutions and Market Issues, U.S. General Accounting Office; and Lawrence Cluff, Assistant Director, Financial Institutions and Market Issues, U.S. General Accounting Office.

Chairman ERDREICH. We welcome you. The written statement of the GAO is made a part of our record.

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Mr. Fogel, as I understand, you are going to carry the ball, and you are accompanied by your associates. Would you summarize your statement?

STATEMENT OF RICHARD FOGEL, ASSISTANT COMPTROLLER GENERAL, GENERAL GOVERNMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY CRAIG SIMMONS, DIRECTOR, FINANCIAL INSTITUTIONS AND MARKET ISSUES, U.S. GENERAL ACCOUNTING OFFICE; AND LAWRENCE CLUFF, ASSISTANT DIRECTOR, FINANCIAL INSTITUTIONS AND MARKET ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. FOGEL. Thank you, Mr. Chairman.

GAO's work on the various components of the financial services industry has identified important similarities in the basic principles that should underlie effective regulation.

To effectively re-create and maintain a national system of insurance regulation, a regulatory organization needs authority to perform several essential functions. We believe these are absolutely critical to have effective regulation of insurance.

One, it should have authority to establish uniform accounting and timely reporting requirements for insurers.

Two, it should have the authority to establish uniform rules defining sound and safe operation of insurers.

Three, it should establish minimum capital standards commensurate with the risks inherent in an insurer's operations.

Four, it should be able to establish minimum standards for effective solvency regulation by State insurance departments.

Five, it should be able to monitor the supervisory and regulatory functions of State insurance departments.

Six, it should be able to compel State regulators to enforce the rules for sale and sound insurer operations, including the minimum capital requirements, and to take appropriate actions to resolve or close troubled insurers.

Last, it should be able to levy assessments to cover the costs of oversight and supervision and maintain sufficient staff and resources to adequately oversee the industry.

While recognizing NAIC's good intentions, we do not believe NAIC could successfully establish a national system of uniform insurance regulations. This is key, because NAIC does not have the authority necessary to require States to adopt and enforce its standards.

Furthermore, GAO does not believe NAIC can be effectively empowered either by the States or by the Federal Government to exercise the necessary authority. Empowerment by the States sill require each State legislature to cede its authority to NAIC. If any State chooses to do this, NAIC's standing as a regulator would be weak, because it could be revoked at any time by each State's legislators. So they would regulate at the pleasure of those whom they regulate.

NAIC is composed of State insurance commissioners. They are accountable to the States and should not be made directly accountable to Federal authorities as well, since this would create an irreconcilable conflict of interest. Congressional delegation of the regu-

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latory authority to establish NAIC as effective public regulators could also raise some constitutional issues.

GAO has identified problems in the State by State systems of insurance regulation. Even though the responsibility rests with each State, NAIC has attempted to address some of these problems by assisting or, in some cases, overseeing the States as they carry out their activities in attempts to strengthen State by State regulation.

We have found NAIC has an improved ability, or is attempting to improve capital standards, is attempting to improve monitoring systems to better identify troubled companies, has established a peer review process to better assure that troubled companies are dealt with, and has created automated data bases to facilitate insurance regulation. These are steps in the right direction, though all of them leave room for further improvement.

NAIC's plans for a regulatory system consistent across the States rests in large part on its accreditation program for solvency regulation. We question whether NAIC can achieve its goal. Their efforts are laudable; however, NAIC does not have the authority necessary to fulfill its assumed role as a national regulator. As a result, NAIC is unlikely to achieve its stated goal of establishing a national regulatory system. It can neither compel State actions nor sustain its reforms.

[The prepared statement of Mr. Fogel can be found in the appendix.]

Chairman ERDREICH. Thank you very much, Mr. Fogel. Your testimony is quite clear that your view is that there should be Federal oversight, I take it.

Mr. FOGEL. No, that is not necessarily the case. I think what we are saying is that the criteria that we have established are important to effectively regulate any type of financial services organization, whether it is an insurance company, banks, S&Ls, whatever—investment banks, for example. We think that these principles should be adhered to.

We also think there are inherent weaknesses in the current system that certainly call for some considerations on how they should be changed.

We have not necessarily said that it ought to be a total Federal system.

Chairman ERDREICH. So those criteria you outlined could be accomplished State by State or through NAIC.

Mr. FOGEL. Yes. I think there has to be a national basis for setting up an organization that could enforce those standards. But we certainly think that whatever is explored, it has to be a cooperative effort between the various levels of Government.

Chairman ERDREICH. Congressman Bereuter mentioned the Medigap policies. That is an area where Congress has moved in partnership with States to set certain standards—in fact, a new measure moved through Congress will have a lot of teeth in it, if it becomes law.

Is that a model you might look at and say, this is an effective method whereby the Federal Government is setting certain standards to be carried out by the State commissioners?

Mr. FOGEL. That is a model we can look at, yes. It is my understand of this legislation that we are going to set at the Federal

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level some standards and look to the States to implement it. Then the Federal Government has some obligation to follow through and see how well that is being implemented.

Chairman ERDREICH. One of the answers that Commissioner Foster from Pennsylvania raised—it was an excellent point—in trying to compare the debacle of the thrift industry and the insurance industry with the S&L, and she said it is not in the same ballpark with the amount of losses that appear at this point.

Of course, things can change. Would you concur in that assessment and do you have any figure as to what those losses would be?

Mr. FOGEL. We certainly concur that nothing is in the ballpark of the S&L disaster, which we are unfortunately having to deal with. We have not done any studies with the potential liabilities of the insurance companies which may fail.

My guess would be that it is nowhere near the level of liabilities the Federal Government and the taxpayers will have to bear for the S&L bailout. One point, from our work on the potential liability of the Federal Government for Government-sponsored enterprises, the most effective time to deal with these types of question, that is, the need to restructure regulation and how you want to deal with it, is not when you are in a crisis situation. The worst time is when we are in the midst of a crisis.

I think it is most appropriate to look at this issue now when we are not where we were with the S&Ls.

Chairman ERDREICH. You raised some concern about the NAIC review team that is authorized to recommend accreditation for States. What do you recommend to strengthen that review process?

Mr. FOGEL. I think there are several things that could be done and, indeed, we had some discussions with the NAIC team when we were with them in one State where they were doing an accreditation review. One is to try to get more specific criteria.

We think it is important when you go in and do an accreditation review, for example, to not just ask the question, "Does the State have adequate capital standards or other adequate standards?" but to develop some criteria of what "adequacy" means in terms of specifics. So we would like to see more specific criteria.

Second, I think we would like to see more documentation by the accreditation team by not only documenting what it does and its approach and methodology, but also the basis on which it reaches conclusions that a State does or does not have standards that are consistent with its criteria.

Last, we also think it is very important, if you are going to do an accreditation review—and perhaps this will happen when they get going—to ask the right questions. It is critical to have an adequate assessment of how well they are carrying out those policy procedures.

Chairman ERDREICH. If we continued with the current regulatory process, that is, State regulation, but meeting standards that are set by the Federal Government, based on what you and your cohorts have seen as the regulatory expertise at the State level, what confidence level do you have as to the States' ability to carry out that regulatory mandate in the future?

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Mr. FOGEL. I would like Mr. Cluff to answer in detail. My sense is it is mixed. In some States we have a fair amount of confidence. In other States, they probably have to do some shoring up.

Mr. CLUFF. I would agree with Mr. Fogel. We have not done extensive work in most State insurance departments.

But what we have seen is that there is significant variation in the quality and capability of the insurance departments where we have visited. We are in the beginning stages of looking at regulation of asset quality in life insurers. We will be looking at a number of States closely for this information.

But early indications are that even in some of the larger States there are inadequacies in the ability to value and effectively monitor the value of life insurer assets. That is one example.

So I think there is a significant variation. Some States do it well or reasonably well, and other States don't do it very well.

Chairman ERDREICH. On page 18 you point out in 71 percent of those cases of solvency or regulatory action the States did not take action until the insurer was already insolvent. If we were looking at the thrift situation, if we were looking at the commercial banks, would it be very difficult as to what the Federal regulators would be able to see in advance?

Mr. FOGEL. As part of our efforts to look at the deposit insurance reform, we did an extensive review of the quality of bank supervision. One of the things we reported was that the bank regulators did not do a good job of taking action early enough to prevent some of the problems from occurring in banks. Indeed, capital seemed to be a lagging indicator of problems in the bank. We are very pleased that the Banking Committee adopted a tripwire set of legislative recommendations that are very consistent with what we recommended.

So what we have found in the industry, insurance in the property casualty area, is certainly not unique to regulators in the insurance industry.

I would make one distinction that the bank regulators have to take a series of formal actions before the institutions become insolvent because then they are closed. We see regulators are reluctant to take formal action as quickly as they could.

Sometimes that is very understandable. You want to deal with the institutions, talk to management and try to get them to improve. We think there can be major improvements. That is why we think the provisions you put in the banking legislation would help.

Both the regulators and the companies need to have a clear understanding of what can happen if certain conditions exist. All too often there is too much neglect, argument. We have to get in to an awful lot of legally-defensive positions before the legislators can take action. If you push this process back further, we might be able to prevent problems from getting as severe as they are before formal action is taken.

Chairman ERDREICH. Mr. Nussle, do you have any questions?

Mr. NUSSLE. Yes, Mr. Chairman.

One of the points that I tried to question the last panel on was exactly what is driving this particular crisis. They mentioned that confidence was one of the biggest factors. It may driving it even more than it needs to be driven because every media intervention,

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congressional intervention, the three-legged stool analogy—all these were part of it.

How would you assess that particular argument that maybe we are concerned far above the necessity to be concerned or whatever? How would you assess that kind of statement?

Mr. FOGEL. Well, I think it is very critical to have good public disclosure and discussion regarding the financial health of our financial services institutions, including the insurance companies. Too often in the past, one of the problems has been not enough people knew what was going on. It was very confusing. Crises would, for example, hit us in certain areas because there had not been enough public discussion.

I would like to let Mr. Simmons comment in more detail, but insurance companies during the 1980's were investing in a lot of the same areas that banks and savings and loans were investing in. I think we don't want irresponsible public discussion of problems, but to the extent there is a problem with companies it rests with the decisions they made and types of investments they got in.

Mr. SIMMONS. I cannot add too much to that. I think one of the things that does cause runs on financial institutions and insurance companies is people being taken by surprise.

I think with Mutual Benefit and some others people have been taken by surprise because they did not have any information. Perhaps if there was more disclosure on the conditions of companies that was made available on a more routine basis perhaps people would not be surprised or they would evaluate more carefully who they decide to buy insurance from and who they did not buy insurance from.

Mr. NUSSLE. Is that on one of your seven outlined recommendations, timely reporting?

Mr. FOGEL. Yes. Timely reporting is really critical. First, it is critical for the regulators to have uniform agreement on accounting standards as to how we want to value assets, what they are, that type of thing. Second of all, to be able to get information fairly quickly so they can make appropriate regulatory decisions.

We have seen the same problems in the S&L and banking industries. The banking industry would put out information late, and by the time the public got that information somebody could be in trouble. However, the time lags with the insurance industry until recently were much longer than for the banking industry.

So that is a first one, yes.

Mr. NUSSLE. There was, I think, a criticism prior to the three of you taking the witness table about informal versus formal procedures. I wondered if you would respond or comment on that—why you did not, if you did not, look into procedures by the State legislators. Is that relevant? What does this have to do with the process. Are these types of questions effective?

Mr. FOGEL. One reason we did not look into formal procedures was because the regulators and NAIC would not give us access or allow us to see the informal procedures. There is no doubt that formal procedures are important.

With the banking industry a lot of informal procedures were dragged on for a period of time.

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I would like to make a plug here because I think it is important for us to be able to effectively assist the Congress in oversight. That is the problem of access.

The Congress through its investigative authority can get access to things through subpoena. But we don't have appropriate access to information to effectively provide the types of assessments we think are necessary regarding how well the insurance industry is being regulated.

Any change in statute would obviously have to be modeled, we think, after the banking legislation where we have to protect propriety information and no disclosure of confidential information.

Mr. NUSSLE. I am sure this is something you and the chairman can work out in future studies.

Mr. CLUFF. On the informal versus formal actions, I think the informal actions are an important part of regulation. We found as Mr. Fogel said, they were apparently carried on too long. Our contention is not that they should not use informal actions, they should.

But the point of insolvency is too late to use informal actions to control the actions of the insurance company.

Mr. NUSSLE. I assume on page 18 where it says "In 71 percent of those cases, the State did not take action until after the insurer was already solvent." That assumes they were in informal action up to that point?

Mr. CLUFF. We don't know about all of them because we were not given that information.

Mr. NUSSLE. I am new around here so maybe I ask dumb questions, but the seven points that you outlined, are those things that cannot be done already by NAIC.

Is that something that cannot be done, something unenforceable? Explain, if you will?

They seem very common sense.

Mr. CLUFF. Most of those can and are being done. NAIC establishes standards for these things.

One can quibble about whether each one is adequate but they can be improved where they are not adequate. The places where NAIC does not have the authority to act and, therefore, would be unable to fulfill these functions are ineffectively monitoring the States ability and actions to effectively regulate. They could do that at the measure of the States but they cannot do it if the States choose not to respond.

Mr. FOGEL. The problem is NAIC can develop model laws and legislation. It cannot and I want to differ to Larry a little on this, it cannot establish any legal requirements.

Those must be established by every single State. When you look at what the States do, although NAIC works hard on model laws and everything, a lot of the States adopt some of those, some change them.

Some are tighter, some are looser. But NAIC does not have the legal authority to do this. It has to work through the States. Then you have to go back through every single State.

What you have is a system of 50 States to some extent adopting large portions of this and in other cases dosing different things.

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It also has to rely on timing so some States can more quickly and others very slowly. There are some model laws that States have been working on for a number of years.

Obviously, in the situation we are in the last couple of years that is moving quicker. Only the States can establish standards that are enforceable with the companies in a legal sense.

Mr. CLUFF. NAIC does propose model laws, but it has no authority to require any one to adopt those either in whole or in part.

Mr. NUSSLE. One area that I did not see in the seven that you outlined was in the area of management, management of the company. It seems in our discussion and our hearings and our debate over the banking bill that that came up quite a bit, our ability to look into the management of the company.

Everything being equal, bad recession, bad real estate market, and so forth, the management of the company may be our last resort.

Is there some way to add that to any of the seven or is that within the reporting or how would you address that?

Mr. FOGEL. I think it could be added and made more explicit. We think there are very critical ways that you can get a handle on how well everything is operating.

For example, looking at the adequacy of internal controls, by looking at the types of activities that the board of directors are taking, are there audit committees?

So there are a series of things, you are absolutely right, that we should get in here. Some of it might be subsumed under the uniformity acting standards and minimum solvency requirements but we should be more explicit.

We have found and you are correct on this, when we have looked time and again, the reasons why banks have failed time and again, it is bad management. They did not have good internal controls.

They made bad business decisions and there was certain, absolute criminal activity involved. I think management ought to be the first line of defense, probably, not the last.

Mr. NUSSLE. I would agree. I gave the devil his due.

Thank you, Mr. Chairman.

Chairman ERDREICH. Thank you, Mr. Nussle.

The State guaranty funds, in your view, Mr. Fogel, should they be identical, or are they now similar, or almost identical?

Mr. FOGEL. They are not identical now. I think that is an area that needs to be looked into, again from the consumer protection standpoint to the policyholders.

I think to the extent we can get consistency it is going to protect policyholders.

Chairman ERDREICH. Also, the role of the Federal Government in regulation of offshore reinsurers. Do you believe there should be a role of the Federal Government in that area?

Mr. FOGEL. We supported the need to change legislation in that regard. We think that is an area that quite frankly gives us a lot of concern.

It is something that we don't have a good handle on in this country because no one can compel it, the technical term is "alien," I thought of them as foreign.

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I think of aliens as being from outer space. But we cannot compel them to provide information.

I think about one-third of all the reinsurance in this country is done by foreign reinsurers. I think it is very important that we work with States and the NAIC in this regard to try to get some legislation that allows us to get more information on their financial condition and their activities.

Chairman ERDREICH. I would agree.

I thank you, Mr. Fogel, and your associates, for being here.

[Whereupon, at 3:50 p.m., the heaing was adjourned.]

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APPENDIX

July 29, 1991

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STATEMENT OF REP. BEN ERDREICH
CHAIRMAN
SUBCOMMITTEE ON POLICY RESEARCH AND INSURANCE

The Subcommittee has called this hearing to consider the effectiveness of the current regulatory structure of the insurance industry. Individuals, workers and retirees, as well as commercial enterprises and financial institutions depend on the safety and soundness of the insurance industry. We all are concerned about any erosion of the industry's financial health, and I have called this hearing to determine what must be done to reverse this trend.

The number of insurance failures has increased alarmingly over the last several years. During the 1970s, there were 108 property/casualty insolvencies; during the 1980s there were 226 insolvencies, with a significant increase beginning in 1984. During the first half of the 1980s, there were 20 life/health company insolvencies; during the last half there were 65 insolvencies, with 26 in 1989 and 13 in 1990. In this year alone, we have witnessed the failures of some of the industry's largest companies, such as Executive Life and Mutual Benefit.

The Banking Committee has a traditional interest in issues important to the U.S. economy, particularly with respect to the availability of credit and the activities of financial intermediaries, such as banks and insurance companies, and this Subcommittee has jurisdiction to consider issues relating to financial intermediation and the insurance industry.

Over the last two years, the Subcommittee has held hearings on solvency issues for property and casualty insurers relating to earthquake risks and pollution liability. In those hearings we learned of the inter-relationships between the insurance industry and other types of financial intermediaries. In particular, we learned that significant insolvencies in the insurance industry may have impacts throughout the financial markets, including impacts on Federally insured banks and thrifts.

The Subcommittee has also issued a report on the insurance industry, with particular focus on their role as financial intermediaries and competitors with banks and thrifts for limited funds from investors and retirees. Increased competition among banks and insurers suggests the need for similar regulatory policies for bank and insurer regulators to avoid creating unintended consequences in the marketplace.

Many of the market forces that influenced investment decisions by failed banks and thrifts have also been at work in

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the insurance industry, and lax regulatory supervision and inadequate regulatory response gives rise to larger problems in the future. Just as increased failures in the banking and thrift industries has required Congress to review regulatory activities and capital standards of these financial institutions, increased insurance company failures require increased scrutiny.

To begin the Subcommittee's inquiry into insurance regulation, I have invited testimony from the National Association of Insurance Commissioners. I have no preconceived ideas about the effectiveness of state regulation or about the potential need of the Federal Government in the regulation of insurance companies, but the number of recent insolvencies and their causes suggest at the very least a need for increased diligence and oversight by regulators. It is clear that the current regulatory oversight of the insurance industry must be enhanced and strengthened.

The NAIC has engaged in a program of strengthening regulatory standards and reserve requirements. This includes an accreditation program for states in an effort to impose uniform regulatory guidelines and standards. With this hearing I hope to determine whether these steps are enough to address the problems, or whether the private, voluntary structure of the NAIC is inadequate to force states to adopt real, uniform guidelines and standards.

I have also invited the GAO to review its findings based on an investigation of the NAIC. The GAO has undertaken numerous studies of the regulation of insurance companies and most recently studied the capabilities of the NAIC to initiate regulatory reform in the states. These studies have raised for the Subcommittee important questions that must be answered in the course of this inquiry.

The Subcommittee intends to conduct several hearings on insurance regulation and the impact of insurer insolvencies on the economy and financial markets. Ultimately Congress must decide what role, if any, the Federal Government must play in the regulation of the industry.

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Douglas Bereuter M.C.

STATEMENT BY CONG. DOUG BEREUTER

POLICY RESFARCH AND INSURANCE

SUBCOMMITTEE HEARING:

INSURANCE INDUSTRY SOLVENCY

JULY 29, 1991

Mr. Chairman, thank you for convening today's hearing. In light of the recent news reports of life insurance companies going bankrupt, it is important for this Subcommittee to exercise its jurisdiction and begin a review of the financial condition of the insurance industry.

Today, we will assess the capability of the National Association

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of Insurance Commissioners to create and maintain an effective national system for insurance regulation.

In my view, regulation of the insurance industry should remain at the state level, however, I am concerned about the ability of states to enforce their regulations.

I understand that the states, through the guidance of the NAIC, have sought to establish uniform guidelines for regulating insurance companies. While well intentioned, it does not seem that the NAIC has successfully compelled individual states to enforce the regulations.

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I look forward to hearing what progress the NAIC has made in terms of regulation, as well as GAO's critique of their efforts.

With a universe of some 3500 insurance companies, adequate regulation of the industry is important -- especially in light of the fact that the industry seems to be going through some of the same growing pains currently being experienced by banks.

Consolidation of the industry and US entry by European insurance companies are two such examples, and are bound to have an effect on the operations of individual insurance companies.

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I take this opportunity to welcome the witnesses, in particular, William McCartney, who is Nebraska's Director of Insurance.

Thank you, Mr. Chairman.

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TESTIMONY BY

the

NATIONAL ASSOCIATION OF

INSURANCE COMMISSIONERS

before the

SUBCOMMITTEE ON POLICY RESEARCH AND INSURANCE

of the

COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS

of the

UNITED STATES HOUSE OF REPRESENTATIVES

on

INSURANCE SOLVENCY REGULATION

The Honorable William H. McCartney
Vice President, NAIC
Director of Insurance
State of Nebraska

July 29, 1991

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I. INTRODUCTION

Mr. Chairman, Members of the Subcommittee, my name is Bill McCartney. I am Vice President of the National Association of Insurance Commissioners (NAIC) and the Director of Insurance for the State of Nebraska. The NAIC is an association of the chief insurance regulators from the 50 states, the District of Columbia, Guam, American Samoa, Puerto Rico, and the Virgin Islands. The NAIC thanks you for this opportunity to discuss with you the important topic of the regulation of insurance companies for solvency.

The regulation of the business of insurance for solvency is fundamentally a task of consumer protection. The goal of the regulator is to protect the interests of consumers -- whether as policyholders, potential insurance claimants, or taxpayers -- from the financial loss associated with insolvency. This means that regulators must closely monitor companies and, where possible, take action designed to prevent an insurance company's insolvency. It also may mean that, where an insolvency is unavoidable, as is sometimes the case in a competitive free economy such as ours, regulators must take action to assure that losses to consumers resulting from the insolvency are minimized. The breadth and depth of the topic of solvency regulation are substantial, and of critical importance to American citizens and to the operation of the American economy. This Subcommittee is to be commended for taking up the study of this vital issue, and for obtaining the perspective of state insurance regulators.

First, we will present an overview of state solvency regulation -- its long history, recent developments in state regulation, and the role played by the NAIC in modern insurance regulation. Second, we will look at the prospect of federal involvement in

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insurance regulation, both its strengths and weaknesses, and particularly at the position taken recently by the General Accounting Office (GAO).

II. THE REGULATION OF INSURANCE BY THE STATES

A. The History of State Insurance Regulation and the NAIC

Before 1850, insurers operated with little formal or direct regulatory supervision in the United States. The power of insurers was defined in their corporate state charters. In 1851, the New Hampshire Legislature created a full-time board of insurance commissioners. Massachusetts and Vermont enacted similar legislation in 1852, New York in 1859, and Rhode Island in 1865. As the number of companies expanded, particularly after the Civil War, the need for regulation grew. That need for increased regulation was met by the states in succeeding years.

Under the 1869 U.S. Supreme Court decision of Paul v. Virginia, insurance was held not to be interstate commerce, and therefore not subject to control by the federal government under the commerce clause of the Constitution. That decision left insurance regulation in the hands of the various states. However, the Supreme Court reversed its position in United States v. South-Eastern Underwriters Association in 1944, holding that insurance is interstate commerce and therefore subject to federal regulation. The following year, in 1945, the Congress passed the McCarran-Ferguson Act, which in effect, invited the states to preempt the federal antitrust laws by regulating the business of insurance.

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As a result of the response of the states to this Congressional invitation, individual states are responsible for regulating the insurance business within their own jurisdictions. To facilitate this state regulation of insurance, each state maintains its own insurance department. Each of these departments is organized under the supervision of a commissioner, director, or superintendent of insurance who is either appointed or elected. Currently, twelve insurance regulators are elected. The size of these departments' staffs varied in 1989 from 19 to 1,300 according to the volume of insurance business which is regulated in the state, with a national aggregate staff in 1990 of 8,956 (excluding contract employees). Similarly, the budgets for 1991 range from $750,000 to $67,000,000, with an aggregate national budget of over $458 million.

Although concerns have been expressed about the understaffing of insurance departments, insurance regulatory staffing is comparable to regulatory staffing for other financial services. In 1989, there were 1.4 insurance regulators per company compared to 1.5 regulators per institution for banks and thrifts.

The professional expertise within state insurance departments is diverse and includes actuaries, financial examiners and analysts, rates and forms analysts, market conduct examiners, attorneys, investigators, and systems analysts. In addition, there is a tremendous amount of experience accumulated by state regulatory staff. According to a recent NAIC survey, senior management staff have, on average, 11 years of regulatory experience. The average tenure of commissioners, directors and superintendents, including all of their time in the department, is 7 years and 4 months.

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The NAIC's involvement in solvency regulation dates back to its formation 120 years ago. In fact, the NAIC was created specifically to address a spate of insurance company insolvencies in the late 1860s and early 1870s. Since then, this nation's state regulators have worked together, through the NAIC, to protect the American consumer from the financial and personal loss that can be the result of the insolvency of an insurance company. The resulting system of insurance regulation provides a high degree of uniformity in the supervision of interstate companies, yet is sufficiently decentralized to provide responsiveness to insurance consumers and a sensitivity to the regulatory needs of a diverse nation.

The history of the NAIC's involvement is one of innovation and adaptiveness in the regulation of an industry that has undergone dramatic changes in the past century. In 1875, the NAIC adopted the predecessor to the Annual Statement Blank which, since then, has served as the uniform financial reporting form for all insurance companies. Thirty-four years later, in 1909, when changing, and sometimes fraudulent, investment practices by insurers threatened the stability of the industry, the NAIC established the Securities Valuation Office (SVO) to provide uniform valuations of insurers' securities.

In the 1930s and 1940s, multi-state insurance companies became more prevalent. The NAIC responded, first by establishing the "zone examination system" for the regional examination of multi-state companies, then by publishing the NAIC EXAMINERS HANDBOOK to standardize zone examination procedures.

During the 1960s and 1970s, as the business of insurance continued to grow more complex, the NAIC responded with a host of improvements in solvency regulation. These

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enhancements included the adoption of model guaranty association acts and the institution of a centralized database and Early Warning System to help identify and prioritize troubled companies. This system was later expanded to become what is now known as the Insurance Regulatory Information System (IRIS). Further standardization of solvency regulation was achieved with the release of the statutory accounting manuals for life and property/casualty companies and the TROUBLED COMPANIES HANDBOOK.

B. Recent Efforts to Enhance State Insurance Regulation

History no doubt will view 1988 as a watershed year in solvency regulation. That year, 50 insurers became insolvent or were the subject of formal regulatory action because of significant financial impairment,[1] one of the largest numbers in years. Far more disturbing was the upheaval in other financial services institutions, primarily regulated by the federal government. The number of bank failures continued to climb, from 184 in 1987 to 200 in 1988. That year the 223 failed thrifts totalled nearly four times the failures in the previous year (Figure 1). Certainly, the states share some of the blame for the S&L debacle, but it is clear that states took their regulatory signals from the federal government which is the case when there is dual regulation by state and federal governments.

[1] Hereinafter, references to companies that have either become insolvent or have been the subject of formal regulatory action because of the seriously impaired condition of the company shall be referred to as "failure."

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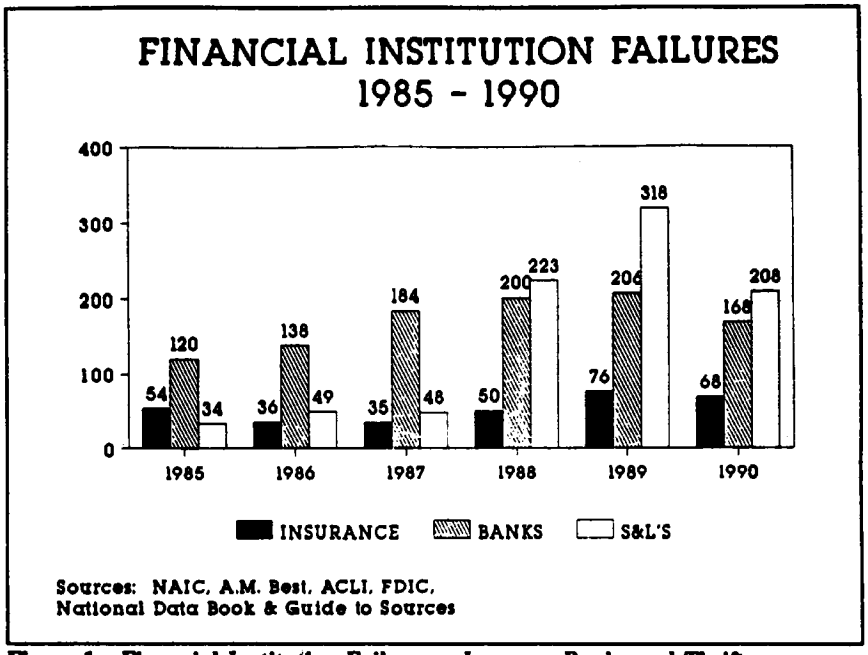

Figure 1 - Financial Institution Failures -- Insurers, Banks and Thrifts

1. Financial Regulation Standards

In this environment, in which troubles in the federally-regulated financial institutions has shaken consumer confidence in all financial institutions, the NAIC has moved aggressively to enhance what has long been a sound system of insurance regulation by beginning the process which led to the 1989 adoption of the Financial Regulation Standards. These minimum standards establish bottom-line requirements for state solvency regulation in three key areas:

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(1) laws and regulations,

(2) regulatory practices and procedures, and

(3) organizational and personnel practices.

In order to provide guidance to the states regarding the minimum standards and an incentive to put them in place, the NAIC adopted a formal certification program in June 1990. 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's Financial Regulation Standards. Departments meeting the NAIC Standards will be publicly acknowledged, while departments not in compliance will be given guidance by the NAIC on how to bring the department into compliance. Furthermore, beginning in January 1994, accredited states will not accept reports of examination from non-accredited states, providing further impetus for states to adopt the minimum standards. We expect that, as the standards are enhanced and more states enact them, greater pressure will be placed on other states to become accredited.

So far, four states, Florida, New York, South Carolina, and Illinois, have been accredited under this nascent program, and other states will be reviewed for accreditation in 1991. This audit process is less than a year old. The conduct of these first audits has served two primary functions. They have verified the capabilities of these four departments and have provided the NAIC with much information on how to improve the audit procedures necessary to obtain a thorough, credible assessment of solvency regulatory resources. Improvements to the procedures are being incorporated into upcoming audits.

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We have been asked in recent months at what point the Accreditation Program will reach a "critical mass" -- at which point enough states will have been accredited that the sanctions for non-accreditation will have sufficient national reach to spur the remaining jurisdictions to adopt the Financial Regulation Standards. This is a difficult question to answer, but we believe that the accreditation of Florida, New York, Illinois, and South Carolina is already adding to the pressure on other states to become accredited. The hundreds of life companies that are licensed to do business in at least one of these four states write over 95 percent of the life premiums in the United States. Similarly, the property/casualty companies licensed in at least one of the accredited states write over 80 percent of the property/casualty direct premiums in the nation. Few, if any, states have no domiciled insurers that would be affected by the sanctions imposed by the NAIC's Accreditation Program, even in the event that no other states were accredited before 1994. This seems quite unlikely.

Some critics of state regulation have questioned whether the states will respond to the NAIC's call for enhanced solvency regulation through passage of the statutes and regulations required for NAIC certification. We are here to report to you that the response in these first few months of the program has been very encouraging. Earlier this year, the National Conference of State Legislatures adopted a resolution calling on the states to adopt the NAIC's standards in every state, and the National Governors' Association passed a similar resolution endorsing the NAIC's Solvency Policing Agenda and reaffirming the organization's opposition to federal preemption of state solvency regulation.

In the state legislatures, it appears that the joint call of regulators, legislators, and

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governors for enhanced solvency regulation is being heard. Across the nation, state legislatures are moving aggressively toward the implementation of legislation called for by the NAIC Financial Regulation Standards. So far, 33 states have adopted legislative packages designed to bring their Departments of Insurance into compliance with the Financial Regulation Standards, with similar packages working their way through 12 other state legislatures (Figure 2). With every passing week, it becomes increasingly clear that 1991 will see the passage of more pro-consumer solvency legislation than in any previous year in our history.

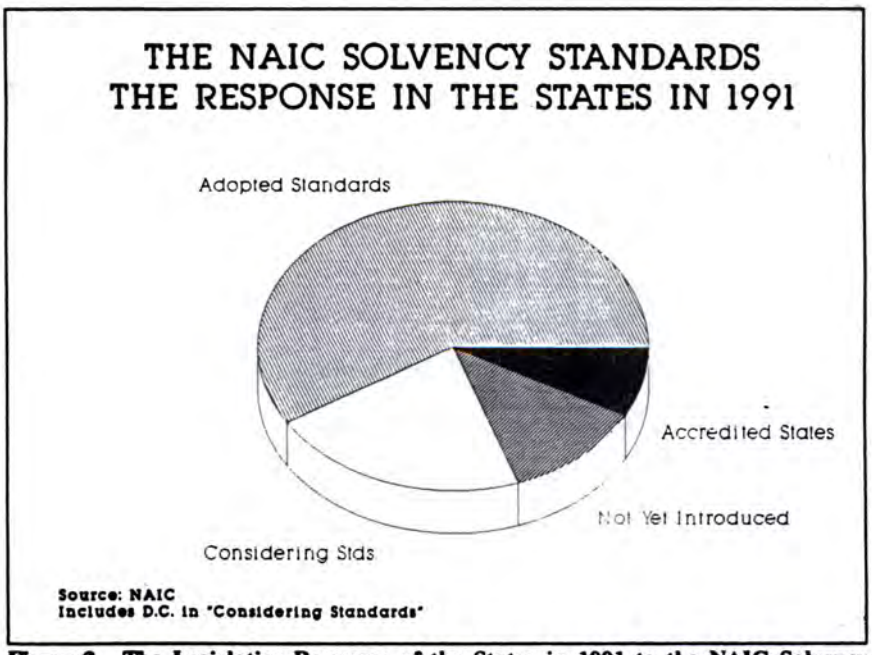

Figure 2 - The Legislative Response of the States in 1991 to the NAIC Solvency Standards

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Another element of the Financial Regulation Standards looks at the resources available to state insurance departments to enforce the laws and regulations imposed on insurance companies. The last several years has witnessed a dramatic increase in resources, both economic and human, that states have brought to bear upon insurance regulation. From 1985 to 1990, funding for state insurance departments increased by 96.7 percent (Figure 3). Similarly, from 1986 to 1989, the aggregate staffs for state insurance departments increased by 23.2 percent (Figure 4). This growth in personnel has resulted in a 12.4 percent increase in the number of insurance department staff per company. Finally, one reason that total department funding has increased faster than staff levels is that insurance departments are making substantial investments in computer technology for improved solvency surveillance.

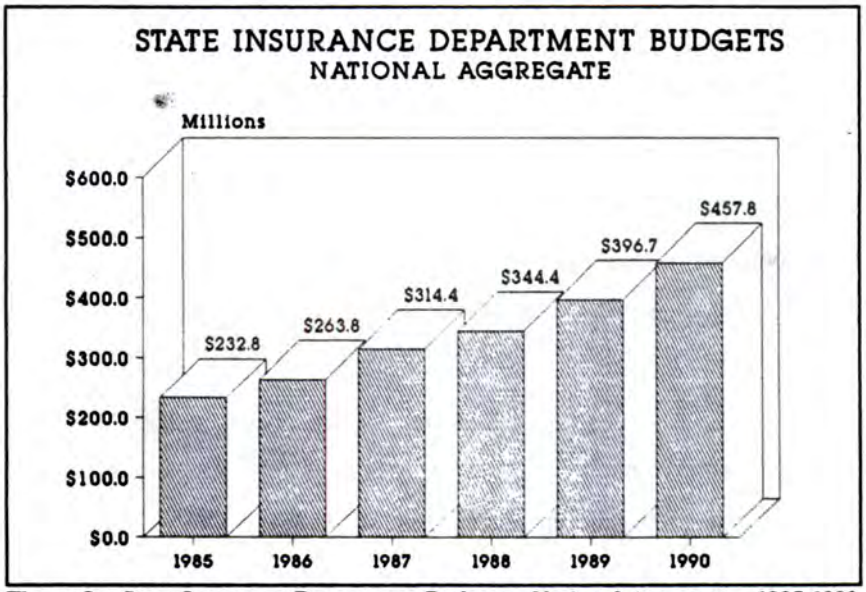

Figure 3 - State Insurance Department Budgets - National Aggregate - 1985-1990

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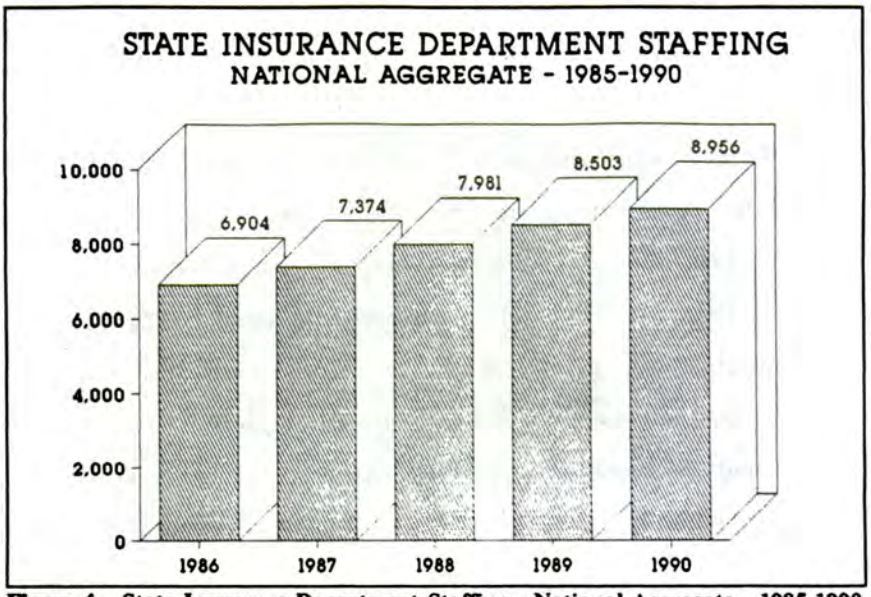

Figure 4 - State Insurance Department Staffing - National Aggregate - 1985-1990

The adoption of the Financial Regulation Standards is, however, but one aspect of a broader Solvency Policing Agenda of the NAIC, an agenda which was first adopted in December 1989, then updated last December. The NAIC Solvency Policing Agenda has five main components:

(1) the Financial Regulation Standards which we have already described;

(2) improved reinsurance evaluation;

(3) a more effective financial examination process;

(4) improved solvency analysis support; and

(5) enhanced capital analysis and requirements.

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2. Improved Reinsurance Regulation

Regulation of reinsurance activity, by which insurers spread their own risk to other companies, is of particular importance to state regulators. In order for insurance consumers to be confident that their own insurance companies can make good on their promises, consumers must be confident that their insurer's reinsurer is willing and able to keep its promises. The regulatory challenge posed by reinsurance is made more complex by the fact that many reinsurers are based overseas, and therefore not subject to the direct regulation of either the state or federal government.

Several decades ago, state regulators devised a method of protecting U.S. insureds by regulating the degree to which the primary insurer may reduce the liabilities on its balance sheet by taking credit for the reinsurance ceded by the insurer. In 1984, this concept was codified in the Model Credit for Reinsurance Act, which allows such a reduction of liabilities only if the reinsurer is (1) licensed in the state, (2) is accredited[2], (3) qualifies under either the so-called Lloyd's or ILU provisions, or (4) establishes either an acceptable trust, letter of credit, or cash deposit. Through the direct impact this treatment has upon the balance sheet of the primary carrier (the "ceding insurers"), state regulators can exercise a formidable influence over reinsurers, whether licensed to do business in a state or not.

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[2] In this context, an "accredited" reinsurer is one which submits to the state's jurisdiction and authority to examine its records, is licensed to transact insurance or reinsurance in at least one state, files its annual statement each year, and either (a) maintains a policyholder surplus of at least $20 million and whose accreditation has not been denied by the Commissioner within 90 days of its submission, or (b) maintains a policyholder surplus of less than $20 million and whose accreditation has been approved by the Commissioner.

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Perhaps the most dramatic changes in the regulation of reinsurance have come about in the area of reporting requirements. The most notable of these is a new detailed requirement which gives primary carriers a financial incentive to assure that their reinsurance companies pay promptly. Furthermore, by incorporating the rule into the NAIC Annual Statement Blank, it has become a uniform reporting requirement in every state. Finally, the rule allows regulators across the nation to quantify the extent of overdue reinsurance and identify slow-paying reinsurers.

Another important development in the realm of reporting requirements is the creation of a more refined, computerized NAIC reinsurance data base. Beginning with the 1989 Annual Statement, reinsurers are now identified with a unique identification number. As a result, regulators can track the reinsurance operations of all companies in the U.S., including reinsurance ceded to virtually any company worldwide, and thus are able to evaluate the ripple effect of potential reinsurance insolvencies upon the rest of the industry. This ability to spot potential land mines that lie in the path of an insurer's financial health will better equip regulators to avoid or minimize solvency problems. Also, regulators are able to quantify reinsurance ceded to alien reinsurers and identify insurers which are highly leveraged by reinsurance transactions.

For some time, American regulators have been concerned about their lack of authority over reinsurance intermediaries and brokers. The potentially dangerous practice by some insurers of turning over critical management decisions to intermediaries, and the resulting improprieties encouraged by this practice, led the NAIC to craft the Reinsurance Intermediary Model Act. This act mandates licensing for brokers and managers of

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reinsurance, and establishes minimum requirements for the relationship between ceding insurers, intermediaries, and reinsurers.

For similar reasons, the role of managing general agents has come under scrutiny, leading to the September 1989 adoption by the NAIC of the Model Managing General Agents Act. A managing general agent is an agent who either handles the reinsurance contracts for an insurer or manages all or part of its insurance business, and underwrites premiums in the amount of at least 5 percent of the company's net worth. Like the Intermediaries Model, the MGA Act prescribes limitations on the relationship between insurers and MGA's, limitations which are designed to weed out the improprieties that led to the abuse of the MGA function in some of the more conspicuous insolvencies of recent times. Both of these models are included in the NAIC's solvency standards and will be necessary for accreditation.

Furthermore, in 1991 we are allocating additional resources within the NAIC to assist state insurance departments in interpreting reinsurance contracts and evaluating reinsurance companies. When combined with our recent creation of a reinsurance database, this will do much to strengthen the ability of regulators to regulate this important sector of the industry.

3. More Effective Examinations

Another key component of the NAIC Solvency Policing Agenda for 1990 was an overall assessment of examination processes. The concept of effective regulatory examination involves several components: (1) a system by which regulators are warned in a timely fashion

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that an examination of a particular company is called for, allowing for a targeted allocation of examination resources, (2) a financial reporting system upon which regulators can place substantial reliance, (3) on-site examinations that are timely and targeted toward those companies most in need of examination, and (4) high quality examinations. While state regulators and the NAIC have operated under an examination system that has proven over time to be quite effective, there has been substantial activity to improve that system.

a. Warning of a Need for Examination

The NAIC is dedicated to improving the system by which regulatory efforts are focused on those companies most in need of close scrutiny. We have created a centralized financial analysis unit within the NAIC which is developing additional statistical measures to the IRIS financial ratios so that they continue to be useful to insurance consumers, regulators and others. This unit also is developing a series of computerized analytical routines which will be utilized by state insurance departments to enhance their financial analysis and solvency monitoring activities.

Furthermore, we also have developed computerized and other financial analysis techniques to support the activities of the Potentially Troubled Companies Working Group in its oversight role. Additionally, the NAIC will continue to assist states in developing and improving financial statement analysis capabilities and techniques.

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b. Verification of Financial Reporting

Of the various planks of the solvency platform adopted in December 1990, one of the most important was the requirement that insurance company financial statements be subject to an annual audit by a Certified Public Accountant (CPA). This requirement was adopted both as a Model Regulation and as an amendment to the Annual Statement Instructions. The significance of the incorporation of the CPA audit requirement into the Instructions is that it takes effect immediately in all 55 jurisdictions.

Last October, the NAIC adopted a multi-faceted proposal which requires that the mandatory actuarial opinions regarding the adequacy of a property/casualty insurer's reserves comment specifically upon items which might materially affect reserves, such as discounting, reinsurance collectibility, financial reinsurance, loss portfolio transfers, and salvage/subrogation (such opinions for life/health companies were already required). Perhaps as important a change was the requirement that the actuarial opinion address both gross and net reserves, a modification that will give regulators a clearer picture of a company's total potential liability if reinsurance agreements were to fail.

c. Timeliness and Targeting of Examinations

Last year, the NAIC adopted a Model Law on Examination which represents a conceptual change with respect to the frequency and scope of on-site financial examinations of insurers. It is designed to direct Department resources toward the examination of companies most likely to encounter financial trouble by authorizing the Commissioner to

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conduct examinations whenever it is deemed necessary, and no less frequently than every 5 years. This conceptual change can be accomplished because of the recent addition of new financial regulatory tools -- such as independent CPA audits, opinions on insurance reserves by actuaries, computerized annual financial statement analyses, and quarterly reporting by insurers, among others -- which mitigate the need for frequent comprehensive periodic examinations of all companies.

d. Improving the Quality of Examinations

At the 1990 Winter National Meeting, the NAIC also received a report from the Examination Processes Committee which included 17 recommendations regarding the examination process. One of the more important recommendations involves improving the EXAMINERS HANDBOOK. This year, we will complete our revision of the HANDBOOK, incorporating the American Institute of Certified Public Accountants' generally accepted auditing standards, tailored where appropriate for the regulatory perspective, and establishing a system for annual review of that HANDBOOK.

One of the challenges facing regulators is expanding the pool of financial examiners, auditors, and regulators with the necessary knowledge to perform complex insurance regulatory activities. To that end, we have created an NAIC education fund to develop and implement intermediate to higher level training courses for these professionals. These efforts will supplement the NAIC's existing training for financial examiners.

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4. Improved Solvency Analysis Support

In recognition of the need to enhance the NAIC's solvency analysis support to the states, the NAIC has bolstered its budget for solvency regulation by $2 million over last year's amount. The NAIC's staff of financial analysts has been increased in order to better track insurance department handling of companies that are facing solvency problems. Our analysts also have developed an additional computer-based financial solvency analysis system.

The NAIC serves a vital coordinating function in the event that a single large, multi-state company experiences financial difficulty. The NAIC's approach to such situations is based upon two fundamental premises: (1) that a smooth flow of information, always important to the effective regulation of the industry, is even more critical when a company gets into trouble, and (2) that a peer-review process involving independent state regulators with common and interdependent interests can provide greater protection for consumers than is available from unitary systems of regulation.

This philosophy can be seen in the operation of the NAIC's Potentially Troubled Companies Working Group. Created two years ago to deal specifically with large, potentially financially troubled insurance companies, the Working Group is a multi-state committee of state regulators supported by the staff of the NAIC's Division of Financial Analysis. When the Working Group identifies, through a sophisticated form of financial analysis based on the results of key financial ratios, a company that may be facing financial difficulties, the NAIC Member in whose state the company is domiciled is contacted by the NAIC and asked to report on that state's regulatory responses to the difficulty. Should the NAIC Member refuse

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to respond or provide a response that, in the opinion of the Working Group, is an inadequate regulatory response to the company's predicament, the Working Group prepares a coordinated interstate plan of action for implementation by the non-domiciliary states most likely to be affected by any problems that might arise.

5. Enhanced Capital Analysis and Requirements

For nearly four decades, state regulators have utilized a form of risk-based capital regulation for stocks and bonds held by insurers. Life and health companies are required to establish reserves for their investments in securities, the size of which are based upon the quality of the assets. For example, a low-grade bond in an insurer's portfolio might require the establishment of a reserve that is twenty times higher than that required for a high-quality bond. Similarly, property-casualty companies may carry high-grade bonds on their books at their amortized value, but must carry their lower-grade bonds at the lesser of market value or amortized cost.

However, like their counterparts in the banking regulatory community, state insurance regulators realize that a more comprehensive risk-based approach to capital requirements -- one that addresses asset risk for all assets (e.g., insurance risk, interest rate risk, and business risk) -- will improve solvency regulation. Work on this concept is proceeding along several lines.

One of the more significant developments at the NAIC's National Meeting in June 1991 was that the NAIC began exploration of a proposal to replace the MSVR system for

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life companies, currently limited to securities, with a reserving system which covers all assets held by insurers. A working group of the association has initiated an evaluation of the Asset Valuation Reserve (AVR) concept, which would establish two new reserves:

1. the Interest Maintenance Reserve (IMR), which captures gains and losses from interest rate changes, and

2. the AVR, which is established both for future credit related losses on bonds, preferred stocks, and mortgages, and for equity investments, such as real estate and other invested assets of insurers.

A much broader approach to risk-based capital requirements is being developed by two working groups that are developing a Model Act on Risk-Based Capital. The two groups are expected to expose for discussion in late 1991 a Model Act (1) to provide a formula to calculate risk adjusted capital ratios for inclusion in the Annual Statement Blank, and (2) to define regulatory review and action, based upon the level of a company's risk adjusted capital ratio or the trend in its ratio.

The NAIC also has adopted a Model Investments in Medium Grade and Lower Grade Obligations Act. The Model establishes an aggregate cap of 20 percent on medium- and lower-grade obligations, with a graded system of caps based upon the quality of the obligations. The purpose of this regulation is to allow insurers some flexibility to invest company assets in medium- to lower-grade bonds, while at the same time assuring that the special risks associated with such bonds are mitigated in terms of the overall solvency of the

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company. These limitations will help to prevent a recurrence of the recent problems encountered by Executive Life and other insurers heavily invested in medium- to lower-grade bonds.

The NAIC also has adopted a proposal to conform preferred stock ratings to the same categories used for bonds, beginning with the 1992 Annual Statement. The change in the procedures of the Securities Valuation Office (SVO) identifies which stocks will be carried at cost and which will be carried at market value. Additionally, a task force of the NAIC is surveying all insurers to develop more detailed information on their investments in real estate, mortgages, and other assets with real estate related exposure. The results of this survey, which are scheduled to be presented at the NAIC's September meeting, will ultimately be used to further improve the reporting of and establishment of valuation reserves for these investments.

C. The NAIC Today -- Serving State Insurance Regulators Nationwide

The NAIC plays an integral role in the insurance regulatory framework, a role which is being significantly enhanced as increasing demands are placed on state regulators. As I have already mentioned, the NAIC coordinates and assists state solvency efforts in a number of ways, including: maintaining an extensive insurance database and computer network linking all insurance departments; analyzing and informing regulators as to the financial condition of insurance companies; coordinating examinations and regulatory actions with respect to troubled companies; establishing and certifying states' compliance with minimum financial regulation standards; providing financial, reinsurance, actuarial, legal, computer and

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economic expertise to insurance departments; valuing securities held by insurers; analyzing and listing non-admitted alien insurers; developing uniform statutory financial statements and accounting rules for insurers; conducting education and training programs for insurance department staff; developing model laws and coordinating regulatory policy on significant insurance issues; and conducting research and providing information on insurance and its regulation to Congress, government agencies and the general public. These activities facilitate state regulators' oversight of a complex industry extending across state and national boundaries while also enabling them to better respond to the concerns and unique aspects of their particular jurisdictions.

The NAIC has grown rapidly in recent years to be able to expand its services to state regulators and the general public (Figure 5). The NAIC currently has a highly trained, professional staff of 157, representing a 240 percent increase since 1982. The NAIC's budget has grown almost four-fold over the last ten years to $16.2 million to support increases in staff, new programs and maintenance and enhancement of its expanded information systems (Figure 6).

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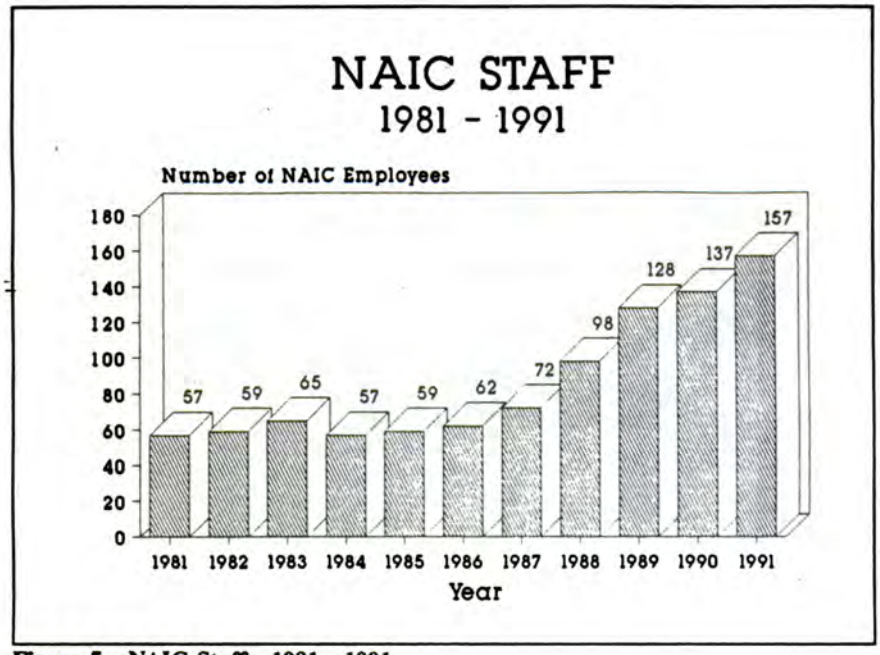

Figure 5 - NAIC Staff - 1981 - 1991

To talk about all of the NAIC's activities in depth would take several days, but it is useful to outline several of those activities in greater detail.

1. Databases and Information Systems

The NAIC has amassed the nation's most extensive financial database on insurance companies. This database is accessible to state insurance departments through an advanced computer information network, and contains five years of detailed annual and quarterly financial information on-line for approximately 5,400 insurance companies, in addition to data

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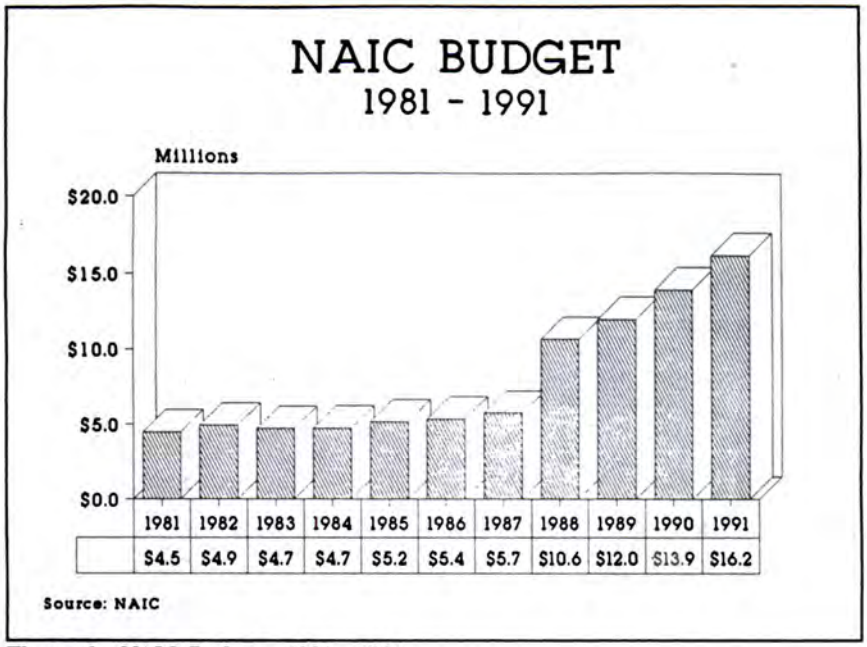

Figure 6 - NAIC Budget - 1981 - 1991

maintained off-line to the mid-1970s. The current database, systems and technology reflect a four-year $17.6 million investment to provide state regulators and NAIC staff with a "state-of-the-art" information facility. Fifty-five people are involved in maintaining and upgrading this system on an ongoing basis. The processing of annual statement data alone for 5,000 plus companies is a massive effort as each filing runs a gauntlet of 13,000 cross-check edits and careful review by a team of data quality specialists. Development of the database is closely integrated with the NAIC's development of the annual statement blank and accounting rules as well as the related specifications for diskette filings, which now comprise 90 percent of all filings.

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The NAIC database serves as the core of the solvency surveillance and other analysis activities of state insurance regulators and the NAIC. State regulators and NAIC staff access the database through a variety of sophisticated application systems which allow them to access data on specific companies, generate "canned" reports on a group of companies, or generate custom reports to suit their specific needs. Every state department has at least one personal computer, provided by the NAIC, plugged into the NAIC network and 19 states have host-to-host connections allowing them to tie in other terminals. More than 500 insurance department users have direct access to the NAIC system and the number continues to grow monthly. Correspondingly, usage of the system has skyrocketed -- 12,620 reports were generated in 1990, five times as many as in 1989. This national insurance database also has been provided to the GAO, the U.S. Office of Management and Budget, the U.S. Treasury Department and other federal agencies, as well as academics, rating organizations and various other users. In addition, the information contained in the database is made available to the public in a variety of statistical reports and special studies.

The NAIC maintains a number of other databases which state regulators and NAIC staff utilize for financial analysis and other regulatory functions. The Alien Reporting Information System (ARIS) provides financial reports that show reinsurance ceded to alien insurers, along with identifying any invalid federal employer identification numbers (FEINs), alien numbers or company locations.

The on-line Valuation of Securities (VOS) system provides a complete VOS manual listing of securities held by insurers, along with historical data beginning with 1989, for financial review purposes. This database also contains individual portfolios of the 275

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subscribing companies that maintain their stock/bond portfolio on the NAIC computer system.

The Omnibus Budget Reconciliation Act (OBRA) reporting system permits states to satisfy Medicare supplement insurance reporting requirements. Companies that write Medicare supplement insurance are instructed to send a completed OBRA reporting form to the NAIC. The NAIC then produces the required reports on behalf of each state and files them with the Health Care Financing Administration (HCFA).

The NAIC maintains other special databases containing information on regulatory actions against insurers and agents, the Regulatory Information Retrieval System (RIRS), and information on entities of regulatory concern, the Special Activities Database (SAD). RIRS, in existence since 1983, and SAD, initiated in 1990, greatly enhance regulators' ability to share information on individuals or companies possibly involved in illegal or questionable activities and prevent their infiltration into new areas. The RIRS database contains information on more than 49,000 agents and companies against which some regulatory action has been taken. More than 1,600 entities already are entered on the SAD database which received 5,000 state inquiries in the last half of 1990. State regulators and NAIC staff also use an electronic mail system on the NAIC's computer network to communicate rapidly and coordinate with each other on examinations, regulatory actions, troubled companies, entities of regulatory concern and a variety of other matters.

In addition to maintaining databases and systems, NAIC staff frequently provide consulting services to state insurance departments seeking assistance in enhancing their

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information systems.

2. Financial Analysis and Solvency Surveillance

Financial analysis and solvency surveillance are also major areas of activity for the NAIC. The NAIC has long served a vital coordinating function in the event that a single large, multi-state company experiences financial difficulty. Since the early 1970s, the Insurance Regulatory Information System (IRIS) has served as the NAIC's baseline system for monitoring insurers' financial condition at a national level and identifying those insurers requiring further regulatory attention. Companies are first processed through a statistical phase consisting of a series of eleven financial ratios followed by a series of additional screening criteria. Companies showing unusual results are then analyzed further by a select team of state financial examiners who recommend further investigation by the companies' domiciliary regulators, if necessary. Companies deemed to be "high priority" are followed up by the NAIC's Examination Oversight Task Force which takes action if the domiciliary state fails to do so. Insurers' IRIS ratio results also are available to regulators over the NAIC network and to the public in a hard copy report.

Although IRIS has and will continue to be an important financial analysis tool for regulators, as explained earlier, the NAIC is developing a new solvency analysis system to complement IRIS and focus efforts on companies of special regulatory concern. The system utilizes statistical analysis, IRIS results, computer-based analytical routines, and other kinds of quantitative and qualitative information to identify companies which may be in financial difficulty.

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3. Other NAIC Functions

The NAIC supports the insurance regulatory process in a number of other ways. In the financial area, the NAIC's reinsurance experts advise state regulators on reinsurance transactions and contracts and reinsurance reporting issues. These experts are also developing a reference manual that will assist regulatory examiners and analysts in evaluating reinsurance agreements. This section also operates the Alien Reporting Information System and produces a series of special reports on companies' reinsurance activities and problems.

The NAIC's Computer Audit Specialist assists insurance examiners in using special audit software and automated procedures to perform more comprehensive and efficient examinations. A number of special examination routines have been developed including analysis of insurers' securities, reinsurance ceded and assumed and loss reserves. In 1987, the NAIC purchased a master license for several audit software products which are now being used by 35 states. To further facilitate this activity, the NAIC's computer audit specialist has developed an Automated Examination Procedures Manual, publishes a quarterly newsletter, and conducts several regional training sessions each year to increase regulators' knowledge of the audit software and automated techniques.

The NAIC's Securities Valuation Office (SVO) determines uniform accounting values of insurers' securities investments which include government, municipal and corporate bonds, and common and preferred stocks. The SVO database contains approximately 185,000 securities for almost 32,000 issuers. Each security in the database is reviewed and valued

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annually and published in the Valuation of Securities Manual.

The Non-Admitted Insurers Information Office (NAIIO) maintains a Quarterly Listing of Alien Insurers which states may utilize to determine surplus lines carriers eligible or approved to operate in their jurisdictions. To qualify for the listing, an alien must submit financial information, pass a financial and operational review, meet certain capital and surplus requirements, and establish a U.S. trust fund.

The NAIC's Special Services Coordinator tracks and advises regulators concerning the activities of individuals, agencies and companies that are causing or have the potential to cause regulatory problems within their jurisdictions. She also assists regulators in investigating and coordinating insurance fraud cases with local, state and federal law enforcement authorities. In addition, the Special Services Coordinator publishes SPECIAL REPORT, a bimonthly newsletter to provide information on companies, individuals and practices that could affect insurers' financial stability.

Market conduct activities also have expanded significantly at the NAIC to better support the states' extensive activities in this area. In addition to maintaining the RIRS and SAD systems, the Market Conduct Coordinator is supporting the development of a new nationwide complaint database and a system for tracking basic profile data on entities involved in the insurance business. Information from the complaint database will be used to target companies for market conduct and financial examinations. These systems will further enhance state regulators' efforts to ensure that consumers are treated fairly in the insurance marketplace and that their claims are handled properly.

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The NAIC's Education and Training Department conducts programs, workshops, seminars and other educational activities that deal with insurance, insurance issues and regulation for commissioners, their professional regulatory staff members and others concerned about the regulatory aspects of insurance. In addition to regular commissioner and staff programs, a special program developed for financial examiners has won a national award and other workshops have been conducted on solvency, health insurance and legal issues. Since 1989, more than 400 regulators from 52 jurisdictions have participated in the basic educational programs alone.

Finally, the NAIC serves an important research and information function for state regulators, Congress, federal departments and agencies, consumers and consumer groups, the industry and the general public. The NAIC's Research Division and other divisions generate a number of standard as well as custom statistical reports and conduct special studies on industry investments, competition and profitability. The NAIC's Research Library maintains an 8,000 volume specialized insurance regulatory collection, conducts research for state insurance departments and answers numerous questions about insurance and insurance regulation from a variety of sources.

III. THE FEDERAL GOVERNMENT AND INSURANCE REGULATION

The NAIC has long opposed the expansion of federal involvement in insurance regulation. We have done this, not out of a sense that our "turf" must be preserved, but because of our frequent experience that, more often than not, such involvement hinders the

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resolution of the very problems the federal involvement is intended to solve. We know that you are familiar with the Employee Retirement Income Security Act (ERISA) and its unfortunate consequences for the states which now must resolve the questions about whether certain health and welfare plans, specifically Multiple Employer Welfare Arrangements (MEWAs), are exempt from state insurance laws. Further, the federal law authorizing risk retention groups and purchasing groups has visited its own unfortunate results upon state insurance regulation.

As a result of these and other entanglements with federal involvement in insurance regulation, we approach the prospect of federal involvement in what historically has been the responsibility of the states with caution, and base our evaluation on a case-by-case analysis. After careful consideration, we see two areas where federal involvement can be of assistance to state insurance regulators. Conversely, we are certain that overly broad involvement by the federal government poses great risks to the protection of the American insurance consumer.

A. The Appropriate Federal Role in Insurance Regulation

1. Fraud

As regulators, we have seen the damage that can be suffered by consumers at the hands of unscrupulous operators -- con artists who ply their trade from board room, office penthouse, or agency. State insurance regulators have two options when these perpetrators of fraud and abuse drive companies into insolvency -- criminal remedies and civil remedies.

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In both cases, the NAIC sees an important role for the federal government.

a. Federal Criminal Statute

In addressing the question of whether the federal government can play a constructive role with respect to criminal sanctions for insurance fraud, we have examined the existing statutory regime of state and federal criminal statutes on the subject.

(1) Existing State Statutes

States have power to deter and punish fraud and other corrupt activities in insurance companies in criminal actions. Additionally, the NAIC has recently created the Special Activities Database to help state regulators track individuals who have a history of involvement in insurance insolvencies. Given the existence of these state remedies and NAIC tools, why, then, is a federal criminal statute necessary? The answer to this question lies in the interstate and sometimes international nature of many insurance fraud schemes. In some cases, prosecution of anyone responsible for a company's downfall in a state court would require extradition on a massive scale, and could fail due to jurisdictional problems. In other cases, not a single witness or piece of paper relating to the fraudulent transactions can be found in the state of domicile of the insurance company.

(2) Existing Federal Criminal Statutes

Certainly, the NAIC is not asserting that there are no federal criminal statutes with

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potential applicability to insurance fraud. Federal prohibitions of mail fraud and wire fraud are available criminal remedies for prosecutors seeking to punish those who would raid the coffers of an insurance company. However, these statutes have a few important limitations. First, the predicate requirement of the use of the mail can be avoided by perpetrators of fraud with relative ease. In the case of the filing of fraudulent financial reports with the state insurance regulator, some unprincipled thieves have been known to hand deliver financial reports to regulators simply to avoid the reach of mail fraud statutes. Furthermore, some types of fraudulent record-keeping never leave the four walls of the insurance company. Deceitful bookkeeping may never touch the U.S. mail system, but may have impact as devastating to consumers as the filing of false reports with state regulators.

The five-year statute of limitations found in federal mail and wire fraud statutes imposes yet another constraint on their usefulness in prosecuting insurance fraud. The detection and investigation of complex multi-state insurance schemes can exceed this time period easily.

In short, existing federal and state laws addressing the recurring problem of deceptive financial reporting and outright theft in the insurance business do not provide the American consumer with adequate protection. The weakness of the existing body of law is clear: there simply is no statute which:

- specifically addresses insurance fraud, and
- prescribes strong criminal penalties, and
- can be used in the prosecution of complicated, multi-state schemes, and
- provides investigators and prosecutors with a statute of limitations which

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provides enough time for the preparation of a solid case.

It is our belief that this weakness can and should be eliminated.

(3) The NAIC Proposal For A Federal Criminal Statute

Earlier this year, the NAIC decided to eliminate this statutory weakness in the form of a specific proposal which consists of a set of amendments to Title 18 of the U.S. Code, patterned after existing federal provisions covering crimes regarding financial institutions. The U.S. Senate has substantially adopted the NAIC's proposal as an amendment to the crime bill it passed earlier this month. The proposal is designed to reach criminal activity by those individuals whose fraud might harm insurance consumers, including any acting as or on behalf of an insurer, reinsurer, producer, reinsurance intermediary, broker, insurance consultant, or adjuster.

The proposed federal statute would specifically establish as federal offenses four types of behavior which, in the experience of state insurance regulators, typifies white-collar insurance fraud:

- the filing with a state insurance regulator of fraudulent financial statements;
- embezzlement and theft of insurance company money, funds, premiums, or credits;
- the falsification of company records with the intent to defraud the company or its policyholders and creditors; and
- the criminal obstruction of proceedings before state insurance regulatory authorities.

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Additionally, the NAIC proposal calls for stiff penalties, appropriate to the seriousness of the harm that can be caused by the perpetrators of insurance fraud, in some cases as high as $1,000,000 and/or 30 years imprisonment. Perhaps as important is a prohibition, absent specific approval by the authorized state insurance regulatory official, of insurance-related activity by a person who has been convicted of any criminal offense involving dishonesty or a breach of trust or any of the offenses described in this statute. We view this as particularly important to the prevention of repeated abuses by previously convicted charlatans who would evade scrutiny by changing jurisdictions after conviction in one state.

The proposal also establishes a 10-year statute of limitations for the offenses proscribed under the act. This is a straightforward recognition that crimes of this sort can take years to detect and investigate, a reality that is reflected in the similar federal statutes dealing with crimes against other financial institutions.

b. Federal Civil RICO Provisions

In 1970, the Congress enacted The Racketeer Influenced and Corrupt Organization Act (RICO) to curb crime and its spreading influence, particularly in the arena of American business. The RICO Act goes about this task with both criminal and civil provisions. In the 21 years the statute has been in place, federal prosecutors have used the criminal sanctions of the bill with increasing frequency, and increasing success.

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The civil provisions of RICO, which allow actual damages to be trebled, have been used not only by the federal government, but by state government and private plaintiffs as well. The advantages of these civil remedies over RICO's criminal sanctions are several.

First, the criminal justice system is confined in its ability to reach some of the subtler forms of fraud. Limitations on law enforcement resources, the cumbersome nature of criminal proceedings, and the higher standard of proof, all combine to restrict the use of RICO's criminal penalties to only a fraction of the instances of fraud that the Congress targeted by enacting RICO 21 years ago.

A second advantage of the civil proceedings provided by the RICO Act is that they extract a very real financial penalty against corporate thieves. The powerful economic deterrent created by the prospect of damages in the amount of three times the actual damages caused by fraud says, loudly and clearly, that this crime will not pay.

Third, an injured plaintiff facing the daunting legal costs of a civil RICO action will find that potential burden less intimidating when balanced against the prospects of treble damages. Furthermore, unlike the criminal penalties, RICO's civil damage provisions offer an injured party a very real prospect of being made whole.

Too often, we have witnessed people entrusted with the health of an insurance company exploit that trust to gut the company and leave its carcass for the insurance commissioner to revive or bury, usually the latter.

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Because of the limitations posed by existing law -- both state and federal -- to state insurance regulators, the civil provisions of RICO are the single most potent weapon in our arsenal against conspiracies to pillage insurance companies and their policyholders. When financially impaired, an insurance company may be taken over at the direction of the state insurance department under a court order for the purpose of accumulating company assets, paying policyholder claims, and winding up the business affairs of the company. The liquidator or rehabilitator of an impaired or insolvent company, in most cases a state insurance regulator, can bring a federal civil RICO action against persons or companies who, through fraudulent activity, contributed to the financial decline of the company. Presently, eight state regulators are in the midst of such civil suits.

It is no accident that RICO is a favorite remedy for the most serious instances of insurance fraud -- the Act was tailor-made for the kinds of abuses that can be found in the insurance industry. As a cash-intensive business that involves the receipt of premiums in exchange for little more than a promise of future payment, insurance acts as a magnet for con artists. As often as not, the fraud we see in connection with the practice of looting an insurance company into insolvency involves a number of people -- corporate executives, agents, brokers, and employees -- engaged in a common scheme involving multiple criminal activities. This is exactly the type of criminal involvement in American business that RICO was intended to address.

Furthermore, a civil RICO action is particularly useful to a state insurance regulator trying to minimize losses to insurance consumers and taxpayers alike. Every state has a property-casualty insurance guaranty fund and a life/health insurance guaranty fund. These

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are designed to pay the claims of policyholders and other claimants of an insolvent company. State guaranty funds are financed by assessments made against the other insurers doing business in the state, which assessments are often passed on, market conditions allowing, to the healthy companies' policyholders and/or the state's taxpayers.

A chief objective of a state regulator in charge of an insolvent insurer is the minimization of guaranty fund costs resulting from the insolvency. When a conspiracy to defraud an insurer contributes to an insolvency and thereby creates the need for such assessments, the policyholders and taxpayers of a state may reap substantial benefits from an insurance regulator's use of civil RICO to recoup at least a portion of the losses to the guaranty fund. In other words, civil RICO is an invaluable means of assuring that the costs of insurance fraud fall upon the culprits instead of the general public.

In recent years, there have been efforts in the Congress to limit the use of the civil provisions of the RICO Act. The most recent effort is found in H.R. 1717, currently pending in the House Judiciary Committee. While it is a major improvement over previous versions, the bill would still inhibit the ability of state insurance regulators to pursue the ill-gotten booty of insurance fraud. Because of this defect, the NAIC will continue to oppose this and any other Congressional effort to hamstring our efforts to bring the perpetrators of insurance fraud to justice.

2. The Regulation of Non-U.S. Insurers

As many Members of Congress, and others, have noted, state insurance regulators

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have faced problems in the regulation of non-U.S. insurance companies. Accordingly, the NAIC has decided that the regulation of insurers could be improved if the federal government would play a limited role in the regulation of non-U.S. insurers.

Specifically, we are developing a proposal which would expand the function of the NAIC's Non-Admitted Insurers Information Office (NAIIO) to include the approval of all non-U.S. insurers doing business in the United States. Currently, the NAIIO, established nearly 30 years ago, maintains the "Quarterly Listing of Alien Insurers," the so-called "white list," an advisory listing of alien insurers approved as surplus lines carriers. Under the draft proposal, the NAIIO would also approve non-U.S. reinsurers.

The federal bill envisioned by the current draft would not create a new federal agency, nor would it require an expenditure of federal funds. Rather, the bill would require that all non-U.S. insurers engaged in insurance in the United States meet the requirements detailed in the legislation. Direct writers would be required to be on the NAIC-eligible list to do business in any state. Further, in order for an insurer to take credit for reinsurance ceded to a non-U.S. reinsurer on its Annual Statement, the reinsurer similarly must be eligible. Additionally, the proposal would require the establishment of trust funds for the protection of U.S. policyholders, claimants, and cedants.

The draft proposal has been publicly disseminated and detailed comments are currently being received. The NAIC is continuing to study its possible impact on capacity as well as consider the ramifications on international trade negotiations.

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In concept, this proposal represents an excellent blend of the strengths of state regulation -- the nearly 30 years of experience in evaluating alien insurers for financial strength, the NAIC reinsurance database, and our pool of technical expertise -- with a key strength of federal law -- uniformity of regulations affecting non-U.S. companies. We hope to have this ready for your consideration in the very immediate future.

3. The NAIC's Examination of the Guaranty Fund System

In February 1991, the NAIC initiated an examination of the guaranty fund system, which protects policyholders and claimants from the most serious harms arising from an insurer's insolvency. Historically, the state-based guaranty fund system has performed quite well. There is substantial, although not complete, uniformity among the various funds, and adoption of guaranty association acts based on the NAIC model laws on the subject has been nearly universal. Furthermore, to date, the guaranty funds have proven to be adequately designed to provide sufficient funding to meet all the needs of policyholders and claimants of insolvent companies.

Yet, state regulators have expressed some concern in recent years that the guaranty system, now 20 years old, should be revised in light of recent increases in numbers of insolvencies and the increasing complexity of those insolvencies. The Guaranty Fund Task Force is holding a series of hearings to determine what, if any, changes need to be made to the system, including the possibility of federal involvement in the system. While no conclusions have been reached by the NAIC on this important subject, we expect to conclude our study later this year. Naturally, we will report any findings to the Congress.

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B. Why The Federal Role in Insurance Regulation Should Be Limited

While the federal government does have a constructive role to play in the regulation of insurance, it is essential for the protection of consumers that that role be carefully limited. There are several important reasons why this is so.

In the 1980s, state insurance regulators were faced with a dramatically changing regulatory environment which featured an explosion of new insurance products, dramatic changes in investment strategies by insurers, and sometimes striking changes in insurers' marketing practices. At the same time, the budgets of state governments across the nation increasingly felt the effects of the collision between a rising need for state government services and a declining capacity to increase state revenue. In fact, much of this budgetary crisis in the states was exacerbated by a sharp increase in federal delegation of program funding to the states.

Yet, despite these fiscal pressures on state budgets, state insurance regulators never lost sight of the importance of strong regulation, unlike their federal counterparts, and continued to strengthen solvency efforts throughout the last decade while federal regulators stepped backward. As Figure 7 illustrates, state expenditures for insurance regulation has grown far more rapidly than expenditures for the regulation of commercial banks and thrifts.

Similarly, states have made a significantly stronger commitment to expanding the human resources needed for sound regulation than their federal counterparts (Figure 8).

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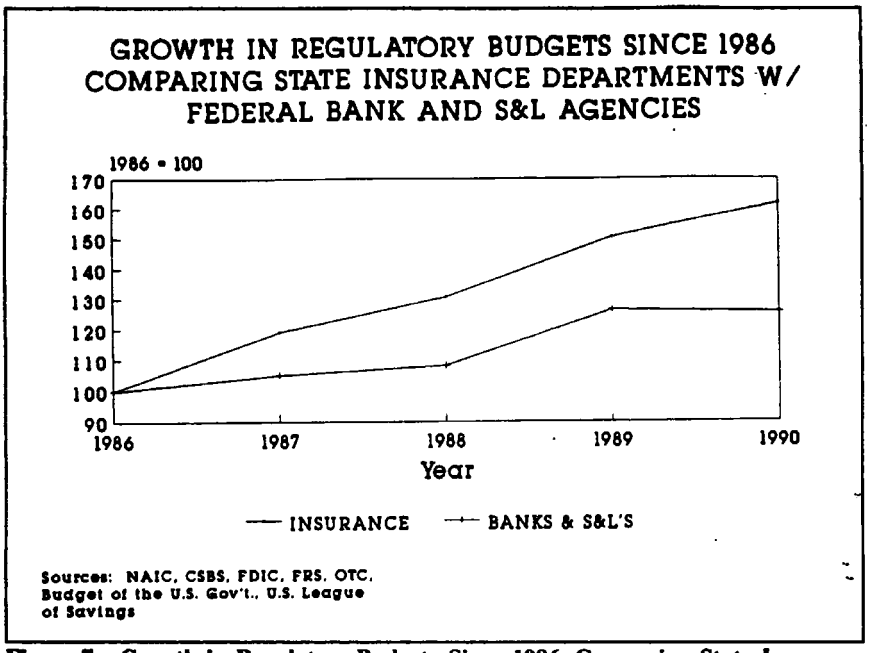

Figure 7 - Growth in Regulatory Budgets Since 1986, Comparing State Insurance Departments With Federal Banking and Savings & Loan Agencies

Not only have states increased their commitment to regulation more rapidly than has the federal government, but they have also devoted more resources when measured against the size of the insurance industry than their federal counterparts. While the relationship between industry size and the resultant regulatory burden is difficult to compare among the various financial services industries, one measure of the relationship is the regulatory budget as a percent of insurance industry premiums and bank and thrift deposits. When looked at this way, state insurance departments devote significantly more resources to the regulation of the insurance industry than their federal counterparts devote to the regulation of banks and thrifts (Figure 9).

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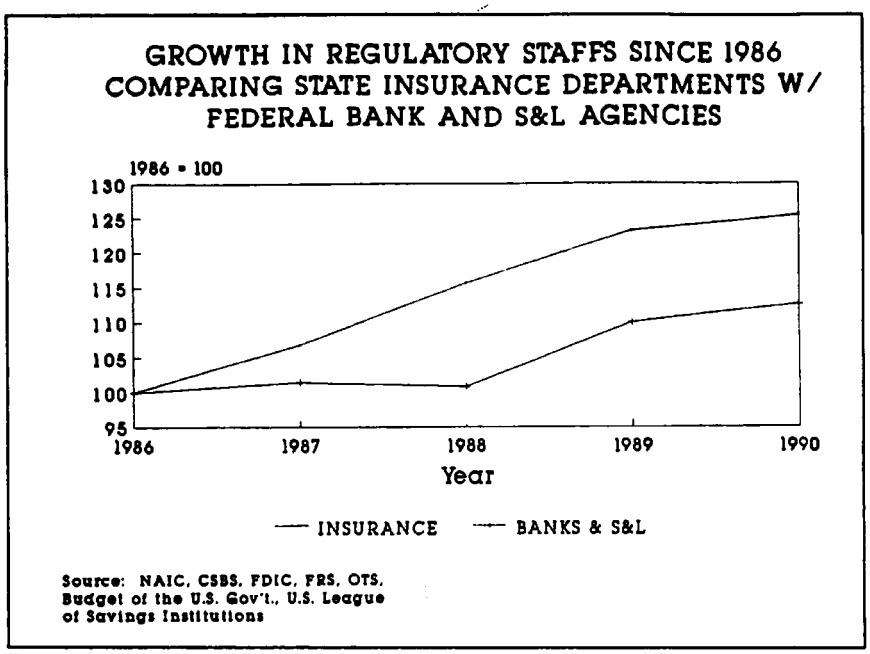

Figure 8 - Growth in Regulatory Staffs Since 1986, Comparing State Insurance Departments With Federal Banking and Savings & Loan Agencies

As these figures suggest, those who would argue that the federal government is more likely to provide a stronger commitment to solvency regulation of the insurance business than the states are wrong.

It is not simply a commitment of resources by the states, however, that provides insurance consumers with solid protection against the pitfalls of insolvency. The very structure of state regulation offers several advantages over unitary regulatory structures.

One such advantage is the two layers of regulatory protection for insurance

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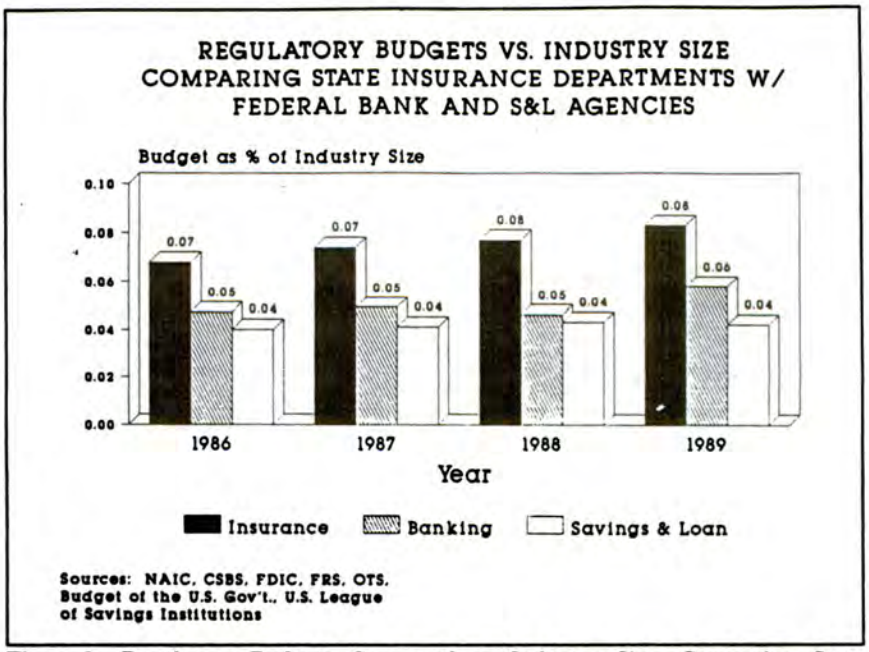

Figure 9 - Regulatory Budgets Compared to Industry Size, Comparing State Insurance Departments with Federal Banking and Savings and Loan Agencies

consumers: (1) regulation by the state of domicile of the insurer, and (2) regulation by the states in which the company is doing business. If regulation in the domiciliary state is inadequate, regulators in other states can still take actions to protect their policyholders. The NAIC's primary focus is on strengthening the first layer of protection, but some of its efforts also strengthen the second layer. Federal preemption of state regulation could undermine this second layer, which could be disastrous if federal regulation proved to be inadequate, as it did over the last decade for other financial institutions.

Even short of complete preemption by the federal government is the possibility of

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federal involvement which could weaken this two-tiered system. A classic example of such a weakening of the second tier by federal involvement can be found in the Liability Risk Retention Act of 1986 (LRRA). Under this act, liability risk retention groups that are licensed in one state can escape the bulk of normal regulatory scrutiny in any other state in which they operate. This aspect of LRRA has created a number of problems for state insurance regulators and the consumers they are pledged to protect.

Yet another structural strength of state regulation can be found in the integration of insurance solvency regulation with other aspects of the regulation of the industry. These functions include company and agent licensing, regulation of policy forms and rates, policing insurers' and agents' marketing practices and claims handling, investigating fraud, conducting legislative and policy research, providing consumer information and handling complaints, monitoring competition, addressing availability problems with special market assistance plans, and collecting premium taxes. These activities are critical to protecting the interests of consumers and ensuring that the promises of insurance contracts are fulfilled.

The integration of these responsibilities in one agency in each state offers tremendous advantages in coordinating public policy toward insurance and preventing conflicting regulatory actions. Adequate rates do not ensure that a company will remain solvent but inadequate rates will ultimately bring it down. Vesting these responsibilities in one entity helps to ensure that rates will not be allowed to fall to a level that would endanger an insurer's solvency. In addition, by monitoring and regulating all insurer operations, state insurance departments are able to take actions more quickly to prevent solvency problems from occurring.

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A further advantage of state regulation is one that has been portrayed by critics as a weakness: the incremental nature of change under state regulation. This advantage has two primary aspects. First, novel approaches to regulation in a changing economic environment may be tried by a state without committing the entire regulatory system to those new approaches. Thus, by utilizing the Jeffersonian concept of the states as "laboratories of democracy," state regulation is better suited to innovation than a unitary national system.

Second, the incremental nature of change in state regulation protects the national system of insurance supervision from sudden and sometimes radical swings in regulatory philosophy. Perhaps if federal and state regulators of the savings and loan industry had not moved a decade ago in lock-step toward deregulation of the industry, at the behest of the President and the Congress, American taxpayers would not be looking at a potential cost of a half-trillion dollar price tag for that policy blunder.

C. NAIC's Response to the GAO's Criticism

On May 22 of this year, the General Accounting Office (GAO) presented testimony before the Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee. That testimony was critical of the state regulation of insurance and of the NAIC, and concluded that no reforms based upon the existing system of regulation could result in adequate insurance regulation.

Furthermore, the GAO departed from its ususal procedure in working with the NAIC

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and the states and did not make its testimony available to the NAIC for comment before its release. We view this as an unfortunate step given that presumably we are all interested in furthering sound public policy-making. Had we had more timely notice of GAO's written views we believe we could have better contributed to the goal to which we are all pledged. The NAIC will soon provide the Oversight and Investigations Subcommittee with a formal and complete response to the GAO's testimony. We will make this response available to the Members of this Subcommittee when it is completed, which will be shortly. However, because the GAO is scheduled to provide testimony at this hearing, I will summarize our critique of the GAO's position on insurance regulation in this testimony.

In the past, we have been fairly impressed with the GAO's reports, even though we have not always agreed with their conclusions. Generally, the auditors have been reasonably well-informed and careful to support their opinions and conclusions with objective findings. However, the GAO's recent testimony departed from this pattern, with opinions and conclusions based upon other opinions and conclusions, and seldom related to audit findings.

Throughout the report, the GAO makes several errors of analysis which are important to note, and which impair the usefulness of its work.

1. The GAO testimony offered legal conculsions that are incorrect.

For example, the GAO claims that it would be unconstitutional for Congress to delegate national regulatory authority to the NAIC. The GAO made no attempt to outline the basis for this legal conclusion. While there are limitations to any delegation of authority

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Congress may make, a thorough review of the cases does not reveal any impediment to federal delegation drafted to come within these limitations. Indeed, such delegation is quite commonplace and, in fact, there are numerous references to the NAIC throughout federal statutes and regulations.[3]

2. The GAO concludes that certain characteristics of state insurance regulations are flaws, without any analysis or explanation.

For example, GAO asserts that one of the three fundamental weaknesses of state regulation is that:

> States vary widely in the quality of their solvency regulation. There are differences in regulatory workload, such as the number, size, and type of companies domiciled or licensed in a state; the available resources in a state; and each state's "regulatory philosophy."

It is a truism that there are differences in regulatory workload, number and size of companies domiciled and licensed in a state, resources and regulatory philosophy. The NAIC does not concede, however, that any of these factors is an indicator of "quality." The difference in workload caused by the differences in company numbers and size result in a rational difference in the amount of resources that should be properly available to handle the workload. A comparison of states for quality of regulation must take into consideration a number of factors not mentioned by the GAO but considered by the NAIC in its

[3] See, e.g., Omnibus Budget Reconciliation Act of 1990, P.L. 101-508; Medicare Catastrophic Coverage Repeal Act of 1989, P.L. 101-234; Medicare Catastrophic Act of 1988, P.L. 100-360.

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accreditation review. These include not only the numbers of staff, their qualifications and training, but also the amount of outside resources that may be available to the department from various sources.

Similarly, regulatory approaches may differ from state to state just as regulatory philosophies may differ with each presidential administration and even with one administration. But, clearly, the potential damage that may be caused to the insurance business as a result of an approach taken by one or more states, however, is held in check by the approaches taken by other states. The likelihood of significan negative effoct on the insurance business of radical changes of philosophy among insurance regulators is therefore minimal. On the other hand, the same cannot be said of the federal regulatory system, as exemplified in the savings and loan and banking industries.

3. The GAO testimony is rife with factual errors which, when taken together, reveal a fundamental lack of understanding of the regulation of insurance.

For example, the GAO describes a third "weakness" of state regulation:

> State regulators do not oversee holding companies and foreign reinsurers. In part, these blind spots may have prevented regulators from acting to forestall several large insurer failures.

In light of the fact that the Model Insurance Holding Company System Act is the law in virtually every state jurisdiction, the GAO is simply wrong. Or, perhaps the GAO is making the preposterous suggestion that a weakness of state regulation is that insurance

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departments do not regulate non-insurer corporations such as General Motors and ITT, both of which have insurance subsidiaries. The fact is that transactions between affiliates are regulated and it is these transactions which relate to the insurer's solvency.

Further, while non-U.S. reinsurers are not directly regulated, their impact on U.S. reinsurers is. Incredibly, the GAO testimony totally omits any mention of the NAIC Model Credit for Reinsurance Act or its inclusion in the requirements for accreditation. The Act determines when a U.S. insurer may take credit for its reinsurance and assures that adequate security is in place to guarantee the obligation of the non-U.S. insurer. Day-by-day regulation of non-U.S. corporations is impractical whether done by the state or by a federal authority. The NAIC is considering a proposal, however, that would establish minimum requirements for non-U.S. reinsurers which would add an extra layer of protection to the safeguards contained in the Model Credit for Reinsurance Act. The proposal has not yet been ratified and further study must weigh the benefits to be derived from the extra layer of protection against the possible effects on capacity/availability and international trade.

Similarly, the GAO's lack of understanding of the complex world of insurance regulation is also revealed in the somewhat naive insistence upon development of a "single uniform standard for determining if an insurer is financially troubled." Insurer solvency is dependent upon a huge number of variables not present in other financial institutions such as banks and savings and loans, and therefore insurer solvency regulation is many times more complex than the regulation of other institutions. Simple principles applying to these other financial institutions are simply not transferable to the insurance industry.

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4. The GAO chose not to evaluate state insurance regulation by comparing state regulation with any other systems of financial institution regulation.

The GAO has analyzed and re-analyzed the regulation, or lack thereof, of thrifts and banks. We are puzzled, therefore, by the fact that, possessing as it does all the resources needed to compare state regulation of insurance to various regulatory structures of other financial institutions, including federal regulation and dual regulation, it declined to do so.

This is unfortunate. We believe that state regulation of the business of insurance compares remarkably well to federal regulation of financial institutions and to a dual federal-state regulatory structure.

It is, of course, true that there are problems at the state level. Prompt communication or action does not always occur in state insurance regulation. Only in an ideal system does it always occur. Our goal is to improve the system to the point that it comes as close as possible to perfection. However, for the GAO to characterize the lack of perfection in the current system as a major inherent weakness is simply absurd.

These are but a few examples of a flawed analytical approach that pervades the GAO testimony. However, we are even more disappointed with the GAO's testimony on a broader, more basic ground: the GAO's testimony is grounded in a strong and rigid bias against state government. This bias is most clearly revealed in the fundamental conclusion of the document, that, the "road to effective insurance regulation does not pass through the NAIC."

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This bias against state government runs directly counter to fundamental principles of American government which vest basic powers of government in the states. The NAIC believes that solvency regulation should meet national minimum standards, but not only need not, but should not, be uniform in all respects. The ability of states to experiment with new forms of solvency regulation is one of the strengths of state regulation.

In sum, the GAO testimony is based more on bias than fact; more on unsupported conclusions than on audit findings; more on simple errors than on simple truths. It is that aspect of the GAO testimony, and not the testimony's conclusion, that disappoints us most.

IV. CONCLUSION

Overall, we believe that the long-standing tradition and operation of state regulation of the business of insurance have served consumers well. Certainly, state regulation of the insurance industry fares better in a comparison with federal regulation of other financial institutions. But, as we have described for you in detail here, we are not standing still, nor are we unconcerned about current problems in the area of solvency regulation. State regulators are responding through the NAIC to the changing and challenging environment of the insurance industry.

We believe the NAIC's Financial Regulation Standards and Accreditation Program will succeed in strengthening the state regulatory system. Other improvements discussed above -- from strengthened solvency analysis support, to enhanced capital analysis and requirements,

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to improved examinations and more -- will provide needed enhancement to a regulatory system that has been successful but could be more so, particularly as we enter the next century.

As we defend state regulation of insurance, we have not been defensive or turf-conscious about state regulation. We have presented what we believe to be a constructive and needed role for the federal government in the areas of fraud and regulation of non-U.S. insurers. We are in the process of analyzing whether there needs to be federal involvement in the guaranty fund system.

We ask that in your policy making process you consider what we have said here today, not unmindful of the problems in the regulation of the business of insurance -- for that is your job -- but mindful of what state regulators have done rather successfully in the past, and what state regulators are doing now, diligently, to continue to protect insurance consumers. Because, in the final analysis, protection of consumers is our job.

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TESTIMONY OF

CONSTANCE B. FOSTER
INSURANCE COMMISSIONER
COMMONWEALTH OF PENNSYLVANIA

BEFORE

THE UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON POLICY RESEARCH AND INSURANCE
OF THE
COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS

JULY 29, 1991

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Good afternoon, Mr. Chairman and members of the sub-committee. I am pleased to appear before you today to discuss the steps Pennsylvania has taken to address insurance company solvency.

There is no doubt that insurance company solvency is of compelling interest on both the national and state levels. The recent publicity surrounding the financial difficulties of Executive Life Insurance Company, First Capital Life Insurance Company and Mutual Benefit Life Insurance Company illustrate the real life problems faced by policyholders of insolvent or troubled companies. As we have seen, even in states such as Pennsylvania where policyholders are protected by guaranty funds, people can be hurt by insurance company failures. For example, a number of Pennsylvania employers funded their pension plans through Executive Life annuities. Today, Pennsylvania pensioners are receiving only 70% of their annuity payments from Executive Life. Regardless of how Executive Life is finally resolved, those individuals have suffered real financial harm.

Pennsylvania currently has 1,518 licensed insurers, 349 of which are domiciled in the Commonwealth. Licensed insurers include property/casualty and life/health companies, fraternal benefit societies, title insurers, health maintenance organizations (HMO's) and preferred provider organizations (PPO's). Although the Department monitors the financial solvency

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of all of its 1,518 licensed insurers, it focuses its solvency surveillance efforts on its 349 domestic companies.

Pennsylvania's financial solvency regulation begins with statutory provisions which govern the financial aspects of an insurer's operation by: (1) setting minimum capital and surplus requirements, (2) requiring minimum reserve levels (amounts set aside to settle outstanding claims), (3) limiting the types of assets insurance companies can purchase, and (4) requiring periodic on-site financial examinations.

Statutory requirements, however, are only as effective as their enforcement by regulatory bodies. Pennsylvania monitors the financial solvency of insurers through review of: (1) annual financial statements prepared and filed by insurers and, in some cases, quarterly statements; (2) certifications of loss and loss adjustment expense reserves; (3) independent reports of certified public accounting firms regarding the financial condition of the insurer; (4) on-site financial examinations; and (5) the IRIS ratios and examiner team synoposes for its domestic carriers.

In addition to the routine review of the above financial information, the department undertakes special analyses of specific financial or operational issues which may impact upon insurer solvency. For example, we are currently analyzing the extent to which domestic insurers have invested in high yield securities, commercial real estate and commercial mortgage loans.

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The Pennsylvania Insurance Department has two program units devoted to monitoring the financial solvency of all insurers licensed to do business in the state. The financial analysis unit is responsible for analyzing the financial statements and CPA reports filed by each insurer licensed in the Commonwealth of Pennsylvania. The unit evaluates each insurer's solvency, profitability and compliance with the insurance laws and regulations. The examination unit is responsible for on-site examinations of the 349 domestic insurers. The Insurance Department Act of 1921 requires the Pennsylvania Insurance Department to inspect and examine the affairs of each domestic insurance company, association and exchange to attest to the insurance company's financial condition, ability to fulfill its obligations and compliance with provisions of the law. These examinations are conducted at least once annually during the first five years of existence and every four years, or as often as necessary, thereafter.

Early detection and intervention are critical elements of any insurance department's solvency surveillance responsibilities. In an effort to modernize insurer solvency surveillance in Pennsylvania, the Insurance Department began in 1987 an initiative to enhance its regulatory ability to identify potential financially troubled insurers. The department contracted with an outside consultant to examine existing solvency surveillance techniques and to develop a conceptual design of a solvency

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surveillance system. As a result, a multi-year, multi-phased implementation plan was developed and has progressed over the past three years with the implementation of comprehensive new financial analysis and examination procedures and staff development initiatives. The department's new solvency surveillance system includes the calculation of financial ratios for comparative analysis of the financial health of property/casualty and life, accident and health insurers to identify insurers whose financial position may be at risk. As a result of the application of the ratios and consideration of other information available within the department, insurers are designated as either high, medium or low priority. This designation allows the department to focus its resources on those high priority insurers which are financially troubled while limiting the amount of time devoted to monitoring the financial conditions of those insurers with the least likelihood of potential financial difficulty. The priority designation also assists the examination unit in prioritizing its on-site examination as well as defining the scope of an examination.

A comprehensive examination planning process has been implemented which involves greater interaction between the financial analysts and the field examiners and improves the efficiency and effectiveness of field examinations. Another result of the study has been the formation of a Policy Directive Group to identify and research issues which arise as a result of financial analysis or examinations and recommend procedures or policy to resolve those issues.

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In addition to establishing new and more effective procedures to detect insurance companies which are experiencing financial difficulties, the department recently implemented a troubled insurance company procedure manual modeled after a handbook developed by the National Association of Insurance Commissioners (NAIC, 1989). The troubled company procedures provide for more effective and efficient management of financially distressed insurers by coordinating the various program units within the Department.

As noted above, the department requires the filing of financial statements, loss reserve certifications and CPA audit reports. The department receives IRIS results from the NAIC and conducts on-site examinations of its domestic insurers. Additionally, the Department makes extensive use of on-site limited scope examinations whenever concerns arise over a particular company. In a limited scope examination, the Department examiners restrict their investigation to particular areas of concern identified through the financial solvency surveillance system. This enables the Department to focus its resources to quickly evaluate potential problems.

Despite these efforts, Pennsylvania recognized, along with other insurance regulators, that more needed to be done. As a result, in 1989 the NAIC began the development of the Financial

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Regulation Standards which established minimum standards for state solvency regulation in three key areas:

(1) legislation
(2) regulatory practices and procedures, and
(3) organizational and personnel practices.

In June of 1990, the NAIC adopted a formal certification program to assist states in implementing the minimum Financial Regulation Standards. Under the formal certification program each state's insurance department will be reviewed by an independent review team whose responsibility it is to assess the department's compliance with NAIC's Financial Regulation Standards. The formal certification process begins only after the three objectives have been met:

(1) Enactment of Legislation
(2) Promulgation of Regulations
(3) Implementation of Organizational Changes

In order to begin the process of gaining NAIC accreditation for Pennsylvania, the Department has had introduced legislation in both houses of the General Assembly which includes the necessary language to meet these standards. Even, more importantly, the legislation contains additional provisions to address problem areas based on the Insurance Department's experience with

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financially troubled insurers and where the Department believes current law is deficient. The legislation provides for major enhancements to the Pennsylvania Insurance Department ability to protect our citizens from insurer insolvency. Although the legislation will not prevent insurance company insolvencies, it will allow the Department to better monitor troubled companies, detect those companies earlier and provide for stricter controls over financial transactions between an insurer and its affiliated companies and the investment practices of insurers. Together with the updated and strengthened departmental regulations and the already completed organizational changes and establishment of strict solvency detection procedures, this legislation will result in minimizing the possibility of insolvent insurance companies. In this regard, I have attached a copy of the testimony department personnel provided which explains, in detail, the proposed legislation.

The sub-committee should also be aware that the solvency issue is not limited solely to licensed insurance companies. During the past year, my office has spent considerable staff time and resources addressing problems resulting from the operation of unlicensed multiple employer welfare associations or employer trusts which provide coverage for employee health plans and assert preemption from state regulation under the guise of ERISA. The department has taken action against a number of these unlicensed entities to stop them from transacting the business of accident and health insurance without being licensed to do so. In each

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case, these entities have been determined to be under reserved and/or insolvent and are placed into liquidation. The Department currently has 10 unlicensed companies in liquidation with four additional petitions to liquidate pending before the courts.

In the coming years, we will intensify our efforts in the financial solvency area through the application of the solvency benchmarks, the refinement of our automated solvency surveillance system, and the aggressive pursuit and liquidation of unlicensed entities and insolvent companies. I am committed to continuing in the future these programs and initiatives which have furthered the Department's ability to affectively regulate insurance company solvency. And in the mean time, we will continue our committment to keeping our consumers aware of the many issues surrounding insurance company solvency. We will continue to answer inquiries through our Consumer Services Office and will provide literature, such as the attached question and answer sheet, to help affected consumers understand the complexities involved when insurance companies have financial difficulties.

I am pleased to answer any questions members of the sub-committee might have.

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STATEMENT OF MIKE WEAVER,

ALABAMA INSURANCE COMMISSIONER,

BEFORE THE HOUSE COMMITTEE ON BANKING,

FINANCE AND URBAN AFFAIRS,

SUBCOMMITTEE ON POLICY, RESEARCH AND INSURANCE

JULY 29, 1991

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Mr. Chairman and members of the Subcommittee, my name is Mike Weaver, and I am the Insurance Commissioner for the State of Alabama. Thank you for inviting me to testify here today.

The Alabama Department of Insurance is responsible for the supervision and regulation of the insurance industry in the State of Alabama and for the State Fire Marshal's office. While consumers tend to focus on their premiums, the safety and soundness of insurance companies operating in the State of Alabama and their ability to pay claims are our primary objectives.

We feel that we have an effective financial surveillance and regulation structure in Alabama. We examine every domestic company once every three years. We also closely monitor the financial data contained in their financial statements. We continually strive to upgrade and change to enable us to do an even better job to protect the insurance companies and citizens of our state.

Also, the computer analysis and support evaluations being conducted by the National Association of Insurance Commissioners regarding the data contained in these annual statements are extremely useful in early detection and financial surveillance. While Alabama law mandates an examination every three years, we have the authority to examine companies whenever it is deemed necessary. We have the authority to review and have complete access to all companies' books, records, agent information and, if necessary, the records of any affiliated companies. While

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some companies have objected to our authority over holding companies, we have maintained and continue to exert our authority to examine these subsidiaries and holding companies. For instance, in the Champion case, without a thorough evaluation of the holding company and all associated subsidiaries, the insurance company appeared to be solvent.

Other states rely and depend on our Department to effectively monitor and regulate our domestic companies. We have had disagreements with other states regarding the regulatory process. Furthermore, the Champion Insurance Company is an example where the State of Alabama disagreed with another state, Louisiana, regarding the regulatory process. Champion was domiciled in Louisiana but was doing a substantial business in Alabama. While Champion officials were falsifying books and providing inaccurate information through intercompany transactions, there was no defense to the record number of consumer complaints we were receiving, and as a result the State of Alabama decided to move against Champion. There is seldom a defense to a large number of consumer complaints. As it turned out, there was criminal involvement from both Champion and from within the Louisiana Insurance Department, which resulted in numerous arrests and convictions. Alabama's strong regulatory posture in this instance potentially saved tens of millions of dollars for consumers, both in Alabama and in Louisiana. Even though the company's insolvency cost in excess of $180,000,000, if this operation had been allowed to continue, the cost would have been even more staggering.

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Clearly one of the best indicators of financial problems is reflected in claims problems. Our success in the supervision or receivership and even liquidations of companies is often dependent on the promptness of our attention to financial problems. We closely monitor our consumer complaints and keep up-to-date records on insurance companies that do business in Alabama. We use this information as an early detection sign of possible financial problems. For instance, the Department recently suspended a foreign health company's license to write new business solely based on an unacceptable number of consumer complaints. These complaints dealt with the timeliness of claims payments. This company is still servicing claims in Alabama, but due to the Department's concern about the large number of complaints, they are not writing any new business. Once the company can provide assurances, and financial support for these assurances that they have addressed these claims, we will lift the suspension. Consumer complaints were one of the leading indicators in the Champion case.

During the first six months of 1991, we recovered three times the amount of money for Alabama consumers as we did the entire year of 1988. With all the publicity and concern of the public over the welfare of their insurance programs, our role has dramatically increased over the past three years and will continue to do so as Alabama's consumers rely more and more on their Insurance Department. Consumer attitudes and confidence also play a role in insurance company solvency as they do with banks and other financial institutions. A very recent example of

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this is the "run" on Mutual Benefit over a two-week period. Any company could be subjected to the same type situation if public confidence diminishes.

Sometimes the solvency situation also goes in reverse as Alabama's largest health insurance writer is currently being sued for allegedly being too financially healthy.

We have continued to address and target problems in the senior market. We were one of the first states to pass the model long-term care and model Medigap regulations. Our staff has continued to increase the number of complaints brought against companies and agents. Our cases against agents, primarily agents in the senior market, have quadrupled since 1988-89. Our company actions have nearly tripled. In a recent report which was based on a ratio between a Department's budget and the premium tax they collect, Alabama was 47th out of 50 states. However, despite being well under the GAO-suggested percentage, we ranked in the top 20 in regulatory actions against companies, agents, and agencies. We are trying to keep pace with the ever enlarging and complicated industry which we regulate, but it is difficult even under the best of circumstances. Given the budget constraints we all work under, it proves to be a formidable task. With the support of our Governor and the State Legislature, the Department's budget has more than doubled during the past three years.

Alabama has been extremely fortunate in that we have had only four domestic insolvencies in the past ten years, all of which were relatively small. This speaks well for both the

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caliber of insurance companies in our state and for the ability of our insurance regulators in overseeing these companies.

We are currently putting together a package of solvency related laws to be presented at our next legislative session. These laws will also help the Alabama Insurance Department with the accreditation process that we are currently undertaking through the NAIC (National Association of Insurance Commissioners.)

Recent actions by the Department in the solvency policing area include:

1. Effective with this past year-end, we required property and casualty insurance companies to file a "Statement of Actuarial Opinion" with their Annual Statements. This statement, which must be prepared by a qualified property and casualty actuary, had never before been required.

2. We are in the process of preparing a Departmental Bulletin to be sent to all insurance companies licensed in Alabama, advising that they will be required to have annual audits by an independent certified public accountant. The first audited financial statements will be as of December 31, 1991, and will be due on or before June 1, 1992.

3. We have utilized the facilities of the NAIC "New Financial Examiners' Workshop" by sending our new insurance examiners to this training session in Kansas City, Missouri.

4. Last year, we acquired personal computers and printers for our field examiners. The use of these computers and appropriate software has increased the effectiveness of our examination process. 5

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5. We are actively seeking additional financial examiners to add to our field force. To be more competitive and attract quality examiners, per diem allowances and pay ranges for the examiner classifications were upgraded last year.

Thank you for allowing me to be here today and share with you the state of the regulatory environment in Alabama. If I can provide your Committee any additional information, please feel free to ask for whatever you need.

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Insurance Regulation: Assessment of the National Association of Insurance Commissioners

Statement of
Richard L. Fogel
Assistant Comptroller General
General Government Programs

Before the
Subcommittee on Policy Research and Insurance
Committee on Banking, Finance, and Urban Affairs
U.S. House of Representatives

GAO/T-GGD-91-61

GAO Form 160 (12/87)

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Insurance Regulation: Assessment of the National Association of Insurance Commissioners

SUMMARY OF STATEMENT BY
Richard L. Fogel
Assistant Comptroller General
General Government Programs

At the Subcommittee's request, GAO is presenting its assessment of the capability of the National Association of Insurance Commissioners (NAIC) to create and maintain an effective national system for solvency regulation.

GAO's work on the regulation of the various components of the financial services industry has identified important similarities in the basic principles that underlie effective regulation. To effectively create and maintain a national system of insurance regulation, a regulatory organization would need authority to perform several essential functions, including the authority to

-- establish rules for the safe and sound operation of insurers;

-- establish minimum standards for effective solvency regulation by state insurance departments;

-- monitor the functions of state insurance departments; and

-- compel the enforcement by state regulators of the rules for safe and sound operation, and the adoption and application by states of minimum standards for effective solvency regulation.

While recognizing NAIC's good intentions, GAO does not believe that NAIC can successfully establish a national system of uniform insurance regulation because it does not have the authority necessary to require states to adopt and enforce its standards. Furthermore, GAO does not believe that NAIC can be effectively empowered either by the states or by the federal government to exercise the necessary authority. Empowerment by the states would require that each state legislatively cede part of its authority to NAIC. However, even if each state chose to do this, NAIC's standing as a regulator would always be weak because the ceded authority would be subject to revocation at any time by each state's legislature. In effect, NAIC would regulate at the pleasure of those it regulates.

Empowerment by the federal government is also undesirable. NAIC is composed of state insurance commissioners. Those commissioners are accountable to their states and should not be made accountable to federal authority as well, since this would create an irreconcilable conflict of interest. Moreover, given NAIC's organizational structure, congressional delegation of the regulatory authority necessary to establish NAIC as an effective public regulator could raise constitutional questions.

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GAO has identified problems in the state-by-state system of insurance regulation. Even though the responsibility for regulating insurance companies rests with each state individually under the state-by-state system, NAIC has attempted to address some of these problems by assisting or, in some cases, overseeing the states as they carry out their activities in attempts to strengthen state-by-state regulation. For example, GAO found that NAIC

-- has improved the credibility of insurers' reported financial information,

-- is attempting to improve capital standards through the promulgation of risk-based capital requirements,

-- is attempting to improve its monitoring systems to better identify troubled companies,

-- has established a peer review process to better ensure that troubled companies are more effectively dealt with, and

-- is providing the states with a variety of automated data bases and tools to facilitate their oversight of companies.

These and other efforts are steps in the right direction, though all of them leave room for further improvement.

NAIC's plan to create a national regulatory system consistent across all the states rests in large part on the success of its program to accredit state insurance departments that satisfy a set of minimum standards for solvency regulation. For several reasons, GAO questions whether NAIC's accreditation program can achieve its goal.

In conclusion, NAIC's efforts to strengthen insurance regulation are laudable. However, NAIC does not have the authority necessary to fulfill its assumed role as a national regulator. As a result, NAIC is unlikely to achieve its stated goal of establishing a national insurance regulatory system. It can neither compel state actions necessary for effective regulation nor, in the long run, can it sustain its reforms.

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to provide you with our findings about the role of the National Association of Insurance Commissioners (NAIC) and its capability to create and maintain an effective national system of solvency regulation.[1] Recent financial difficulties involving insurers, as well as other financial institutions, show clearly that effective regulation is crucial to maintaining the safety of financial institutions and their customers' funds. In 1945, Congress enacted the McCarran-Ferguson Act[2] delegating the day-to-day responsibility for insurance regulation to the states but not forfeiting its responsibility for insurance regulation. In our view, the consequences of insolvency, both actual and possible, justify a continuing federal interest in the effectiveness of insurer solvency regulation.

We did fieldwork at NAIC's Kansas City headquarters to evaluate NAIC's activities and operations. We did our work between January and May 1991. I want to emphasize at the outset that we worked closely with NAIC in doing our review, and we met with NAIC twice to discuss our findings and give them an opportunity

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[1]NAIC is a voluntary association of the heads of the insurance departments of the 50 states, the District of Columbia, and 4 U.S. territories. NAIC has two organizational elements: the group of state insurance commissioners and its centralized Support and Services Office (support office) headquartered in Kansas City, Missouri.

[2]15 U.S.C. Sections 1011-1015.

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to provide additional information. I also want to emphasize that NAIC was cooperative in our current review. However, we do not have statutory access to state insurance departments or NAIC. This lack of access has on several past occasions limited our ability to assess the effectiveness of state insurance regulation.

MARKET TRENDS AND REGULATORY PROBLEMS

Financial markets and industries have changed dramatically in recent decades. Many of the changes in financial institutions result from changes in information and communication technologies, which have made the world smaller and competition greater within the financial services industry. Geographic boundaries--always loose for insurance companies--have faded, and new products and services have blurred the distinctions between financial markets and institutions. There is no indication that this era of change is over. On the contrary, changes in financial markets and institutions continue.

The need to adapt to the increasingly competitive environment has presented problems for many types of financial institutions--commercial banks, savings and loans, securities firms, and insurers. We see these stresses in the insurance industry in increasing insolvencies among both the property/casualty and life/health insurers. For property/casualty insurers, the

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average number of liquidations from 1970 to 1983 was about six per year. However, from 1984 to 1989, the average number of property/casualty liquidations increased to 24 per year, with a high of 36 in 1989. For life/health insurers, the average number of liquidations from 1975 to 1983 was about five per year. However, from 1984 to 1990, the average number of life/health liquidations was about 19 per year, with a high of 43 in 1989.

The strains on the insurance industry have greatly expanded the burden on regulators. The increase in the numbers of failures and their potential consequences for consumers and the economy make effective regulation of the insurance industry more important than ever.

However, in our view, state-by-state solvency regulation has three inherent weaknesses:

(1) States vary widely in the quality of their solvency regulation. There are differences in regulatory workload, such as the number, size, and type of companies domiciled or licensed in a state; the available resources in a state; and each state's "regulatory philosophy."

(2) States do not have consistent solvency laws and regulation, nor do they fully coordinate their efforts despite their interdependence in regulating a national insurance market.

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The primary regulator for a multistate insurer--the regulator in its state of domicile--must rely on other states where the insurer operates to voluntarily share information about the company. This does not always occur. Conversely, other states rely on the primary regulator to take prompt corrective action to resolve a troubled or failing insurer. This does not always occur either.

(3) State regulators do not oversee holding companies and foreign reinsurers. In part, these blind spots may have prevented regulators from acting to forestall several large insurer failures.

EFFECTIVE REGULATION MANDATES USE OF AUTHORITIES THAT NAIC DOES NOT POSSESS

State insurance commissioners created NAIC, in part, to help address the problems that differing state-by-state authorities and regulatory tools caused as the states regulated multistate insurers. Since 1987, NAIC has expanded its support staff and computer facilities to provide more services for state regulators. In 1991, the support office has a budgeted staff level of 142 and expenditures of $15.5 million, which is funded mainly by fees paid by insurance companies. Appendix I contains information about NAIC's revenue sources and expenses.

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NAIC has recently stated the goal of creating a "national" regulatory system. We do not believe that NAIC can successfully attain that goal.

We have assessed the adequacy of regulation in virtually all financial services sectors--savings and loans, commercial banks, credit unions, the farm credit system, government-sponsored enterprises, securities dealers and markets, futures markets, and insurance companies. Despite the differences among these sectors, we see the need for effective regulation in each and important similarities in the basic characteristics that underlie effective regulation. In our view, to effectively create and maintain a national system of insurance regulation, a regulatory organization would need authority to

-- establish uniform accounting and timely reporting requirements for insurers;

-- establish uniform rules defining safe and sound operation of insurers;

-- establish minimum capital standards commensurate with the risks inherent in an insurer's operations;

-- establish minimum standards for effective solvency regulation by state insurance departments;

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-- monitor the supervisory and regulatory functions of state insurance departments;

-- compel state regulators to enforce the rules for safe and sound insurer operations, including the minimum capital requirements, and to take appropriate actions to resolve or close troubled insurers; and

-- levy assessments to cover the costs of oversight and supervision, and maintain sufficient staff and resources to adequately oversee the industry.

Furthermore, like any public regulator, a national insurance regulator would be subject to statutory and constitutional constraints, including appropriate oversight. A public regulator, for example, must often comply with disclosure requirements, restrictions on employee activities, conflict-of-interest laws, and mandatory decision-making procedures such as those contained in federal or state administrative procedures acts. Public regulators are subject to constitutional restrictions--they may not deprive any person of property without due process of law.

We do not believe NAIC can effectively carry out all the functions necessary for effective solvency regulation nor is it subject to the appropriate statutory and constitutional

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constraints. Although NAIC can and does establish voluntary standards for insurers and state regulators, the states have conferred no governmental power on NAIC, and it does not have the authority to enforce its standards. In the state-by-state system of solvency regulation, NAIC cannot compel states to accept and implement its standards. Because Congress has allocated authority to regulate the business of insurance to the states, each state has exclusive authority to establish and implement solvency regulation within its jurisdiction. However, each state could legislatively cede some of its authority to NAIC. Even if each state volunteered to do this, NAIC's standing as a regulator would always be weak because its authority would be subject to revocation at any time by each state's legislature. In effect, NAIC would regulate at the pleasure of those it regulated.

Furthermore, because NAIC is a private organization controlled by state insurance commissioners, it does not appear that NAIC should be delegated federal authority to regulate state insurance departments for at least two policy reasons. First, state insurance commissioners are accountable to their states and should not be accountable to federal authority as well, since this would create an irreconcilable conflict of interest. Second, congressional delegation of the regulatory authority necessary to establish NAIC as an effective public regulator could raise constitutional questions.

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NAIC IS WORKING TO IMPROVE
STATE SOLVENCY REGULATION
--BUT IT HAS NO AUTHORITY

The authorities that I enumerated for effective supervision and regulation of the industry should be exercised to accomplish five key objectives. These key regulatory objectives are (1) consistent and timely accounting and reporting, (2) early identification of troubled insurers, (3) timely resolution of troubled companies, (4) effective oversight of holding companies and foreign reinsurers, and (5) uniform state solvency laws and regulations.

The states have primary responsibility for accomplishing each of these regulatory objectives. However, we have identified problems in the state-by-state system in meeting these objectives. In an effort to address these problems, NAIC has acted to assist or oversee the states as they carry out their activities. As I indicated, the ultimate success of NAIC's actions in each of these areas is limited by its lack of authority to compel more effective regulation.

Consistent and Timely
Accounting and Reporting

To effectively monitor solvency and identify troubled insurers, regulators need accurate and timely information. In addition, the financial reports that regulators need should be prepared under consistent accounting and reporting rules that result in

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the fair presentation of an insurer's true financial condition. Although NAIC is working to address these needs, we have identified a number of areas where improvements are needed.

First, a lack of uniformity in the statutory accounting practices (SAP) of the states may hinder effective monitoring of a multistate insurer's financial condition. Although each state requires most domiciled and licensed insurance companies to use and file the annual financial statement that NAIC developed, individual states may allow accounting practices that differ from those codified in NAIC's practices and procedures manuals. Since a multistate insurer generally prepares its annual statement in accordance with the SAP of its state of domicile, that annual statement filed in other states may not be consistent with or comparable to the SAP of those states. Other states where the insurer is licensed may require the company to refile or file supplements in accordance with their SAP. In this case, the states would be using different financial data to evaluate the same insurer.

In an effort to encourage greater consistency in accounting practices, NAIC plans to revise its accounting manuals to unify existing statutory practices. However, even if NAIC adopts more uniform statutory accounting principles, each state could interpret or modify those accounting principles.

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Second, certain requirements of SAP may result in an insurer not fairly reflecting its true financial condition. For example, SAP requires insurers to reduce their surplus by 20 percent of certain reinsurance amounts overdue by more than 90 days. In contrast, Generally Accepted Accounting Principles--used by insurance companies for other-than-regulatory reporting--require an evaluation of the collectability of the entire amount recoverable and could require as much as a 100-percent write-down. This GAAP requirement would result in the insurer's annual statement reflecting the amount of reinsurance ultimately expected to be collected, a better measurement than the arbitrary percentage required by SAP.

Third, false and misleading financial statements have contributed to insurer insolvencies. Many states had been relying on unverified insurer-reported financial data. NAIC now requires both actuarial certification of loss reserves for property/casualty insurers and, beginning this year, annual audits by independent certified public accountants (CPA) as part of its annual financial statement which every state uses. In this instance, NAIC has succeeded in using its authority to prescribe reporting requirements to try to improve the credibility of insurer-reported data. But, problems persist despite NAIC's improvements. For example:

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-- The annual independent audit requirement is a definite improvement. But, the basis of the audit opinion still varies from state to state. This is because the (CPA) audit opinion is based on those statutory accounting practices prescribed or permitted by the state where an insurer is headquartered. Attempts by NAIC to unify statutory practices could facilitate comparisons of insurers, but differing state laws or prescriptions would still take precedence over NAIC's accounting guidance.

-- The actuarial certification of loss reserves is not necessarily credible. NAIC allows states the option of accepting certification by insurance company employees. We believe loss reserves should be independently verified and certified.

Fourth, even when insurers correctly report their financial information, regulators are not getting it soon enough to identify troubled insurers. As we have previously reported,[3] annual statements do not give regulators an indication of problems occurring early in a calendar year until between March and May of the following year. That means a lag of between 15 and 18 months from when the problem started and when the annual statement is reviewed. Because a financial entity can fail

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[3]Insurance Regulation: Problems in the State Monitoring of Property/Casualty Insurer Solvency (GAO/GGD-89-129, Sept. 29, 1989).

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quickly, we believe quarterly reporting is necessary. NAIC said that, as of February 1991, 21 states required their companies to file quarterly statements, and another 16 states asked insurers to file on a quarterly basis. NAIC cannot require states to adopt quarterly reporting, but it has started to capture quarterly filings that are required by the states. These data are now available on-line to the states and will be used in NAIC's solvency analysis.

Fifth, current capital and surplus requirements, which vary widely from state to state, are not meaningfully related to the risk an insurer accepts. For example, minimum statutory surplus requirements for a life insurer range from $200,000 in Colorado to $2 million in Connecticut. Likewise, minimum statutory surplus requirements for a property/casualty insurer range from $300,000 in the District of Columbia to $2.9 million in New Jersey. NAIC is developing risk-based capital requirements to be determined by the nature and riskiness of a company's assets and insurance business. It plans to incorporate formulas for calculating capital needs into the annual statement. This would have the effect of requiring all companies to report their risk-based capital target as well as their existing capital. NAIC is also working on a model policy for states' consideration to encourage uniform state action against insurers that do not meet the new capital requirements. To be effective, the model would have to be adopted without modification by all states.

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Early Identification of Troubled Insurers

Without early identification of troubled companies, state regulators cannot reverse the affairs of troubled companies or act to minimize the damage resulting from insolvency. As we have previously reported, regulators have been relying on delayed and unverified insurer-reported financial data and infrequent field examinations to detect solvency problems. NAIC has a number of initiatives underway to help remedy deficiencies in timely identification of troubled insurers.

Database Services

Since 1988, NAIC has increased its support staff and computer facilities to improve collection and analysis of financial and other data on insurance companies. Through NAIC's telecommunications network, states have on-line access to NAIC's database of annual financial statements. The most recent 6 years of financial data for about 5,200 insurance companies are maintained on-line for regulatory analysis, with tapes available back to 1979. However, NAIC's financial database is only as good as the insurer-reported data, and, as I said, its actions to improve data quality have not been sufficient to ensure that outcome.

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NAIC has also developed legal and regulatory databases to help state regulators share information about troubled multistate insurers. This way, states can get a better picture of the complete activities of a troubled multistate insurer and prevent suspicious operations from spreading. Among these databases, NAIC's Regulatory Information Retrieval System gave states on-line access to the names of more than 49,000 insurance companies, agencies, and agents, as of April 1991, that have been subject to some type of formal regulatory or disciplinary action.[4] Its new Special Activities Database, which has been operating since June 1990, is a clearinghouse for information on companies and individuals that may be involved in questionable or fraudulent activities.

NAIC also is developing a national complaint database that will help each state assess policyholder complaints from other states about multistate insurers and agencies. Complaint information, which can give states indications of solvency and other problems, is now maintained only state-by-state.

NAIC's databases are important steps in the right direction, but their ultimate success depends on the quality of insurer-reported financial data and the willingness of state regulators to volunteer information and use the databases.

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[4]Examples of formal regulatory or disciplinary actions include license revocations, fines, and suspensions.

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NAIC's Independent Solvency Analysis

State regulators generally focus their resources on insurers domiciled in their state. NAIC independently operates two solvency analysis programs to help states identify potentially troubled multistate insurers operating in their state but domiciled in another state. This is an important service because only a few states routinely provide others with regular updates on financially troubled insurers. Although state regulators are still ultimately responsible for determining an insurer's true financial condition, NAIC's solvency analysis is intended to be an important supplement to the states' overall solvency monitoring.

The first of NAIC's solvency analysis programs--the Insurance Regulatory Information System (IRIS)--is intended to help states focus their examination resources on potentially troubled companies. NAIC also makes preliminary IRIS results available to the public. We have reported our concern that IRIS' effectiveness and usefulness as a regulatory tool is limited by certain deficiencies:[5] (1) it relies on insurer-prepared annual statements that previously were not always independently verified and are subject to significant time lags, (2) its financial ratios have a limited scope and may not identify all

[5]Insurance Regulation: The Insurance Regulatoty Information System Needs Improvement (GAO/GGD-91-20, Nov. 21, 1990).

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troubled insurers, (3) it is not equally effective in assessing different types and sizes of insurers, (4) it does not adequately address some important aspects of insurer operations, (5) it does not consider some readily available sources of solvency information, and (6) it is identifying an increasing number of companies, some of which may not warrant immediate regulatory attention.

In 1990, NAIC developed a new computer-based financial analysis system to identify potentially troubled companies requiring state action. The Solvency Surveillance Analysis System appears to address a number of weaknesses we identified with IRIS. However, this new solvency system is only in its second year of operation, so it is too soon to assess how well it will identify potentially troubled companies or whether it will identify them early enough for effective state action.

As part of its 1991 Solvency Agenda, NAIC plans to help the states identify troubled insurers by improving its solvency analysis systems. NAIC also added, in January 1991, a centralized division of financial analysis, which is intended to help states improve their financial analysis capabilities.

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Automated Analysis Tools

In addition to NAIC's database and analysis systems to identify troubled insurers, the support office has developed automated tools to help state regulators more efficiently analyze financial statements and examine insurance companies. NAIC also purchased audit software and offered it to state insurance departments at no charge; 35 states had obtained the software by early 1991. Of particular note, NAIC has developed new tools to help states assess reinsurance collectability. Uncollectible reinsurance has contributed to several large property/casualty insurer failures. NAIC now requires insurers to disclose overdue amounts recoverable from reinsurers and has automated these data. State regulators can use NAIC's reinsurance database to quantify overdue reinsurance and identify slow-paying reinsurers. NAIC acknowledges that its reinsurance database is only as good as insurer-reported financial data, and it is working to identify insurers who report incorrect or incomplete information.

Resolving Troubled Companies

Once regulators decide that an insurer is troubled, they must be able and willing to take timely and effective actions to resolve problems that may otherwise result in insurer insolvency. When problems cannot be resolved, regulators must be willing and able

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to close failed companies in time to reduce costs to state guaranty funds and protect policyholders.

In a recent report, we analyzed the timing of state regulatory action against financially troubled or insolvent property/casualty insurers.[6] Regulators in 46 states and the District of Columbia reported to us the dates of insolvency for 122 insurers and the dates on which formal regulatory action was initially taken against those insurers. In 71 percent of those cases, the states did not take formal action until after the insurer was already insolvent. We also found that states delayed liquidating insolvent insurers under state rehabilitation.

Delays in regulatory action against financially troubled or failed property/casualty insurers increased costs for state guaranty funds and delayed payment of policyholder claims. In 36 failed insurer cases where financial data were available, the company increased its sales of insurance policies, even after state regulators identified financial trouble. This obviously increases the burden on state guaranty funds. In 47 cases where liquidation was delayed, policyholders with claims did not get paid promptly because claim payments were suspended.

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[6]Insurance Regulation: State Handling of Financially Troubled Property/Casualty Insurers (GAO/GGD-91-92, May 21, 1991).

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We found many reasons for regulatory delay in dealing with troubled or insolvent insurers. In addition to relying on inaccurate and untimely data reported by insurers, states also generally lacked legal or regulatory standards for defining a troubled insurer, and vague statutory language made establishing insolvency difficult. Actions that are needed to correct these problems include developing a single uniform standard for determining if an insurer is financially troubled, requirements that certain actions be taken when specific hazardous conditions are present, and a single uniform legal definition of insolvency based on loss reserves and capital adequacy. Such action would improve protection of policyholders and state guaranty funds.

In 1989, NAIC created a new multistate peer review committee--the Potentially Troubled Companies Working Group--to track how states are handling problem companies. The group looks at the companies that NAIC's independent financial analysis identifies as potentially troubled and selects certain companies for special attention. It requests states to respond in writing to its questions about those companies. State commissioners also are asked to appear before the NAIC commissioner committee that oversees the working group to discuss how they are handling potentially troubled insurers. According to NAIC, regulators are to, at a minimum,

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-- demonstrate an understanding of both the nature and extent of the company's problem;

-- establish that the state has a sufficient plan of action to assist in correcting or stabilizing the company or that the state has an orderly process to withdraw the company from the marketplace;

-- establish that the state has the laws, regulations, and personnel to effectively carry out the necessary regulatory actions; and

-- establish that the state has effectively communicated its concerns to other regulators in states with policyholders who are at risk.

NAIC follows up on potentially troubled insurers and, if necessary, may form a special group of state regulators to oversee regulatory activities for a troubled company. According to NAIC, peer review helps to ensure that individual states are promptly addressing problems and keeping other states informed about troubled multistate insurers.

We do not know whether this peer review process, which is in only its second year, will prompt individual states to take more timely action to deal with troubled insurers or the extent to

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which it will enhance coordination of supervision of troubled multistate insurers. Whatever the influence of peer pressure, supervisory actions to address problems of a troubled insurer remain the primary responsibility of the domiciliary state regulator, and the coordination of such actions involving multistate insurers is a matter of negotiation among all involved states. NAIC has no enforcement power to compel a state to take action against a troubled insurer.

Oversight of Holding Companies And Foreign Reinsurers

To effectively monitor insurer solvency, regulators must be able to routinely oversee insurance holding companies. Interaffiliate transactions are common in the insurance industry and are not necessarily detrimental. However, such transactions are subject to manipulation and may be used to obscure an insurer's true financial condition. Abusive interaffiliate transactions caused the Baldwin-United failure--the largest life insurance failure in history.

States do not regulate insurance holding companies and cannot regulate the noninsurance affiliates or subsidiaries of an insurance company. Consolidated statements for insurers and affiliates might help states evaluate the overall financial condition of a holding company, but, according to NAIC, only 13 states require some form of consolidated reporting. NAIC has

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adopted model laws on holding companies to emphasize the need to regulate these transactions and encourage uniform state regulation. However, not all states have adopted NAIC's current model laws.

As we previously reported,[7] states have no authority to monitor the financial condition of reinsurers in other countries that do business with U.S. insurers. To effectively monitor insurer solvency, regulators need this authority. Foreign reinsurers provide more than one-third of the reinsurance written in the United States. While many foreign reinsurers are responsible and reliable institutions, some foreign reinsurers have failed to pay claims. Uncollectible reinsurance has contributed to several large insurer failures.

NAIC has tried to help state regulators monitor foreign reinsurers operating in the United States by providing to them a database of reinsurance activity reported by U.S. insurers. State regulators can now quantify amounts reported as ceded to any reinsurer worldwide and totals ceded by country. However, NAIC has made little progress in helping states evaluate the financial condition of foreign reinsurers. While NAIC

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[7]Insurance Regulation: State Reinsurance Oversight Increased, but Problems Remain (GAO/GGD-90-82, May 4, 1990).

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maintains a so-called white list of acceptable foreign insurers,[8] it specifically excludes foreign reinsurers. NAIC cannot require foreign companies to submit financial reports. Thus, its authority to evaluate either foreign insurers or reinsurers is no greater than a private rating organization's. NAIC believes that federal legislation is necessary to empower it to require foreign insurers and reinsurers to submit to monitoring as a condition for doing business in the United States and to require the states to use NAIC's listing.

State Solvency Laws and Regulations Are Not Uniform

Without uniformity in solvency laws and regulations, the state-by-state regulatory system is only as strong as the weakest link. Because insurers operate in many states, lack of uniformity in state solvency regulation provides opportunities for unsafe and unsound operations while it complicates regulatory detection of those activities.

Over the years, NAIC has developed and proposed for states' consideration about 200 model laws and regulations designed to foster state acceptance of the legal and regulatory authorities necessary to effectively regulate insurance. However, NAIC has

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[8]NAIC's Non-Admitted Insurer Information Office maintains a quarterly listing of acceptable foreign insurers--those that have capital and surplus of at least $15 million, maintain a U.S. trust fund of not less than $2.5 million, and have a reputation of character, trustworthiness, and integrity.

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no authority to require states to adopt or implement its model policies. Before this year, NAIC had only limited success in getting states to adopt its model laws and regulations. Moreover, states that do adopt model laws can--and do--modify them to fit their situations. For example, every state has a property/casualty guaranty fund to pay policyholders of failed insurers. Although most guaranty funds are patterned after the NAIC model, significant differences between state laws result in some funds offering less protection than others. This undermines NAIC's efforts to achieve uniformity. (Appendix II compares the provisions of property/casualty guaranty funds in each state.) Another impediment to uniformity is the uneven adoption by states of NAIC amendments to its model laws and regulations.

Frustrated by the difficulty of getting states to enact model polices and provide sufficient regulatory resources, NAIC adopted a set of financial regulation standards for state insurance departments in June 1989. These standards identified 16 model laws and regulations, as well as various regulatory, personnel, and organizational practices and procedures, that NAIC believes are the minimum for effective solvency regulation. Appendix III describes model law development and presents statistics on state adoption of those NAIC models.

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Since January 1991, the National Conference of State Legislatures and the National Conference of Insurance Legislators have called on the states to comply with NAIC's standards. Likewise, the National Governors' Association has endorsed NAIC's efforts.

NAIC's Accreditation Program

In June 1990, NAIC adopted an accreditation program to encourage state insurance departments to comply with its new financial regulation standards. According to NAIC, its new accreditation program will have the effect of establishing a national system of solvency regulation consistent across all states.

However, we question whether NAIC's accreditation program can achieve this goal. First, even if the standards were implemented by all of the states, they would provide little more than an appearance of uniformity. The standards, for the most part, are general, and their implementation can vary widely. Second, the accreditation review process has significant shortcomings that cast doubt upon the credibility of NAIC's program. Third, even if the first two problems were solved, NAIC remains in the position of attempting to regulate the state regulators with no authority to compel their compliance.

Overview of the Accreditation Program: To become accredited, a state must submit to an independent review of its

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compliance with NAIC's financial regulation standards. An accreditation team[9] is to review laws and regulations, past insurance company examination reports, and organizational and personnel policies; interview key department personnel regarding how legal provisions and regulatory practices are implemented; and assess the department's levels of reporting and supervisory review. The team is to report its recommendation as to whether or not a state meets the standards to the NAIC Committee on Financial Regulation Standards and Accreditation.

This committee of state insurance commissioners decides whether or not a state becomes accredited. To avoid a direct conflict of interest, the commissioner from a state applying for accreditation cannot vote on that state's accreditation. Nevertheless, since each state ultimately will undergo an accreditation review, a commissioner voting to deny accreditation to another state may be subject to retaliation. Likewise, commissioners could engage in "backscratching," trading an affirmative accreditation vote for another state to obtain an affirmative vote for their own state accreditation. While we have no evidence that this has occurred, we note that the committee process is not sufficiently devoid of potential conflicts of interest to preclude the opportunity.

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[9]A review team member must be knowledgeable about insurance and its regulation and should not currently be associated with the state insurance department under review including representing insurers in matters before that state.

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States that satisfy NAIC's financial regulation standards will be publicly recognized by NAIC as "accredited" while departments not in compliance will receive guidance on how to comply. Accreditation is for a 5-year period; to be reaccredited, a state must undergo an independent review. NAIC is developing procedures for maintaining accreditation during the 5-year period and decertifying states no longer in compliance.

NAIC plans to have accredited states penalize insurers domiciled in states that do not become accredited. Among the planned restrictions, beginning in January 1994, an accredited state would not license an insurer domiciled in an unaccredited state unless the insurer agrees to submit to the accredited state's solvency laws and regulations and associated oversight. Whereas the home state usually has primary responsibility for solvency monitoring and regulation, this penalty would subject a multistate insurer domiciled in an unaccredited state to regulation in every accredited state in which it is licensed. Given the varying state solvency laws and regulations, NAIC's penalties would be onerous for insurers domiciled in unaccredited states. If the accredited states carry out the penalties, according to NAIC, this would give insurers the incentive to lobby for the increased authority and resources their home state needs for accreditation.

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In December 1990, NAIC accredited Florida and New York, the first two states to undergo review. Illinois and South Carolina were accredited by NAIC in June 1991. At least eight other states have applied for accreditation as of July 1991.

Standards May Not Achieve Uniformity And May be Inadequate: NAIC's standards may not achieve uniformity since they do not set specific criteria or practices for the states to meet. This is why even universal adoption of the standards would provide little more than the appearance of uniformity. For example, NAIC's current capital and surplus standard requires, in part, that a state have a law that establishes minimum capital and surplus requirements. However, the standard does not specify what those minimum requirements should be. NAIC has said that this standard will be replaced when NAIC completes its new risk-based capital requirements.

Another example is the standard for investment regulation. NAIC's standard is that a state should require insurance companies to have a diversified investment portfolio, but the term "diversified" is not defined. Other important terms--"sufficient staff" and "competitively based" pay, for example--in the standards are similarly vague.

Furthermore, we believe that some of the standards, in addition to being nonspecific, are inadequate to address regulatory

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problems that we have identified. For example, the model regulation underlying NAIC's standard for corrective action against troubled insurers is qualitative even when dealing with quantifiable conditions. NAIC's standard does not set a uniform measure for determining if an insurer is financially troubled or prescribe regulatory actions to be taken when specific hazardous conditions are present. As previously mentioned, lack of such regulatory guidance causes delay in states' handling of troubled insurers.

NAIC's Accreditation Review Process Has Serious Shortcomings: NAIC's accreditation review process suffers from two serious shortcomings. First, because the standards are not specific, there are no criteria for the accreditation teams to use in assessing compliance with the financial regulation standards. Second, the lack of documentation and procedural requirements for the team review has, to date, made it impossible to independently decide whether a team's work was sufficient to justify a recommendation for or against accreditation.

To evaluate compliance with NAIC's standards, each accreditation team has to develop its own criteria for what constitutes acceptable compliance. To define terms and set more specific criteria for its standards, NAIC plans to have future review teams keep records of the criteria they use in assessing compliance with NAIC's standards. They will document the

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criteria in their reports to the NAIC accreditation committee. NAIC said all criteria will be shared with the states in an effort to achieve greater consistency in the process and so that individual states can better prepare for accreditation.

Due to the lack of documentation, we do not know the basis for the findings of the accreditation team in Florida and New York. The review reports for the two states--each about one-half page in length--recommended that the state insurance department be accredited "based upon this evaluation effort and the knowledge and experience of the evaluation team." While the four-page report for the Illinois accreditation better documented what work the review team did, the report still did not document the basis for the team's findings or recommendations. Without such documentation or elaboration, it is impossible to independently verify that the team's analysis was sufficient to support its recommendation. NAIC's accreditation committee required the Illinois review team to submit an additional summary of its findings to support the team's conclusions that the state complied with each standard.

Based on lessons learned in Florida and New York, NAIC developed a more detailed work plan for use in subsequent accreditation reviews. The expanded work plan is a good starting point, but it will still be necessary to develop more detailed procedures and documentation requirements to ensure consistency between review

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teams and support for findings in the future. We base this conclusion on our observations of an accreditation review team planning session in March 1991 and the team's visit to the Illinois Insurance Department in April 1991. We question whether NAIC's work plan for the Illinois review was sufficient to ensure accreditation reviews that are consistent and sufficiently documented. NAIC's only quality control over the team's analysis has been to have an observer from the support office on each review.

A final problem with the accreditation review work plan is that coverage of work does not seem to have been sufficient to assess how well a state implements NAIC's standards. We question, for example, how the accreditation team assessed implementation of Florida's regulations given that several key provisions were adopted through emergency rule-making only weeks before the review. Although the standards called for the review team we observed to assess whether Illinois had implemented NAIC's guidance on handling troubled insurers, the team did not. Team members said that they assumed Illinois had followed NAIC's procedures because Illinois helped write the handbook.

CONCLUSIONS

Although insurance is a national market, the state-by-state system of insurance solvency regulation is characterized by varying regulatory capacities and a lack of uniformity.

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NAIC has taken a number of steps toward strengthening the state-by-state regulatory system and addressing a variety of problems. It has been successful in using its authority to prescribe reporting requirements to achieve uniformity in some aspects of state solvency regulation. NAIC has not been as successful with its model laws, which must be adopted by each state.

NAIC is trying to establish a national system of effective solvency regulation through its accreditation program. In effect, NAIC has assumed the role of a regulator of state insurance regulators. However, we do not believe that state adoption of NAIC's current standards will achieve a consistent and effective system of solvency regulation. The underlying standards for accreditation are often undemanding and, in some cases, inadequate.

Even if NAIC devised sufficiently stringent standards for effective solvency regulation, however, we do not believe that NAIC can surmount the fundamental barriers to its long-term effectiveness as a regulator. Most importantly, NAIC lacks authority to enforce its standards. NAIC is dependent on consensus--indeed unanimity--among state insurance commissioners and legislatures to enact and implement its policy recommendations in a manner that achieves consistency in state-by-state regulation. Progress toward such consensus and unanimity appears to be occurring presently under the glare of

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intensified public scrutiny of the insurance industry and its regulators. Given NAIC's historical lack of success in securing state adoption of its model policies, it is highly questionable whether such progress will be sustained over the long run as interest in the industry's condition wanes.

NAIC does not have the authority necessary to compel state action or to sustain its reforms. We do not believe it can effectively be given such authority, at least on a lasting basis, by either the states or the federal government. The main road to effective regulation of the insurance industry does not pass through NAIC.

This completes my prepared statement. We would be pleased to respond to your questions.

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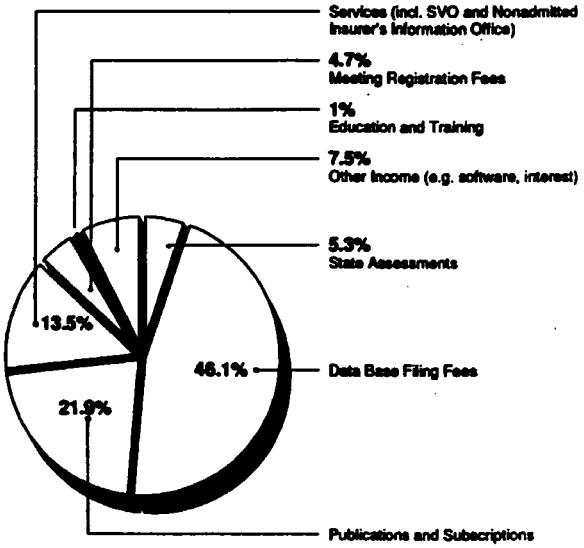
NAIC'S FUNDING AND EXPENSES

NAIC is a voluntary association of the heads of the insurance departments of the 50 states, the District of Columbia, and 4 U.S. territories. NAIC has two organizational elements: the group of state insurance commissioners and its centralized Support and Services Office (support office) headquartered in Kansas City, MO. This appendix presents the funding sources and the expenses for NAIC's activities and operations.

NAIC's Revenue Sources

NAIC estimates that its total 1991 revenue will be about $16.2 million. Figure I.1 illustrates NAIC's revenue sources. While NAIC serves state regulators, assessments on the states on the basis of the premium volume of their domestic insurers represent about 5 percent of NAIC's revenue. Other than education and training, which represent 1 percent of NAIC's revenues, NAIC's services and publications are available to the states at no cost.

Figure I.1: NAIC 1991 Revenue Sources



Total 1991 budget revenue $16,155,800

Source: NAIC 1991 Budget

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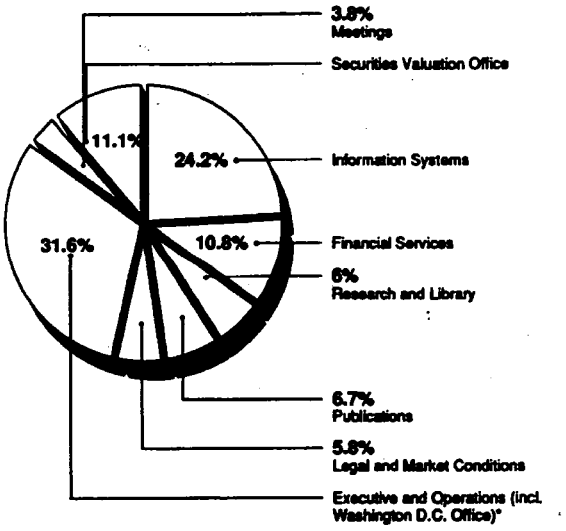
NAIC relies on the insurance industry for most of its revenue. Database filing fees--which represent 46 percent of NAIC's revenue--are mandatory fees on insurance companies that are required by their states to file with NAIC. The insurance industry also purchases NAIC publications and the services of NAIC's Securities Valuation Office (SVO) and the Nonadmitted Insurers Information Office. Finally, only industry representatives pay to attend NAIC's meetings.

NAIC's Expenses

Figure I.2 shows NAIC's proposed expenses for 1991. Nearly one-third of its $15.5 million expense budget is spent on its executive office and operations to support the NAIC committee system. This also includes overhead costs, such as rent and equipment depreciation, for the entire support office. The other major expenses in 1991 are NAIC's information systems ($3.7 million), Securities Valuation Office ($1.7 million), and financial services ($1.7 million).

Figure I.2: NAIC 1991 Proposed Expenses



* Includes rent ($836,676) and depreciation ($1,216,549)

Total 1991 budget expenses $15,492,562

Source: NAIC 1991 Budget

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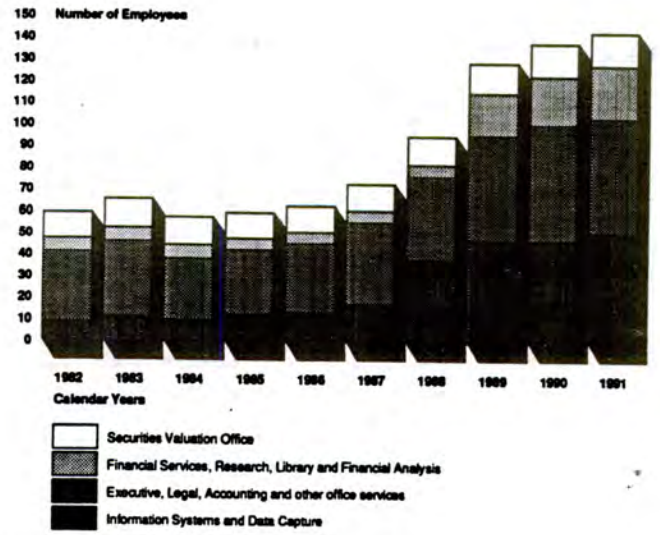
NAIC's Staffing Growth

Since 1987, NAIC's support office has grown rapidly. NAIC's budget has increased over two and a half times, from $5.9 million in 1987 to $15.5 million in 1991. Figure I.3 shows the growth in employment within various departments of NAIC's support office. The number of employees has about doubled from 72 in 1987 to 142 in 1991. NAIC's employment growth reflects its efforts to provide more service to state regulators.

Much of this staffing growth occurred in the information systems department. NAIC operates a $4.5 million computer system and telecommunications network for states to share information and have on-line access to NAIC's financial, legal, and regulatory databases. Computer support staff grew from 17 persons in 1987 to 51 persons in 1991.

Figure I.3: NAIC Staffing by Department (1982-1991)



Source: NAIC

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APPENDIX II

STATE-BY-STATE COMPARISON OF PROPERTY-CASUALTY GUARANTEE FUND PROVISIONS

The National Association of Insurance Commissioners developed a Property and Liability Insurance Guaranty Association Model Act in 1969. Provisions of the Model Act include:

— Lines Covered: all direct lines of insurance except life, annuity, health, disability, mortgage guaranty, financial guaranty, government guaranty, fidelity, surety, credit, warranty and service contracts, ocean marine and title insurance. There is no coverage of insurance for any transaction which involves the transfer of investment or credit risk unaccompanied by a transfer of insurance risk.

— Claim Limits: the maximum amount paid for any claim is $300,000, with the exception of unlimited coverage for workers' compensation.

— Maximum Annual Assessment: insurers are assessed no more than 2 percent of their in-state insurance revenue annually.

— Unearned Premium Coverage: policyholders should be paid for insurance coverage that the policyholder has purchased but not received because the company failed.

— Recoupment Provision: recommendation that insurance companies recover assessments through increasing rates.

Fourteen property-casualty guaranty fund statutes meet or exceed all five of these NAIC standards. The remaining 37 states follow some but not all of these standards. Most differences are in claim limits and maximum annual assessments. A minimum of twelve states have lower claim limits than the NAIC standard, and a minimum of 17 assess insurers at a lower rate than prescribed. Fewer differences exist in the types of insurance covered. For example, only six states offer less coverage than the NAIC standard, and only two states do not cover unearned premiums. Table II.1 compares the property-casualty guaranty fund statutes with selected provisions of the Model Act.

Table II.1: Property-Casualty Guaranty Fund Provisions

State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Alabama	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	1.0%	Yes	Premium tax offset
Alaska	NAIC standard coverage plus ocean marine	$500,000 per claim and unlisted workers' compensation	2.0%	Yes	Rate increase

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Arizona	NAIC standard coverage	$100,000 per claim, workers' compensation covered through other provision	1.0%	Yes	Premium tax offset
Arkansas	NAIC standard coverage	$300,000 per claim including workers' compensation claims	2.0%	Yes	Premium tax offset
California	NAIC standard coverage	$500,000 per claim and unlimited workers' compensation	1.0%	Yes	Policy surcharge
Colorado	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
Connecticut	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Delaware	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset
District of Columbia	NAIC standard coverage plus surety and fidelity, credit, and ocean marine insurance	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Florida	NAIC standard coverage except excludes wet marine	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset (credit against income tax for domestic only)
Georgia	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Hawaii	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Policy surcharge
Idaho	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
Illinois	NAIC standard coverage plus title and credit insurance	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	None
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%	Yes	Premium tax offset
Iowa	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Kansas	NAIC standard coverage plus surety and fidelity and ocean marine insurance	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset
Kentucky	NAIC standard coverage plus surety and fidelity insurance	$100,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
Louisiana	NAIC standard coverage	$150,000 per claim and $300,000 per occurrence and unlimited workers' compensation	2.0%	Yes	Premium tax offset
Maine	NAIC standard coverage plus surety and fidelity and some marine insurance	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Maryland	NAIC standard coverage plus surety and fidelity, title, credit, and ocean marine insurance	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Massachusetts	NAIC standard coverage	$300,000 per claim including workers' compensation claims	2.0%	Yes	Rate increase
Michigan	NAIC standard coverage plus surety and fidelity, title, credit, mortgage guaranty, and ocean marine insurance	1/20 of 1 percent of aggregate premiums written by member insurers during the preceding year and unlimited workers' compensation	1.0%	Yes	Rate increase
Minnesota	NAIC standard coverage plus surety and fidelity insurance	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Policy surcharge
Mississippi	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
Missouri	NAIC standard coverage except excludes general damages	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Premium tax offset
Montana	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Nebraska	NAIC standard coverage except excludes general damages	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Premium tax offset
Nevada	NAIC standard coverage plus credit insurance	$300,000 per claim including workers' compensation claims	2.0%	Yes	Premium tax offset

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
New Hampshire	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
New Jersey	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	2.0%	Yes	Policy surcharge
New Mexico	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
New York	NAIC standard coverage plus surety and fidelity, and ocean marine insurance	$1 million per claim including workers' compensation	2.0%	Yes	Rate increase
North Carolina	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	2.0%	Yes	Rate increase
North Dakota	NAIC standard coverage	$300,000 per claim including workers' compensation claims	2.0%	Yes	Rate increase
Ohio	NAIC standard coverage	$300,000 per claim including workers' compensation claims	1.5%	Yes	Rate increase
Oklahoma	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	The lesser of 2 percent of net premiums or one percent of surplus	Yes	Rate increase
Oregon	NAIC standard coverage except excludes transportation	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Pennsylvania	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	2.0%	Yes	Rate increase
Rhode Island	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
South Carolina	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
South Dakota	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase
Tennessee	NAIC standard coverage except excludes general damages	$100,000 per claim and unlimited workers' compensation	1.0%	Yes	Premium tax offset
Texas	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset
Utah	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%	No	Premium tax offset
Vermont	NAIC standard coverage	$100,000 per claim and unlimited workers' compensation	2.0%	Yes	Rate increase
Virginia	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	Yes	Premium tax offset

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State	Lines of insurance covered[a]	Claim limits	Maximum annual assessments	Coverage includes unearned premiums	Recoupment provisions
Washington	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	2.0%	Yes	Premium tax offset
West Virginia	NAIC standard coverage	$300,000 per claim, workers' compensation covered through other provision	2.0%	Yes	Rate increase
Wisconsin	NAIC standard coverage	$300,000 per claim and unlimited workers' compensation	2.0%	No	Premium tax offset or rate increase
Wyoming	NAIC standard coverage	$150,000 per claim and unlimited workers' compensation	1.0%	Yes	Rate increase

[a] State statutes vary as to which guaranty fund (i.e., property-casualty or life and health) provides coverage for accident, health, and disability insurance written by property-casualty companies. Nonetheless, these lines are covered in every state by one of the funds, except for Colorado, Louisiana, New Jersey, the District of Columbia and New York.

Source: National Conference on Insurance Guaranty Funds; updated by GAO, April 1990.

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ADOPTION OF KEY NAIC MODEL LAWS AND REGULATIONS

Historically, one of NAIC's principal functions has been to develop model laws and regulations for the states' consideration. These models are designed to improve state insurance regulation and promote uniformity among the states.[1]

Even though NAIC's models represent a consensus of state insurance commissioners on the minimum requirements for effective regulation, the record of their adoption by the states has been mediocre to poor. This is because NAIC can only recommend policies and encourage state adoption. NAIC has no authority to compel states to adopt and implement models which it considers essential for effective solvency regulation. Because states have not universally adopted the models, the state-by-state system of solvency regulation lacks uniformity.

HOW NAIC MODELS ARE DEVELOPED

When NAIC recognizes a regulatory issue needing study or action, it forwards the issue to a group of state regulators. The group generally researches the issue and may hold hearings and request input from industry advisory groups. When the NAIC group believes it has sufficient information, the group may draft and propose a model law or regulation to address the issue. The draft is then discussed and reviewed within NAIC. NAIC can elect to expose the draft model for comment by interested parties. The draft is eventually submitted to NAIC's Executive Committee of officers for approval. If approved, the draft is submitted to all state commissioners for consideration. Models are adopted or rejected by the state insurance commissioners through a majority vote during a plenary session at an NAIC national meeting.

As of April 1991, NAIC had adopted about 200 model acts and regulations for the states' consideration. In addition to solvency-related matters, NAIC models address other regulatory issues, including rate regulation and consumer protection.

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[1]For convenience, our discussion refers to adoption of model laws and regulations by states. In fact, the jurisdications include the 50 states and the District of Columbia for a total of 51 jurisdictions.

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KEY NAIC MODELS
HAVE NOT BEEN ADOPTED

Through its financial regulation standards adopted in June 1989, NAIC has identified the legal and regulatory authorities which it considers, at a minimum, to be essential for effective solvency regulation. Among other things, the standards include those model laws and regulations which a state insurance department should have to be accredited by NAIC. According to NAIC, its accreditation program has served as a catalyst to drive the adoption of a minimum set of solvency laws and regulations by the states. NAIC has identified 38 states which as of April 1991, have legislation or regulation pending for adoption.

NAIC must rely on state insurance commissioners to introduce the models in their various state legislatures and work for their passage. Individual states, in turn, may modify NAIC models depending on local needs and circumstances.

Using NAIC's Model Laws, Regulations and Guidelines publication service, we tabulated states's adoption of 14 model laws and regulations referenced in NAIC's financial regulation standards. Table III.1 lists 14 model laws and regulations and presents aggregate statistics on the states' adoption of these models as of April 1991.[2] Table III.2 shows the numbers of states which have changes to current legislation or regulation pending and of states which had new legislation or regulation pending as of April 1991, according to NAIC. Table III.3 presents each state's record for adopting the NAIC models.

As these figures show, adoption of NAIC models varies widely. For example, only two of the four NAIC models adopted before 1980--the Standard Valuation Law and the Insurance Holding Company System Regulatory Act--have been substantially enacted in all states. NAIC's Insurers Rehabilitation and Liquidation Act, or legislation that NAIC identified as substantially similar, has been enacted in 24 states, while 27 other states have legislation or regulations related to the subject but not the same or substantially similar to NAIC's model.

While the original insurance holding company model was enacted in virtually every state, most states have not adopted key provisions that NAIC added in 1984 to control abusive

[2]The figures do not include two NAIC model laws for state guaranty funds. Appendix II compares state provisions for property/casualty guaranty funds.

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interaffiliate transactions.[3] In this regard, only seven states adopted expanded authority to issue cease and desist orders and to impose civil penalties, while only six have added a provision allowing a receiver to recover funds from an affiliate. Additionally, NAIC's model regulation to supplement its holding company model act still has not been adopted in nine states.

Of the models proposed by NAIC since 1980, only the Model Risk Retention Act has been adopted in more than half of the states. In contrast, the Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Condition has been adopted by only four states since its adoption in 1985.

NAIC recommended independent annual audits by certified public accountants in 1980. However, by the end of the 1980s, only 15 states had adopted this requirement. NAIC effectively abandoned the model law process as a means to get states to require this important regulatory tool. Instead, NAIC used its authority to prescribe annual statement reporting to require independent annual audits for insurers. This requirement now applies to all states.

For new model laws, proposed after NAIC promulgated its original financial regulation standards in June 1989, states have two years to comply. For example, the Managing General Agents Act and the Reinsurance Intermediary Model Act were added to NAIC's standards in 1990, so the states have until 1992 to comply.

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[3]The 1984 amendments to the insurance holding company act were in response to the Baldwin-United Life insurer failure.

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Table III.2: Summary of States' With Legislation or Regulations Pending Related to NAIC Accreditation Models

NAIC Model	Date Model Adopted by NAIC	States With	
		Changes to Legislation or Regulation Pending	Initial Legislation or Regulation Pending
Examination Authority (1)	1991	6	0
Regulation to Define Standards and Commissioner's Authority for Companies in Hazardous Financial Condition	1985	0	4
Holding Company Act	1969	16	0
Holding Company Regulation	1971	0	0
Standard Valuation Law	1943	4	0
Credit for Reinsurance Act	1984	12	1
Regulation for Life Reinsurance Agreements	1986	0	1
CPA Audit Regulation	1980	4	5
Rehabilitation and Liquidation Model Act	1978	11	0
IRIS Model Act	1985	3	4
Risk Retention Act	1983	3	1
Business Transacted w/Producer Controlled P/C Insurer Act (1)	1988	0	7
Managing General Agent Act (1)	1989	5	10
Reinsurance Intermediaries Act (1)	1990	2	9

(1) States Have Until 1992 to Adopt

(Information as of April 1991)

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Table III.3: States' Adoption of NAIC Models Related to Accreditation

NAIC MODEL	STATE		
	WI	WV	WY
Examination Authority (1)	R	R/P	R
Regulation to Define Standards and Commissioner's Authority for Companies in Hazardous Financial Condition		M	
Holding Company Act	R	M	M
Holding Company Regulation	R		
Standard Valuation Law	M	M	M
Credit for Reinsurance Act		R	M/R
Regulation for Life Reinsurance Agreements			
CPA Audit Regulation	M	M	
Rehabilitation and Liquidation Model Act	M	M/R	R
IRIS Model Act		M	M
Risk Retention Act	R	M	M
Business Transacted w/Producer Controlled P/C Insurer Act (1)			
Managing General Agent Act (1)			R
Reinsurance Intermediaries Act (1)			

LEGEND
M:Enacted Model/Similar Legislation
R:Enacted Related Legislation/Regulation
P:Pending Legislation/Regulation
(1)States Have Until 1992 to Adopt
(Information as of April 1991)

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TESTIMONY OF

THE INSURANCE DEPARTMENT

BEFORE

THE HOUSE INSURANCE COMMITTEE

JUNE 13, 1991

ALFRED M. MANGANIELLO, LEGISLATIVE LIAISON

RONALD CHRONISTER, DEPUTY INSURANCE COMMISSIONER,

BUREAU OF REGULATION OF COMPANIES

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Good morning, Mr. Chairman and members of the Committee. I am Alfred Manganiello and I am the Legislative Liaison for the Pennsylvania Insurance Department. With me today is Mr. Ronald Chronister who is the Deputy Insurance Commissioner for the Office of the Regulation of Companies. Mr. Chronister has worked for 23 years in this office and started as a financial examiner in 1968 and worked his way through several capacities up to his appointment as Deputy Commissioner in 1986. I will be providing background regarding the process which led to the development of this legislative package and Mr. Chronister will provide the details of the legislation. Thank you for the opportunity to comment on this very important legislation which enhances and improves financial regulation of insurance companies.

Insurance company insolvency is a compelling issue on both the national and state scenes. The recent publicity surrounding the trouble of the Executive Life Insurance Company and First Capital Life Insurance Company illustrate the real life problems faced by policyholders of insolvent or troubled companies. As we have seen, even with guaranty fund protection, people are hurt financially by these insurance company failures. A number of Pennsylvania employers had placed their retirement benefits with Executive Life by purchasing annuities for their employees. And, as a result, Executive Life is paying 70% of qualified annuity retirements which is causing much financial distress for these individuals.

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The National Association of Insurance Commissioners (NAIC), is an organization of insurance commissioners of all the states which provides technical assistance to state insurance departments such as the Insurance Regulatory Information System (IRIS) which Mr. Chronister will discuss later in his testimony. The NAIC also holds educational seminars for insurance department staff such as market conduct training seminars. Furthermore, the NAIC serves as a conduit for the exchange of information regarding financially troubled insurers and insurers who have had enforcement actions taken against them. The NAIC also recommends model legislation which regulates the insurance industry.

The NAIC began the process to address insurance company insolvency with the development and adoption in 1989 by the NAIC of the Financial Regulation Standards. Recognizing the increased public scrutiny of the regulation of insurance company solvency, the NAIC established minimum standards for state solvency regulation in three key areas:

(1) legislation

(2) regulatory practices and procedures, and

(3) organizational and personnel practices.

In June of 1990, the NAIC adopted a formal certification program to assist states in implementing the minimum Financial

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Regulation Standards. Under the formal certification program each state's insurance department will be reviewed by an independent review team whose responsibility it is to assess the department's compliance with NAIC's Financial Regulation Standards. The formal certification process begins only after the three objectives have been met:

(1) Enactment of Legislation
(2) Promulgation of Regulations
(3) Implementation of Organizational Changes

Beginning in 1994 accredited states will not accept reports of examination from unaccredited states, providing further impetus for states to adopt minimum financial standards. As a result, being domiciled in a non-accredited state will increasingly become a liability, thereby inducing states to meet the standards or witness the redomestication (moving to other states) of the companies currently domiciled in their state.

So far, four states, Florida and New York initially, and Illinois and South Carolina most recently, have been accredited under this program and other states will be accredited this year and next. In fact, six additional states will be undergoing the review this year. There is legislative activity in all but a few of the states. All of this activity demonstrates the states' legislative and regulatory committment to insurer financial

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solvency. We would like Pennsylvania to be in the forefront of this important movement.

In the February 1990, in the Congressional Report by the Sub-Committee on Oversight and Investigations entitled Failed Promises: Insurance Company Insolvencies, the committee asserted that the present system for regulating the solvency of insurance companies is seriously deficient. The committee suggested ways to improve regulation, such as increasing capital requirements, regulating Managing General Agents, increasing reinsurance accountability and recognizing the absence of the relationship between insurance companies and their holding companies. This legislation is designed to remedy the problems expressed in the Congressional Report and you will see in Mr. Chronister's remarks a discussion of all of the above mentioned issues expressed by the Congressional Committee.

The National Conference of State Legislators (NCSL) and the National Conference of Insurance Legislators (NCOIL) have adopted resolutions calling on the states to adopt the NAIC's standards.

More specifically the NCSL said that, "state insurance regulation must be strengthened in order to protect policyholders," and that, "solvency regulation must be improved". Furthermore, NCSL said, "in order to achieve these goals, NCSL recommends adoption of the model laws and regulations developed

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by the National Association of Insurance Commissioners".

NCOIL stated in their resolution their support for "efforts of the individual states and the National Association of Insurance Commissioners to establish standards necessary for the enhancement of the present system of monitoring for solvency in order to minimize the potential for insurer insolvency in the future".

The proposed legislation includes the necessary language to meet the minimum statutory authority designed by the NAIC model acts and most importantly, contains additional provisions to address problem areas based on the Insurance Department's experience with financially troubled insurers and where the Department believes current law is deficient.

This legislation is necessary to continue the enhancement of insurance solvency regulation. Mr. Chairman and members of the Committee, thank you for your time and I will now turn to Mr. Chronister for his comments.

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Mr. Chairman, members of the committee, good morning. I am pleased to be able to address the specific highlights of this financial solvency legislation. As Mr. Manganiello has expressed, the importance of this legislation cannot be overstated. The legislative package is contained in two bills. One bill amends the Insurance Department Act and the second amends the Insurance Company Law. The legislation provides for major enhancements to the Pennsylvania Insurance Department's ability to protect our citizens from insurer insolvency. Although the legislation will not prevent insurance company insolvencies, it will allow the Department to better monitor troubled companies, detect those companies earlier and provide for stricter controls over financial transactions between an insurer and its affiliated companies and the investment practices of insurers, and result in minimizing the possibility of insolvent insurance companies.

A) This legislation achieves the objectives of increased financial solvency regulation by:

- strengthening the state insurance department's regulatory authority
- improving the regulatory system of financial surveillance of insurance companies
- improving the efficiency of financial solvency surveillance through the modernization of the state regulatory system of insurance

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B) Let me describe each of these three items in more detail:

First, the financial solvency package strengthens the state Insurance Department's regulatory authority.

1) It allows the department to take quicker action to revoke the license of a financially troubled insurer which is organized outside of Pennsylvania. This provision provides the commissioner with the authority to revoke or refuse to renew an insurer's license and provides the insurer with the right to an administrative hearing on the matter. Presently, the commissioner must bring an action in Court when a licensed insurer organized outside of Pennsylvania no longer meets minimum financial requirements or is in hazardous financial condition.

2) The legislation would give the department the authority to require "working capital" over and above the minimum amounts required by law. "Working capital" consists of the liquid assets an insurer needs to meet its obligations as they fall due. Insurers would be required to secure and maintain an amount of "working capital" in addition to the present minimum capital and surplus amounts

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required. The amounts required would be based upon the risks associated with the nature, type and volume of the business contracted by the insurer. This change reflects the growing recognition that risk based capital and surplus requirements are more meaningful than the specific dollar minimum amounts required under existing law when insurers enter the market.

3) This legislative package would require insurers to formulate and adopt investment plans which provide for the liquidity and diversity of investments. The investment plans would describe investment strategies of the insurer and would have to be authorized by the insurer's board of directors. For the first time, insurers management will be required to develop an annual investment strategy, taking into account cash needs to meet obligations under its policies as well as obtaining investment returns. The Department's financial examiners would have access to these plans.

4) The legislation establishes the Department's authority in regulating the activities of risk retention groups and purchasing groups as permitted under the Federal Liability Risk Retention Act of 1986.

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It clarifies for risk retention groups, purchasing groups, agents, brokers, and insurers the requirements and restrictions related to this area of the insurance market. This legislation makes it clear that purchasing groups must obtain coverage from insurance companies which are authorized to do business in Pennsylvania and will provide for adequate notice to insureds of risk retention groups of the lack of guaranty fund protections.

5) The legislation provides the Department with jurisdiction and authority to regulate the financial solvency of unlicensed health care benefit plans which claim to be exempt from state regulation under the Employee Retirement Income Security Act of 1974 (ERISA). A provider of health care benefit plans would be required to submit to a financial examination by the Insurance Department unless the provider can document that its financial solvency is regulated by another government agency. The Department has become involved in an increasing number of situations where a provider claims exemption from state regulation under ERISA and is, in fact, operating as an unlicensed or unauthorized insurer. All too frequently these plans become

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insolvent, leaving persons covered by the plan with no guaranty fund protection, since this protection is not provided for insureds of unlicensed insurance companies.

6) Finally, the legislation formalizes the Department's existing practice and requirements for the completion and filing of annual financial statements by insurers with the department. As a result, insurers will be required by law to complete their financial statements in accordance with uniform accounting practices and procedures and to file copies of their statements with the NAIC for use in the Insurance Regulatory Information System ("IRIS"). This section also provides for confidentiality and immunity with respect to the IRIS or "Early Warning System" which is critical to assure the Department's continued access to financial ratios and examiner team reports generated each year under IRIS.

Due to the large volume of financial statements received by the department, it is impossible to immediately review and assess the financial condition of each insurer which submits an annual financial statement by March 1 each year. IRIS was

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developed by a committee of state insurance regulators to assist state insurance departments in meeting their basic solvency surveillance responsibilities. Through generation of financial ratios from each insurer's financial information in the NAIC data base and, more importantly, the follow-through financial analyses by a team of financial examiners and analysts dedicated to the project each year, states are better able to prioritize the companies needing annual statement analysis and examination.

Penalties for late filings would increase from a maximum of $100 to $200 per day and the penalty for filing false statements would increase from a maximum of $5,000 to $10,000. Furthermore, the commissioner would be given the authority to suspend, revoke or refuse to renew the license of an insurer for failing to file financial statements.

Second, the legislation would improve the regulatory system of financial surveillance of insurance companies by creating additional regulatory requirements and restrictions on certain aspects of insurer operations.

1) This legislation establishes regulatory controls necessary to reduce the potential for negligence,

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fraud and abuse in the reinsurance market. Reinsurance is an agreement by which one insurance company transfers a portion of the risk it has assumed in issuing insurance policies to another insurance company along with a portion of the premium received for the policies. Reinsurance abuse has been cited as a major factor in many insolvencies which occurred in the late 1980's. Reinsurance transactions are frequently arranged by an intermediary whose role is akin to that of an insurance broker. By establishing limits on the intermediary's authority to remit funds or commit the insurer to a transaction without the insurer's prior approval and by establishing record keeping and reporting requirements for both the intermediary and the insurer, the insurer's responsibility to monitor the activities of intermediaries is increased and consequently the potential for negligence and abuse should be lessened.

2) The proposed legislation requires an insurer to monitor the performance and control the activities of certain agents or brokers. Managing general agents (MGA), unlike traditional agents not only

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produce business but also control underwriting risks, claims payments and, sometimes, the purchase of reinsurance for the business they produce.

This legislation provides for the licensing and regulation of MGA's. This is similar to the provisions relating to reinsurance intermediaries in that it establishes requirements and restrictions with respect to these individuals and the insurer and authorizes the commissioner to order the MGA to reimburse the insurer for any loss caused by the MGA's violation of the act. Additionally, the legislation proposes to regulate broker controlled insurers. This article applies when an insurance broker producing business for an insurer also controls, either by ownership or management contract, the insurer or its reinsurer. This article is intended to assure accountability in such relationships and to provide safeguards with respect to transactions which may affect the solvency of the insurer.

3) The legislation strengthens requirements with regard to certain higher-risk investments, such as unimproved real estate. The legislation would limit investments in higher-risk or in non-income

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producing property, such as, limited partnership interests and developmental real estate. In addition, it would specify appropriate valuation of certain types of investments such as those which are not purchased by the insurer but acquired by other means such as in satisfaction of a debt. The legislation sets limits on investments in subsidiary corporations by property and casualty insurers.

4) The proposed bills increase minimum capital and surplus requirements for insurers eligible to participate in the surplus or excess lines market and updates the existing surplus lines law. The proposed law would improve the quality of insurers eligible to participate in the Pennsylvania surplus lines market through increased minimum capital and surplus requirements and would increase the surveillance of the market through the creation of an advisory organization.

5) Finally, these proposed bills establish more stringent safeguards to protect the solvency of a domestic insurer which is part of a holding company structure. Although the department already

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has certain regulatory authority over insurers which are part of holding company systems, this legislation strengthens the existing law. It is intended to prevent activities or transactions between an insurer and its holding company or an affiliated party, if the transaction would have a detrimental impact on the solvency of the insurer. It establishes annual reporting requirements, requires departmental prior approval for mergers and acquisitions of insurers, sets "fair and reasonable" standards for transactions, and provides a 30-day prior review period for certain "material" transactions, such as reinsurance agreements. It also provides for penalties for violations and liability of and right of recovery against controlling shareholders in the event a violation threatens or causes the insolvency of the domestic insurer.

Third, the legislative package will improve the efficiency of financial solvency surveillance through the modernization of the state regulatory system of insurance.

1) **The legislation modernizes the procedures for conducting financial examinations of insurers to**

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give the commissioner the flexibility to direct more attention to problem areas or companies having or likely to have financial difficulties. It would extend the mandatory examination cycle from four to five years and grant the commissioner the discretion to determine the scope of regularly scheduled examinations.

2) This proposed legislation updates and clarifies the law establishing the Pennsylvania Life and Health Insurance Guaranty Association which pays claims in the event of the insolvency of a licensed insurer. The fund would be activated by an order of liquidation which includes a declaration of insolvency. A $100 deductible currently applied to all payments would be eliminated. Claimants would receive "first dollar" coverage. Coverage would be limited to Pennsylvania residents rather than all policyholders of the insolvent insurer. Further, it requires the issuance of a notice to insureds if a policy is not covered by the Guaranty Fund.

3) Finally, the legislation would establish uniformity in the application of minimum financial requirements to all types of insurance companies

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and clarifies the financial requirements for the organization of mutual insurance companies.

As you can see the proposed legislation is comprehensive and is necessary to improve the Department's surveillance of insurance company solvency. And, as you may know, the department began working on this package earlier this year. Department personnel evaluated the NAIC model legislation with the purpose of updating our laws regarding insurance company solvency and to gain NAIC accreditation. This proposal represents the department's legislative package to achieve this accreditation. The Department does have some concerns about some technical and substantive issues within these two bills and we wish to address our concerns and suggested recommendations.

1) The definition of "actuary" in the articles which establish the licensing and regulation of Reinsurance Intermediaries and Managing General Agents should be expanded to give the department clear authority to require membership in the American Academy of

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Actuaries. Both articles contain provisions which require insurers to obtain annual opinions from actuaries on the adequacy of reserves for future losses when those reserves are established by a reinsurance intermediary or a managing general agent. This requirement is intended to impose an important oversight responsibility on part of the insurer with respect to the establishment of proper reserves. Membership in the Academy means that an actuary not only has proved his or her knowledge of actuarial science through the successful completion of a series of examinations but also that the actuary is subject to standards of conduct which determine the type of opinions an actuary is qualified to give based on his or her experience or area of expertise. The proposed definition speaks only to necessary educational background and does not clearly provide the department with the authority to impose requirements to

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assure that an actuary issuing an opinion on the adequacy of loss reserves has the required experience in loss reserving to permit the department to have confidence in the quality of the opinion. Inadequate or improper reserving has been a major factor in several insolvencies in Pennsylvania. The definition of actuary should be strenghtened to provide the department with clear authority to impose standards of conduct in addition to educational requirements.

2) The provisions relating to extraordinary dividends paid by insurance companies are significantly more restrictive than provisions in current law. While this provision may appear beneficial in the interest of solvency, there are other isssues that have to be evaluated in looking at the benefits of such a change. Historically, we have not had an insolvent or financially troubled insurer in Pennsylvania that resulted from the payment of excessive dividends.

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Therefore, there is no perceived problem with extraordinary dividends in Pennsylvania that needs to be addressed at this point. In considering an appropriate restriction, it is necessary to look at the impact on shareholders and those who may be contemplating making an investment in an insurance company. A more restrictive requirement on the payment of dividends may discourage investment in the insurance industry. This requirement may be particularly vexing when a financially troubled insurer is looking for an infusion of outside capital to restore its viability. Those who invest in insurance companies must assess their investment risk and expected investment return. Existing law regulating the payment of dividends has not been shown to be deficient and the department recommends that it be retained.

3) The legislation includes a provision requiring the commissioner to adopt

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regulations to restrict pyramiding, that is, an insurer's ability to invest in subsidiaries in such a manner as to create a holding company structure of subsidiary insurers without the additional capitalization necessary to operate those subsidiaries in a financially sound manner. Provisions in current law regulating insurance company investments permit the commissioner to prohibit an investment or order divestiture if, after a hearing, she has reason to believe that an insurer has or is about to engage in an investment practice which would have a detrimental impact on the company's solvency. It is the department's position that existing law is adequate as the commissioner already has the authority to address any potential problem in this area on a case-by-case basis.

Mr. Chairman and members of the Committee, thank you for your time and I am willing to answer any question you may have.

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INSURANCE FACTS for Pennsylvania Consumers

Questions and Answers Concerning Insurance Company Solvency

Q. What happens when a company becomes insolvent and is liquidated?

A. Liquidation is similar to bankruptcy. When a company is liquidated, the Insurance Department gathers the company's money and assets and determines what liabilities, such as bills and claims payments, it has. The department then develops a plan to distribute the company's assets according to established law and submits it to the court for approval. When the plan is approved, the money from the company's estate is distributed by the courts.

The liquidation procedure also applies if a company was operating illegally, without a license. If a company was not licensed, the chances are greater that there will be less money available to pay claims and bills. Policyholders and creditors will only receive payment from the funds available from the unlicensed, liquidated company.

Q. If my company is placed into liquidation, will my claims be paid?

A. When a Pennsylvania licensed insurance company is placed into liquidation, claim payments are generally provided by guaranty funds. These funds are a safety net for consumers insured by licensed insurance companies in the commonwealth. The funds generally pay policyholder claims based on limits established by law. The guaranty funds become creditors of the liquidated estate instead of the consumer. The guaranty funds raise the necessary money to pay policyholder claims by making assessments against other licensed insurance companies.

Q. Will my claim be paid in full?

A. All claim payments made by the guaranty funds are subject to a $100 deductible. That means that you pay the first $100 of your bill and the guaranty fund will pay the remainder of your bill up to its established limits (See question nine for explanation of limits.). You may file a claim against the company's estate to recover the $100 you initially paid.

Q. How long will it take for claims to be paid by the guaranty fund(s)?

A. If a company licensed in Pennsylvania is placed into liquidation, the guaranty funds are typically activated to pay claims as soon as the court orders the liquidation. Claims payments usually begin within 60 to 90 days after the court order is issued. If a company that provided workers' compensation benefits is liquidated, your payments usually begin within 30 days.

Q. How many guaranty funds are there and how can I contact them?

A. There are three different guaranty funds:

1. The Pennsylvania Insurance Guaranty Association (PIGA) is responsible for claims payments of liquidated property and casualty insurance companies. Auto, homeowners and liability insurance are a few examples of property and casualty insurance. This fund has a $100 deductible per claim and a limit of $300,000 per claim. You may mail claims or questions to 1620 Suburban Station Building, 1617 J. F. Kennedy Boulevard, Philadelphia, PA 19103, or call (215) 568-1007.

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2. The Pennsylvania Life and Health Insurance Guaranty Association (PHLIGA) is responsible for claims payments of liquidated life, accident and health insurance companies. An example of accident and health insurance is medical insurance. PHLIGA has a $100 deductible and limits of $100,000 for cash values of policies and $300,000 for all benefits. A cash value is that amount of money specified in your insurance contract that you receive when you "cash in" a policy before it matures.

   Claims or questions may be submitted to PHLIGA at the Robert Morris Building, 17th and Arch Streets, Suite 1100, Philadelphia, PA 19103 or call 1-800-253-3148 or 215-687-6222.

3. The Workers' Compensation Security Fund is responsible for paying workers compensation benefits should an insurer providing such payments becomes insolvent. Workers' compensation insurance protects employees against medical and rehabilitation expenses and loss of income caused by a job related injury or illness.

   The administrative offices for the Workers' Compensation Security Fund are located at the Pennsylvania Insurance Department, 1300 Strawberry Square, Harrisburg, PA 17120.Questions regarding claims should be directed to INSERVCO Insurance Services, P.O. Box, 8898, Camp Hill, PA 17001-8898, or call 1-800-634-6807 or (717) 761-8018.

Q. Do I have guaranty fund protection if I bought insurance from an unlicensed insurance company?

A. No, Unfortunately, when an insurance company is not licensed, policyholder claims are not covered by guaranty funds. This means that claims must be paid from the estate of the liquidated unlicensed entity. As a result, policyholders may not receive any payment or only partial payment for their claims.

In the past few years, the Insurance Department has discovered 16 unlicensed insurance companies operating in Pennsylvania. All of these entities have offered health insurance to Pennsylvanians, often at a cost much lower than other health insurers, and have become insolvent. The department has been aggressive in trying to stop these entities from doing business in Pennsylvania and has been successful in convincing the court to place them into liquidation.

Q. How can I determine if my insurance company is licensed and solvent?

A. You can check several sources to determine if your insurance company is licensed and solvent. First, ask your insurance agent or broker. Second, contact the insurance company. Third, call the Pennsylvania Insurance Department, Bureau of Consumer Services at (717) 787-2317 or the Bureau of Licensing and Financial Analysis at (717) 787-2735.

The department can tell you if the company is licensed in Pennsylvania. For information on the company's financial condition, check your local library for the A.M. Best, Moody's or Standard and Poor's reference books which rate licensed insurers.

The fact that an insurance company is licensed does not guarantee that it will always remain solvent. It does mean, however, that policyholders' claims are covered by the guaranty fund(s) if it should become insolvent. This safeguard is not available for policyholders of unlicensed insurance companies.

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National
Association
of Insurance
Commissioners

September 11, 1991

The Honorable Ben Erdreich, Chairman
Subcommittee on Policy Research and Insurance
Committee on Banking, Finance and Urban Affairs
U.S. House of Representatives
Room 139, Ford House Office Building
Washington, DC 20515

Dear Chairman Erdreich:

This letter is in response to your letter of August 20, 1991 requesting responses to several questions following the Subcommittee's July 29 hearing on insurance regulation. On behalf of state insurance regulators and the National Association of Insurance Commissioners, I appreciate the opportunity to respond to these questions and provide additional information to the Subcommittee relating to these issues. Your questions are repeated in bold type followed by my response.

1. **Should state guaranty funds be uniform in coverage and assessment requirements?**

As you are aware, insurance guaranty funds are established at the state level and governed by state laws. The NAIC has adopted model guaranty association laws for property/casualty and life/health insurance. These model laws reflect what the NAIC believes to be an adequate guaranty fund system but it is not expected that every state's system will be exactly the same.

Most guaranty fund laws generally follow the NAIC models in their substantive provisions but there are some differences among states (charts showing state guaranty fund provisions are enclosed). The guaranty fund law in a given state ultimately reflects the economic factors present in that state and the preferences of its policymakers and citizens.

While the NAIC does not discourage a certain degree of diversity among states, it does recognize that questions are raised when the guaranty fund protection that a policyholder receives depends, to a certain extent, on where he or she lives. Because of these concerns, the NAIC is conducting an inquiry into the existing state guaranty fund system and the differences among states.

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While it would be premature to predict the conclusion of that inquiry, I personally favor promoting greater uniformity and coordination among state guaranty funds. I believe that it would be appropriate to explore at least certain minimum standards for guaranty funds which all states would be encouraged to meet. These standards could encompass such areas as: 1) the types of insurance or products covered; 2) limits of coverage; 3) coverage of residents versus non-residents; and 4) maximum annual assessment rates and borrowing authority. The objective of such standards would be to ensure that policyholders receive a certain minimum level of protection wherever they reside.

The states could be induced to meet these minimum standards by incorporating them into the NAIC financial standards and accreditation program. The possibility of using an interstate compact to accomplish this goal also is under discussion. I believe that the objectives of greater uniformity and coordination among state guaranty funds can be achieved without federal involvement.

2. **Should consumers be made aware of the extent of coverage by state guaranty funds and should products not covered by state guaranty funds be clearly designated by insurance companies as not covered?**

This question has become especially pertinent as the financial difficulties of several large life insurers have shaken consumer confidence in the solidity of the industry. Most states have restricted insurance agents' ability to cite guaranty fund protection in their marketing of insurance products. These restrictions are intended to prevent abuse and misinformation. It is likely that, at the time they purchase a policy, most consumers do not think about the possibility of insolvency and how their interests are protected. However, many state insurance departments have consumer services divisions with toll-free hotlines to answer inquiries. A number of insurance departments also have established consumer education programs and commissioners have been very active in speaking to the media and various groups about recent developments and their implications for consumers. In addition, for surplus lines, many states require policyowners to sign a disclaimer acknowledging that their policy is not covered by the guaranty fund.

The NAIC also is looking at the issue of how consumer information could be improved with respect to guaranty fund protection and residual risks involved with purchasing insurance products. One option under discussion is distributing standard consumer information material with policy applications. Standard materials could address consumers' need to know but limit the possibility of misinformation and abuse by agents. These materials could explain what insurance products are covered by the guaranty fund and what that coverage entails.

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3. Under current state laws, what level of flexibility do regulators have in responding to troubled insurance companies, and under what circumstances, if at all, must regulators take specific action?

State insurance regulators have some flexibility in responding to financially troubled insurance companies but they also are governed by due process requirements and the provisions in their state laws. Generally, regulators can and do take informal actions in dealing with troubled insurers before they have to petition a court to place a company in receivership. In many cases, these informal actions are sufficient to obtain the necessary corrective action and resolve the company's difficulties. The threat of formal court action can be used to induce insurers to cooperate with regulators. Also, in a few states, regulators have authority to place companies in administrative supervision or conservation without first seeking court approval.

If an insurer does not cooperate with informal regulatory efforts or those efforts are not successful, then regulators must petition a court for a formal order of conservation, rehabilitation or liquidation. In court proceedings, regulators must demonstrate that the insurer is substantially impaired or insolvent and that the requested action is needed to protect the interests of policyowners, beneficiaries or claimants. The burden of proof placed on regulators in these proceedings is high which does limit their flexibility and may, sometimes, impede regulators from acting more quickly than they would like to. However, insurance regulators are not the only government officials subject to due process requirements and it is unlikely that state legislatures or the courts could constitutionally do away with such requirements.

At the same time, state laws require insurance regulators to take action when an insurer's capital and surplus falls below minimum requirements set by law or there is reason to believe that policyholders' interests are jeopardized by an insurer's financial condition. Insurance regulators' authorities and obligations with respect to troubled insurers are generally contained in state statutes dealing with licensing of companies and laws similar to the NAIC's model Insurers Rehabilitation and Liquidation Act, model Administrative Supervision Act, and Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (copies enclosed).

4. What information should regulators maintain on the financial condition of reinsurance companies and the business ceded to reinsurance companies?

Traditionally, insurance regulators have regulated reinsurance activity through rules governing the granting of credit for reinsurance ceded. Insurers are only allowed to claim credit for reinsurance ceded to reinsurers meeting certain criteria. These requirements are codified in the NAIC's Modal Law on Credit for Reinsurance (enclosed) and other laws/regulations. Domestic reinsurers licensed in the U.S. are required to file statutory financial statements with state insurance departments and the NAIC and are subject to the same solvency

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requirements as primary carriers. Financial information on alien reinsurers is available from other sources. In their statutory financial statements, insurers are required to report the amount of reinsurance premiums and losses ceded to each reinsurer, identified by a unique number assigned by the NAIC. This allows the NAIC and state regulators to track the amount of business ceded to each reinsurer, monitor the timeliness of their payments back to primary carriers, and assess the impact of uncollectible reinsurance on the capital and surplus of any company and the industry as a whole.

I believe that current regulations and reporting requirements are adequate in regulating reinsurance and protecting policyholders' interests. At the same time, the NAIC recognizes that regulatory protections with respect to reinsurance activity could be further improved by establishing a "vetting office" for alien reinsurers. We are currently working on a federal legislative proposal that would establish such an office at the NAIC. This office would "list" alien insurers and reinsurers which meet certain criteria, have filed required financial information and have established trust accounts in the U.S. Insurers would not be allowed credit for cessions to reinsurers unless these reinsurers were listed by the NAIC. This would further strengthen the regulatory system already in place.

I hope that my answers here adequately respond to your questions. Please let me know if you would like me to elaborate further or if I can be of any other assistance to you.

Sincerely yours,

William H. McCartney
Vice President

Enclosures

rwk\letters\erdreich

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POST ASSESSMENT INSOLVENCY FUNDS

ENACTED 1969 THROUGH 1990

STATE	EFFECTIVE DATE	LINES COVERED BY FUND	REFUND OF UNEARNED PREMIUMS	MAXIMUM COVERED CLAIM	DEDUCTIBLE PER CLAIM	RECOUPMENT PROVISION	MAXIMUM ANNUAL ASSMNT %	EARLY ACCESS & PRIORITY IN LIQUIDATION	SEPARATE ACCOUNTS	TERMINATION PROVISIONS
AL Code of Alabama 27-42-1	1/1/81	All kinds of direct insurance except Life, Annuities, Disability, A & H, Title, Surety, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$150,000 Except WC	$100 Except WC Claim	Premium Tax Offset	1 %	YES	a) WC b) Auto c) All Other	NO
AK Alaska Stat 21-80-010 et seq	8/6/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$300,000 per claim except WC	$100 Except WC Claim	Premium Tax Offset	2 %	NO	a) WC b) Auto c) All Other	YES
AZ Arizona Rev Stat Ann 20-661 et seq	8/27/77	All kinds of Direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, Worker's Compensation, Ocean Marine, includes Prof. Liability retroactive to 8/27/77.	YES	$100,000 per claim except no limit on unearned Premiums over $25.	$100	Premium Tax Offset	1 %	YES	a) Auto b) All Other Insurance	NO
AR Arkansas Rev Stat 23-90-101 et seq	3/30/77	All kinds of direct insurance except Life, Annuity, Health, disability, Mortgage Guaranty, Financial Guaranty, Bail or Appearance Bonds, Credit, Insurance of Warranties or Service Contracts, Title, Ocean Marine, Any transaction between a person and an insurer which involves the transfer or investment or credit risk unaccompanied by transfer of insurance risk.	YES up to $25,000 per policy	$300,000 Punitive damages are not covered	None	Premium Tax Offset	2 %	NO NOTE: The Receiver pays all claims. The Assn. does not process or pay claims.	None	NO

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CA California Ins Code 1063 et seq	9/2/69	All kinds of direct insurance except Life, Title, Fidelity, Surety, Disability, Credit, Mortgage Guaranty, Financial Guaranty, Annuity, Health, Ocean Marine & Retrospective Rated & Retroactive policies.	YES	$500,000 per claim Except WC Punitive damages are not covered	$100 Except WC claim	Policyholder Surcharge	1% on account of any single insolvency subject to 1% per year.	YES	a) WC b) Auto c) All Other	NO
CO Colorado Rev Stat Ann Rev 10-4-501 et seq	7/1/71	All kinds of direct insurance except Life, Title, Surety, Sickness & Accident, Disability, Credit, Mortgage Guaranty, Ocean Marine, Financial Guaranty insurance.	YES	$100,000 Except WC Act does not apply to persons with net worth exceeding $50 mil. as of 12/31/90. (See Michigan Footnote).	$100 Except WC claim	Rates and Premiums	1 %	YES	a) WC b) Auto c) All Other	YES
CT Connecticut Gen Stat Rev 38-273 et seq	10/1/71	All kinds of direct insurance except Life, Title, Surety, Accident & Health, Credit, Mortgage Guaranty, Financial Guaranty Ocean insurance pursuant to the Federal Flood Disaster Protection Act of 1973.	YES	1) 1/2 of unearned premium to $2,000 Maximum per policy 2) $300,000 per claim except in case of a WC claim. Fund can recover from insured any liability payments made on insured's behalf if net worth exceeds $50 million (See Michigan Footnote).	$100 on WC claims	Rates and Premiums	2 %	YES	a) WC b) Auto c) All Other	NO

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DE Delaware Code Ann. Title 18 4201 et seq	7/1/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$300,000 per claim Except WC	$100 Except WC claims	Premium Tax Offset	2 %	YES	None	NO
DC District of Columbia Ann Title 18 4201 et seq	8/14/73	All kinds of direct insurance except Life, Title, Disability and Mortgage Guaranty insurance.	YES	$300,000 Except WC	$100 Except WC claims	Rates and Premiums	2 %	NO	a) WC b) Auto c) All Other	YES

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FL Florida Stat 631.50 et seq	10/1/70	All kinds of direct insurance except Life, Annuity, Health or Disability insurance, Mortgage Guaranty, Financial Guaranty, or other forms of insurance offering protection against investment Risks, Fidelity or Surety Bonds, Credit Insurance, Vendors' Single Interest Insurance, or Collateral Protection Insurance, Warranty, including Motor Vehicle Service, or Prepaid Funeral merchandise or service, Optometric Service Plan, Pharmaceutical Service Plan, or Dental Service Plan, Legal Expense Health Maintenance, Prepaid Health Clinic, or Continuing Care, Ocean Marine or Wet Marine insurance Self-insurance, Title, Surplus Lines, and transactions or combination of transactions between a person, & an insurer, including affiliates of such person, and an insurer, which involves the transfer of investment or Credit risk unaccompanied by the transfer of insurance risk, or any insurance provided by or guaranteed by government.	YES	$300,000 per claim Except WC	$100 Except WC claims	Premium Tax Offset (Credit against income tax - Domestics only)	2 %	YES	a) WC b) Auto Liability c) Auto Physical d) All Other	NO
GA Georgia Code Ann 56-33-34-1 et seq	7/1/70	All kinds of direct insurance except Life, Annuity, Accident & Health, Title, Credit Life, Disability, Mortgage & Financial Guaranty Fidelity, Surety, Insurance of Warranties or Service contracts, Ocean Marine & any transaction involving transfer of investment or credit risk unaccompanied by transfer of insurance risk.	YES	$100,000 per claim Except WC Punitive damages are not covered or claimants with net worth greater than $3 million (See Michigan Footnote)	None (GF does not pay any claim under $25)	Rates and Premiums	2 %	NO	a) WC b) Auto c) All Other	YES

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HI Hawaii Rev Stat 431:16-101 et seq	5/25/71	All kinds of direct insurance except Life, Annuity, Health, Title, Fidelity, Surety, Disability, Credit, Life & Credit Disability, Mortgage Guaranty, Financial Guaranty, and Ocean Marine insurance, Warranties, Service Contracts, Transfer of investment or credit risk unaccompanied by transfer of insurance risk.	YES	$300,000 Except WC No punitive damages	None	Policyholder Surcharge	2 %	YES	None	NO
ID Idaho Code 41-3601 et seq	5/6/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$300,000 Except WC	$100 Except WC claims	Rates and Premiums	1 %	YES	a) WC b) Auto c) All Other	YES
IL Illinois Rev Stat, Chapter 73 Section 1065.82 et seq	7/21/71	All kinds of direct Property and Casualty insurance except Life, Accident and Health, Marine insurance, Mortgage Guaranty or other Financial Guaranty coverages written as Suretyship obligations, Suretyship obligations, guaranteeing loans and Suretyship obligations issued to indemnify government Bodies, Fidelity or Surety Warranties or Service Contracts, Retrospective Rating.	YES up to $10,000	$300,000 per claim Except WC No punitive damages, or first party claims of insureds net worth exceeds $50 million (See Michigan Footnote)	$100 Applies only to Unearned Premiums	NO	1 %	YES	a) Auto b) All Other including WC	NO
IN Indiana Code Stat Ann 27-6-8-1 et seq	1/1/72	All kinds of direct insurance except Life, Annuity, Health, Title, Surety, Disability, Warranty or Service Contract, Credit, Financial Guaranty, Mortgage Guaranty and Ocean Marine insurance investment risk, bonding obligations, any insurance provided or guaranteed by government entity or agency.	YES, but limited to lesser of 80% or $650/month up to 12 months	$100,000 per Claim with maximum $300,000 per occurrence. Claimants with net worths exceeding $50 million are excluded. (See Michigan Footnote).	None	Premium Tax Offset	1 %	Yes	a) WC b) Auto c) All Other does not cover general damages	YES

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IA Iowa Code 515B.1 et seq	7/1/70	All kinds of direct insurance except Life, Title, Surety, Fidelity, Disability including Accident and Health, Credit, Mortgage Guaranty and Ocean Marine insurance, Financial Guaranty or other forms of insurance offering protection against investment risk, or any transaction which, although denominated as insurance, does not result in the transfer of an insurance risk.	YES, Except for unearned premium calculated on a retrospective or experience rated plan, or premiums subject to adjustment after the date of liquidation.	$300,000 per claim for all damages arising out of any on accident regardless of the number of persons making claims, except in case of a WC claim.	$100 Except WC claims	Rates and Premiums	2 %	YES	None	NO
KS Kansas Stat Ann 40-2901 et seq	3/27/70	All kinds of direct Property and Casualty insurance except Accident and Health, Title, Mortgage Guaranty, Mortgage Credit, Credit Life insurance (Life insurance is excluded).	YES	$300,000 per claim on WC	$100 Except WC claims	Premium Tax Offset	2 %	YES	None	YES
KY Kentucky Rev Stat Ann 304.36-010 et seq	6/15/72	All kinds of direct insurance except Life, Health (except Health insurance written by a member of the KY Insurance Guaranty Assn.), Title, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$100,000 except for WC	None	Rates and Premiums	1 %	YES	None	NO
LA Louisiana Rev Stat 22:1379 (3) & 1382 (1) (a) et seq	9/1/70	All kinds of direct insurance except Life, Health and Accident, Title, Disability, Mortgage Guaranty, Ocean Marine insurance, Financial Guaranty, Credit insurance, Vendors Single Interest insurance, Collateral Protection insurance, Vehicle Mechanical Breakdown insurance, Fidelity and Surety and Bail Bond contracts.	YES up to $10,000 per policy	$150,000 except WC claim	$100 Except WC claims or unearned premium claims	Premium Tax Offset	2%	YES	None	NO

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ME Maine Rev Stat Ann Title 24-A, 4431 et seq	5/9/70	Property, Surety, Casualty, Marine and Transportation except Wet Marine, Title, Financial Guaranty, Reinsurance, Mortgage Guaranty, Credit Insurance and Insurance contracts procured as surplus lines coverages	YES not to exceed $100,000	$300,000 per claim except WC	None	Rates and Premiums	2 %	Immediate Access	a) WC b) Auto except those writing PD which shall be included in all other c) All Other	YES
MD Maryland Code Ann Art 48A/ 504 et seq	7/1/71	All kinds of direct insurance except Life, Health, Annuities and Mortgage Guaranty.	YES	$300,000 except WC. An aggregate limit of $1 Million applies to the total claims paid arising under any one surety bond.	$100	Rates and Premiums	2 %	YES	a) Title ins. b) Motor Vehicle c) WC d) All Other	YES
MA Massachusetts Ann Laws Ch 175D 1 et seq	1/1/71	All kinds of direct insurance except Life, Accident and Health, Title, Surety, Disability, Credit, Mortgage Guaranty, Financial Guaranty, Warranty, and Ocean Marine Insurance.	YES	$300,000	None	Rates and Premiums	2 %	YES	None	YES

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MI Michigan Comp Laws Ann 500.7901 et seq	9/11/69	All kinds of direct insurance except Life, and Disability insurance.	YES up to $500 annually for cost of living	That portion of any claim other than a WC claim which is in excess 1/20 of 1% of the aggregate premiums by member insurance in MI in preceding year. Excludes first party claimants with net worth greater than 1/10 of 1% of aggregate premiums (But see Borman's Inc. v. Michigan Property & Casualty Guaranty Assn Michigan Supreme Court declared net worth exclusion unconstitutional).	$10	Rates and Premiums	1 %	YES	a) WC b) Auto c) Title d) Fire, Allied lines, Farm Owner's multiple, peril Home Owner's multiple peril, Inland Marine, Earthquake & Credit. e) All Other	NO
MN Minnesota Stat 60C.01 et seq	7/1/71	All kinds of direct insurance except Life, Title, Accident and Sickness written by Life Insurance Companies, Credit, Mortgage Guaranty and Ocean Marine Insurance.	YES	$300,000 per claim Except WC	$100 Except claims eligible for payment under the assigned claims plan or WC	Policyholder Surcharge	2 %	Early Access	a) Auto b) Township Mutuals c) Fidelity & Surety d) All Other e) WC	NO
MS Mississippi Code Ann 83-23-101 et seq	4/6/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine Insurance.	YES	$300,000 per claim except WC	$100 Except WC claims	Rates and Premiums	1 %	Early Access	None	NO

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MO Missouri Rev Stat 375.785	9/13/71	All kind of direct insurance except Life, Accident and Sickness, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance. Does not cover general damages.	YES up to $10,000	$300,000 per claim Except WC	$200	Premium Tax Offset	1 %	NO	a) WC b) Auto c) Fully assessable Farmers Mutual d) All other	NO
MT Montana Ins Code 33-10-101	7/1/71	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance.	YES	$300,000 Except WC	$100 WC claims	Rates and Premiums	2 %	YES	None	NO
NE Nebraska Rev Stat 44-2401 et seq	5/26/71	All kinds direct insurance except Ocean Marine, Life, Annuity, Accident & Sickness, Surety, Fidelity Credit, Title, Mortgage Guaranty, Financial Guaranty, Legal Expense & Mechanical Breakdown insurance.	YES up to $10,000	$300,000 Except WC	$100 WC claims	Premium Tax Offset	1 %	YES	a) WC b) Auto c) All other	NO

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NV Nevada Rev Stat 687 A.010 et seq	5/5/71	All kinds of direct insurance except Life, Health, Title, Annuity, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance.	NO	$300,000	None	Premium Tax Offset	2 %	YES	None	NO
NH New Hampshire Rev Stat Ann 404-B:1 et seq	5/4/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, Ocean Marine and Health insurance.	YES	$300,000 per claim Except WC	$50	Rates and Premiums	2 %	YES	a) WC b) Auto c) All other	NO
NJ New Jersey 17:30A-1 et seq	4/11/74	All kinds of direct insurance except Life, Accident and Health WC (existing fund) Title, Annuities, Surety, Credit, Municipal Bond, Mortgage Guaranty, Fidelity, Investment Return Assurance, Ocean Marine, Pet Health, & insurance provided by the Motor Vehicle Security Fund until funds comprising said funds are declared exhausted by the Commissioner	YES	$300,000 ($75,000 in case of medical expenses incurred as a result of personal injury sustained in an auto accident)	None	Policyholder Surcharge	2 %	Early Access	None	YES
NM New Mexico Stat Ann 59-A-43-1 et seq	4/4/73	All kinds of direct insurance except Life, Health, Title Guaranty, Surety, Accident & Health, Credit, Mortgage Guaranty, Ocean Marine Annuities, Surplus Lines, Motor Club Coverages & any coverage issued by a person not organized under laws providing expressly for the formation of insurers.	YES	$100,000 Except WC	$25	Rates and Premiums	2 %	YES	a) WC b) Auto c) All others	YES

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NC North Carolina Gen Stat 58-155.41	6/25/71	All kinds of direct insurance except Life, Annuities, Title, Surety, Accident & Health Credit, Mortgage Guaranty, Ocean Marine and WC, Employers Liability, Disability, Financial Guaranty, fidelity, Surety, Vendors Single interest Collateral protection, Warranty/Service Contracts, Transactions involving transfer of investment or credit risk no accompanied by transfer of insurance risk. (present WC fund retained).	YES	$300,000	None, but Fund need not pay any claim under $50	Rates and Premiums	2 %	Priority	a) Auto b) All others	YES
ND North Dakota Cent Code Ann 26.1-42-01 et seq	7/1/71	All kinds of direct insurance except Life, Accident & Health, Title, Surety, Credit, Mortgage Guaranty, and Ocean Marine insurance.	YES	$300,000	$100	Rate and Premiums	2 %	YES	None	NO
OH Ohio Rev Code Ann 3955.01 et seq	9/4/70	All kinds of direct insurance except Title, Surety, Credit Guaranty, Mortgage Guaranty, Ocean Marine, insurance written or reinsured by any agency of the State or U.S., Health contracts, Life insurance, Fraternal Benefits, Mutual Protective insurance, Accident & Health insurance pursuant to Ohio CH 3923 and reciprocals, any political subdivision self insurance program under Chapter 3345.202, Credit Union Share Guaranty insurance under Chapter 1761.	YES	$300,000	None	Rates and Premiums	1-1/2 %	YES	a) Auto b) All other	YES

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OK Oklahoma Stat Title 36 2001 et seq	6/27/80	All kinds of direct insurance except Life, Accident, Health, Ocean Marine, Surety, & Title, Mortgage or Financial Guaranty insurance or other forms of insurance offering protection against investments risks, Credit insurance, insurance of Warranties or Service Contracts, Annuities, Vendors Single Interest insurance, Collateral Protection insurance & any transaction between a person & an insurer which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.	YES up to $10,000 per policy	$150,000 Except WC No punitive damages	None	Rates and Premiums	The lesser of 2% of the insurer's net direct written premium or 1% of that insurer's surplus as regards policyholders	YES	a) WC b) Auto c) All others	NO
OR Oregon Rev Stat 734.510 et seq	9/9/71	All kinds of direct insurance except Life, Health, Title, Surety, Credit, Mortgage Guaranty, Home Protection, Wet Marine and Transportation insurance.	YES	$300,000 Except WC	None	Premium Tax Offset	2 %	Early Access Only	None	NO
PA Pennsylvania Stat Ann 40 P.S. 1701.101 et seq	1/25/70	All kinds of insurance specified under Section 202 of the PA Insurance Code except Life and Annuities, Health and Accident, Title, Credit insurance on accounts receivable, Mortgage Guaranty, Surety, Ocean marine, WC insurance (WC continues to be covered by a prior insolvency fund law).	YES	$300,000 per claim	$100 per claim	Rates and Premiums	2 %	YES	a) Auto b) All other	NO
PR Puerto Rico Laws Ann Title 26 2001 et seq	7/3/74	All kinds of direct insurance except Life, Disability, Health, Title, Credit, Surety, insurance against Marine-Ocean accidents & Foreign trade, and Mortgage Loan insurance.	YES	$150,000	$50	Rates and Premiums	2 %	YES	a) Auto b) Casualty other than Auto c) All other	NO

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RI Rhode Island Gen Laws Ann 27-34-1 et seq	5/7/70	Any contract of direct insurance except Life, Annuities, Health, Disability, Credit, Warranty Title, Surety, Fidelity, Mortgage Guaranty, Financial Guaranty, Ocean Marine insurance.	YES up to $10,000	$300,000 Except WC No punitive damages	$100 for unearned premium (except for WC)	Rates and Premiums	2 %	YES	a) WC b) Auto c) All other	YES
SC South Carolina 38-31-10 et seq	6/25/71	All kinds of direct insurance except Life, Annuity, Health, Accident, Title, Fidelity Surety, Disability, Credit, Mortgage Guaranty Financial Guaranty, and Ocean Marine insurance.	Yes, but with $100	$300,000 Except WC	$250 Except WC claim	Rates and Premiums	1 %	YES	a) WC b) Auto c) Homeowners/ Farmowners Multiple Peril d) All other	YES
SD South Dakota Comp Laws Ann 58-29A-1	7/1/70	All kinds of direct insurance except Life, Health, Title, Surety, Fidelity, Disability, Warranty, Credit, Mortgage Guaranty, Financial Guaranty, Ocean Marine insurance, transactions in which no insurance risk is transferred, and insurance guaranteed or reinsured by a governmental body.	YES Up to $25,000	$300,000 per claim Except WC	$100 Except WC claim	Rates and Premiums	1 % Administrative assessment not to exceed $50/yr	YES	a) WC b) Auto c) All other	NO
TN Tennessee Code 56-12-101	7/1/71	All kinds of direct insurances except Life, Surety, Credit Life, Title, Disability, Credit Accident & Health, Credit Mortgage Guaranty, Credit, Ocean Marine insurance and all insurance issued on a limited or unlimited assessable basis.	YES, but only that amount of each covered claim in excess of $250 and less than $10,000.	$100,000 per claim Except WC	$250 Except WC claim	Premium Tax Offset	1 %	NO	a) WC b) All other Does not cover general damages	NO

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POST ASSESSMENT INSOLVENCY FUNDS

ENACTED 1969 THROUGH 1990

STATE	EFFECTIVE DATE	LINES COVERED BY FUND	REFUND OF UNEARNED PREMIUMS	MAXIMUM COVERED CLAIM	DEDUCTIBLE PER CLAIM	RECOUPMENT PROVISION	MAXIMUM ANNUAL ASSMNT %	EARLY ACCESS & PRIORITY IN LIQUIDATION	SEPARATE ACCOUNTS	TERMINATION PROVISIONS
TX Texas Ins Ann Art 21.28-C 1 et seq	5/25/71	All kinds of insurance including WC written by Stock and Mutual Fire insurance companies and Fire and Casualty insurance companies licensed to do business in this state; and shall also include all kinds of insurance written by County Mutual Insurance Company, Lloyd's & Reciprocal Exchanges licensed to business in this state; but shall not apply to insurance written by Farm Mutual insurance companies or Title insurance written by any insurer; and shall not apply to Mortgage Guaranty insurance nor to Ocean Marine insurance nor to Credit insurance insuring a lender against loss due to default by a borrower in the repayment of a loan secured by a jr. lien mortgage; nor to insurance insuring a municipal bond holder against loss due to default of a political subdivision of the bond; nor to Fidelity, Surety and Guaranty bonds; nor to Home Warranty insurance; and shall no apply to Mexican casualty insurance companies nor federally reinsured Crop and Flood insurance Risk Retention groups or Financial Guaranty.	YES 75% up to $1,000	$100,000 Except WC	25% of unearned premium claim. None on all other	Premium Tax Offset	2 %	NO Note: The receiver pays all claims. The Guaranty Fund does not process or pay claims	a) Administrative b) WC c) Auto d) All other	NO
UT Utah Code Ann 31A-28-201 et seq	5/11/71	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, Financial Guaranty, Ocean Marine, Warranties & all insurance guaranteed by the U.S. Government.	NO	$300,000 Except WC No punitive damages. Fund may recover claims paid on behalf of any insured whose net worth exceeds $50 million (See Michigan Footnote).	$100 Except WC Claim	Premium Tax Offset	2 %	Yes	a) WC b) Auto c) All other	YES

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POST ASSESSMENT INSOLVENCY FUNDS

ENACTED 1969 THROUGH 1990

STATE	EFFECTIVE DATE	LINES COVERED BY FUND	REFUND OF UNEARNED PREMIUMS	MAXIMUM COVERED CLAIM	DEDUCTIBLE PER CLAIM	RECOUPMENT PROVISION	MAXIMUM ANNUAL ASSMNT %	EARLY ACCESS & PRIORITY IN LIQUIDATION	SEPARATE ACCOUNTS	TERMINATION PROVISIONS
VT Vermont Stat Ann Title 8 3611 et seq	7/1/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, and Ocean Marine insurance.	Yes, but $25 deductible	$300,000 per claim Except WC	None	Rates and Premiums	2 %	YES	a) WC b) Auto c) All other	NO
VA Virginia Code 38.2-1600 et seq	6/25/70	All kinds of direct insurance except Life, Annuity, Health, Disability, Title, Fidelity, Surety, Credit, Ocean Marine, classes of insurance written by cooperative non-profit Life Benefit Companies, Mutual Assessment Life, Accident and Sickness insurers, Mortgage Guaranty, Financial Guaranty, and transactions that transfer investment risk unaccompanied by transfer of risk.	YES	$300,000 per claim Except WC Punitive damages are not covered and fund can recover third party liability payments made on behalf of insureds whose net worth exceeds $50 million. (See Michigan Footnote)	$50 for unearned premium claims	Premium Tax Offset	2 %	YES	a) WC b) Auto c) All others	YES
WA Washington Rev Code 48.32.-.010 et seq	5/21/71	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, Ocean Marine, and WC insurance.	YES	$300,000	$100	Premium Tax Offset	2 %	YES	a) Auto b) All other	YES
WV West Virginia Code Ann 33-26-1 et seq	5/12/70	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty, Ocean Marine and WC insurance.	YES	$300,000	$100	Rates and Premiums	2 %	YES	a) Auto b) All other	YES

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POST ASSESSMENT INSOLVENCY FUNDS

ENACTED 1969 THROUGH 1990

STATE	EFFECTIVE DATE	LINES COVERED BY FUND	REFUND OF UNEARNED PREMIUMS	MAXIMUM COVERED CLAIM	DEDUCTIBLE PER CLAIM	RECOUPMENT PROVISION	MAXIMUM ANNUAL ASSMNT %	EARLY ACCESS & PRIORITY IN LIQUIDATION	SEPARATE ACCOUNTS	TERMINATION PROVISIONS
WI Wisconsin Stat Ann 646.01 et seq	6/12/69	All kinds of direct insurance except the non-guaranteed provisions of annuities and life insurance contracts, title insurance Surety, Bail Bonds, Mortgage Guaranty, Financial Guaranty, Ocean Marine, Credit insurance, product liability or completed operations coverages provided to a purchasing group or group member operating under the Federal Risk Retention Act, and any liability for dividends or experience rating credits payable after the liquidation date, warranties transfers of investment risk unaccompanied by transfer of insurance risk.	NO	$300,000 Except WC Additional limit placed on first party claims by insureds whose net worth exceeds $10 million. Fund may also recover third party liability payments made on behalf of such insureds. (See Michigan Footnote).	$200	YES alternative PTO if rate recoupment not possible	2 %	Early Access (Modified)	a) Life b) Annuities	NO
WY Wyoming Stat Ann 26-31-101 et seq	2/27/71	All kinds of direct insurance except Life, Title, Surety, Disability, Credit, Mortgage Guaranty and Ocean Marine insurance	YES Up to $7,500	$150,000 Except WC	$250 Except WC claim	Rates and Premiums	1 %	Priority; Immediate Access for WY Ins Guaranty Association in States with immediate access provisions (reciprocal basis)	None	NO

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NAIC
LIFE AND HEALTH GUARANTY FUNDS

STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
AL	§§ 27-44-1 to 27-44-21 (1982)	direct life, disability, annuity, supplemental contracts		3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	1%	20% for 5 years beginning year after assessment paid	No	No
AK	§§ 21.79.010 to 21.79.150, 21.70.900 to 21.79.990 (1990)	direct life, disability, annuity, supplemental contracts, unallocated annuity contracts	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $300,000 death benefits - $100,000 disability - $100,000 net cash - $100,000 present value annuity - $300,000 all benefits - $5 million unallocated annuity	2%	No	Yes	No
AZ	§§ 20-681 to 20-695 (1977/1991)	direct life, disability, annuity, supplemental contracts		3: health, life, annuity	on one life: - $100,000 cash value and annuity - $300,000 all benefits	2%	20% for 5 years beginning year of assessment	Yes	No
AR	§§ 23-96-101 to 23-96-121 (1989)	direct life, disability, annuity, supplemental policies, unallocated annuity contracts	Yes	2: health; life and annuities with 3 subaccounts	on one life: - $100,000 each: Life/dis./ann. - $300,000 all benefits - $1 million unallocated annuity to one contract holder	2%	20% for 5 years beginning year after assessment paid	Yes	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
CA	§§ 1066 to 1066.18 (1991) (Health GF)	direct health	N/A	1: health	on one person: - $200,000 health benefits, but this amount may increase or may decrease based on health care costs	1%	No, premium tax surcharge instead	Yes	No
	§§ 1067 to 1067.18 (1991) (Life GF)	direct life, annuity, supplemental contracts/ certificates	No	2: life, annuity	on one life: - limited to 80% of insurer contractual obligations - $250,000 death benefits - $100,000 net cash - $100,000 present value annuity - $250,000 all benefits - $5,000,000 all policies	1%	No	Yes	N/A
CO	§§ 10-20-101 to 10-20-120 (1991)	direct life, health, annuity and supplemental contracts	No	3: life, health, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender for life policy - $300,000 health benefits - $100,000 present value of annuity	1%	20% for first, second and third years after assessment paid, 7.5% for fourth and fifth years for life and annuity account assessments, recoup health assessments by surcharge	Yes	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
CT	§§ 38-301 to 38-318 (1972/1988)	direct life, health, annuity, supplemental contracts, includes unallocated annuity contracts	Yes	2: health, life and annuities with 3 subaccounts	one one life: - $300,000 death benefits - $100,000 net cash surrender for life policy - $300,000 health benefits - $100,000 present value of annuity - any one contract holder of unallocated annuity: $5 million in total benefits - $300,000 all benefits	2%	50% in year of assessment	Yes	Yes
DE	tit. 18 §§ 4401 to 4419 (1982/1991)	direct life, health, annuity, supplemental contracts, unallocated annuities	Yes	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 life insurance death benefits - $100,000 present value of annuity benefits - $100,000 health benefits - $300,000 maximum total - $1,000,000 unallocated annuity	2%	20% for 5 years beginning year after assessment paid	Yes	No
DC		NO GUARANTY FUND							
FL	§§ 631.711 to 631.735 (1982/1991)	direct life, health, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	1%	10% for 10 years beginning year after assessment paid	Yes	No

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GA	§§ 33-38-1 to 33-38-21 (1981/1990)	direct life, health, annuity, supplemental contracts, includes unallocated annuity contracts	Yes	2: health, life, and annuities with 3 subaccounts	on one life: - $100,000 cash value - $300,000 all benefits - any one contractholder of an unallocated annuity, $5 million in total benefits	2%	20% for 5 years beginning year after assessment paid	Yes	No
HI	§§ 431:16-210 to 431:16-219 (1987)	direct life, disability, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 death benefits - $100,000 disability benefits - $100,000 present value annuity - $300,000 all benefits	2%	20% for 5 years beginning year after assessment paid	Yes	No
ID	§§ 41-4301 to 41-4319 (1977/1987)	direct life, disability, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	100% any of 5 yrs. following year assessment paid	Yes	No
IL	ch. I.C. §§ 531.01 to 531.19 (1981/1990)	life, health, annuity, supplemental contracts, includes unallocated annuities, medical & health care service contracts	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $100,000 cash value - $300,000 death benefits - $300,000 health benefits - $100,000 present value annuity - $300,000 all benefits - $5 million unallocated annuity	2%	20% for 5 yrs. beginning year after assessment paid; offset only allowed if aggregate assessment of all insurers exceeds $3 million	Yes	Yes

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	'PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
IN	§§ 27-8-8-1 to 27-8-8-18 (1978/1986)	direct life, health, annuity policies, annuity contracts, supplemental contracts to life and health policies		3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	20% for each year following year assessments paid until aggregate offset, or include in premium rates	No	No
IA	§§ 508C.1 to 508C.19 (1987/1990)	direct life, health, annuity, supplemental contracts, includes unallocated annuity contracts	Yes	4: health, life, allocated annuities, unallocated annuities (but for assessments treated more like states w/subaccounts	on one life: - $100,000 cash and termination values - $300,000 for all benefits - aggregate liability as to any one holder of an unallocated annuity is $1 million	2%	20% for 5 yrs. beginning year after assessment period	Yes	No
KS	§§ 40-3001 to 40-3018 (1972/1986)	direct life, health, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $100,000 death benefits - $100,000 net cash surrender/withdrawal value for life policy - $100,000 health benefits - $100,000 present value annuity - $200,000 all benefits	2%	20% for 5 yrs. beginning year after assessment peid	Yes	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
KY	§§ 304.42.010 to 304.42.190 (1978/1986)	direct life, health, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal value for life policy - $100,000 health benefits - $100,000 present value annuity	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
LA	§§ 1395.1 to 1395.19 (1991)	direct life, health, annuity, supplemental contracts, unallocated annuities	Only 403(b) plans	4: life, indiv. annuity, 403(b) plans, health	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal value for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 maximum on one individual	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
ME	tit. 24-A §§ 4601 to 4618 (1984/1990)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	No - recoup from premiums charged	No	No
MD	art. 48A §§ 520 to 537 (1971/1989)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: health benefits: not liable for care received after the date of the the insurer's impairment unless care was in progress as of that date or unless other health care coverage is not available from another insurance source or nonprofit health service plan	2%	No	Yes	Yes

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MA	ch. 175 § 1468 (1985/1987)	direct life, health annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal value for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits	2%	10% for 5 yrs. beginning year after assessment paid; with $3 million aggregate for all insurers per year	Yes	No
MI	§§ 500.7701 to 500.7780 (1982/1990)	direct life, health, annuity, supplemental contracts and certificates, unallocated annuities	Yes	3: health, life, and annuities with 3 subaccounts, legal expense insurance	on one life: - $100,000 cash value - $300,000 death benefits - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits - $5 million unallocated annuity	2%	No	Yes	No
MN	§§ 618.01 to 618.16 (1977/1984)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	No	Yes	Yes
MS	§§ 83-23-201 to 83-23-235 (1985/1990)	direct life, health, annuity, supplemental contracts, unallocated annuity	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $100,000 cash value - $300,000 death benefits - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits - $5 million unallocated annuity	2%	25% for next two years (Eff. 7/1/91)	Yes	No

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MO	§§ 376.715 to 376.758 (1988)	direct life, health, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal value for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	Yes
MT	§§ 33-10-201 to 33-10-230 (1974/1987)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 death benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
NE	§§ 44-2701 to 44-2720 (1975/1986)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal value for life policy - $100,000 present value annuity - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
NV	§§ 686C.010 to 686C.370 (1973/1991)	direct life, health, annuity, supplemental contracts	No, except for structured settlements	2: health, life, and annuities with 2 subaccounts	on one life: - $100,000 life policy cash value - $300,000 death benefits - $100,000 health benefits - $100,000 present value annuities - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER RE/RE
NM	§§ 404-0:1 to 404-0:18 (1971)	direct life, health annuity, supplemental contracts, legal services		3: health, life, annuity	on one life: - $100,000 cash values - $300,000 all benefits	4%	No	No	No
NJ	AB 5051 (1991)	direct life, health, annuity and supplemental contracts, long-term care policies, unallocated annuities	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $500,000 in life insurance benefits - $100,000 cash value - $500,000 present value annuity benefits - $2 million unallocated annuity - unlimited health	2%	10% per year for 5 years beginning third year after assessment made, but no more than 20% of tax liability.	Yes	No
NM	§§ 59A-42-1 to 59A-42-16 (1985)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $100,000 cash values - $300,000 all benefits Superintendent may set limits higher	2%	No	No	No
NY	§§ 7701 to 7718 (1985)	direct life, health, annuity, funding agreements, supplemental contracts		2: health, life, annuity and funding arrangement	on one life: - $500,000 all benefits; does not apply to group life or health - $1 million group annuity benefits	2%	80%; formula effective when aggregate assessments for insurers exceed $100 million	Yes	No
NC	§§ 58-62-1 to 58-62-92 (1973/1991)	direct life, health, annuity, variable contracts, supplemental contracts		3: health, life, annuity	on one life: - $300,000 all benefits	4%	No	Yes	No

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ND	§§ 26.1-38.1-01 to 26.1-38.1-16 (1989)	direct life, health, annuity, supplemental contracts, unallocated annuity contracts	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $300,000 death benefits - $100,000 net cash surrender for life policy - $100,000 health benefits - $100,000 present value of annuity - any one contractholder of unallocated annuity: $5 million in total benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
OH	§§ 3956.01 to 3956.20 (1989)	direct life, health, annuity, supplemental contracts, unallocated annuity contracts	Yes	2: health, life and annuities with 3 subaccounts	on one life: - $300,000 death benefits - $100,000 net cash surrender for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits - any one contractholder of unallocated annuity: $1 million in total benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
OK	tit. 36 §§ 2021 to 2043 (1981/1987)	direct life, health, annuity, and supplemental contracts	No	3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender for life policy - $300,000 health benefits - $300,000 present value annuity - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid	Yes	No
OR	§§ 734.750 to 734.890 (1975/1987)	direct life, annuity, health, supplemental contracts	No	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid	No	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
PA	tit. §§ 40-41-101 to 40-41-123 (1979/1988)	direct life, health and accident, annuity, endorsements, riders, and supplemental contracts		3: health life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2% paid	20% for 5 yrs. beginning year after assessment	No	No
PR	26 §§ 3901 to 3918	direct life, health, disability, annuity, supplemental contracts			on one life: - $300,000 death benefits				Yes
RI	§§ 27-34.1-1 to 27-34.1-20 (1985)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits	3%	10% for 5 yrs. beginning year after assessment paid	Yes	No
SC	§§ 38-29-10 to 38-29-200 (1988)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 all benefits	4%	20% for 5 yrs. beginning year after assessment paid	No	No
SD	§§ 58-29C-1 to 58-29C-43 (1989)	direct life, health, annuity, supplemental contracts	No	3: health, life, annuity	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal for life policy - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits	2%	20% for 5 yrs. beginning year after assessment paid, up to $2 million per annum	Yes	No

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STATE	CITE TO INSURANCE CODE	TYPES OF POLICIES COVERED	COVER UNALLOCATED ANNUITIES?	NO. AND TYPE OF ACCOUNTS	LIABILITY LIMITS FOR WHICH ASSOCIATION MAY BECOME LIABLE SHALL NOT EXCEED THE LESSER OF CONTRACTUAL OBLIGATIONS OR:	MAXIMUM ASSESSMENTS	PREMIUM TAX OFFSET?	COVER RESIDENTS ONLY	COVER BC/BS
TN	§§ 56-12-201 to 56-12-220 (1989/1990)	direct life, health, annuity, supplemental contracts, includes unallocated annuities if qualify under § 403(b)	Yes, if qualify under §403(b)	4: health, life, allocated annuities, defined contribution plan account	on one life: - $300,000 death benefits - $100,000 cash surrender value - $100,000 health benefits - $100,000 present value annuity - $300,000 all benefits	2%	10% for 10 yrs. beginning year after assessment paid; or 1% premiums written	Yes	No
TX	art. 21.28-D (1985/1989)	direct life, accident, health, annuity, supplemental contracts, includes unallocated annuity with limitations	Yes, with limitations	4: health, life, annuity, administration	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal for life policy - $100,000 aggregate on annuity - $5 million on unallocated annuity - $200,000 accident and/or health benefits	1%	20% for 5 yrs. beginning year after assessment paid; assessments for administrative expenses may be subtracted from year's tax owed	Yes	Yes
UT	§§ 31A-28-101 to 31A-28-119 (1986/1990)	direct life, health, annuity, supplemental contracts, and unallocated annuities	No, except amounts guaranteed to individuals by insurer	3: health, life, annuity	on one life: - $100,000 cash value - $100,000 health benefits - $100,000 present value annuity - $300,000 death benefits - $100,000 disability - $300,000 all benefits - $5 million unallocated annuity	2%	20% for 5 yrs. beginning year after assessment paid	Yes	Yes
VT	tit. 8 §§ 4151 to 4169 (1972/1990)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 death benefits	2%	20% for 5 yrs. beginning year after assessment paid	No	No

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VI		NO GUARANTY FUND							
VA	§§ 38.2-1700 to 38.2-1721 (1986/1988)	direct life, health, annuity, supplemental contracts	No, except amounts guaranteed to individuals by insurer	3: health, life, annuity	on one life: - $100,000 cash value - $300,000 all benefits	2%	May offset .05% of gross premium for insurance written for account each year	Yes	No
WA	§§ 48.32A.010 to 48.32A.930 (1971/1990)	life, disability, annuity, unallocated annuities	Yes	3: life and annuity, health, general account	on one life: - $500,000 death benefits - $500,000 disability - $500,000 present value annuity - $500,000 all benefits - $5 million unallocated annuity	2%	20% for 5 yrs. beginning year after assessment paid	No	No
WV	§§ 33-26A-1 to 33-26A-18 (1977)	direct life, health, annuity, supplemental contracts		3: health, life, annuity	on one life: - $300,000 death benefits	2%	No	Yes	No
WI	§§ 646.01 to 646.73 (1979/1988)	all kinds and lines of direct insurance		5: life, annuities, health, P/C, administrative account	on one life: - obligation on a single risk limited to $300,000	2%	20% for 5 yrs. if can't recoup with rate adjustments.	Yes	No

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WY	§§ 26-42-101 to 26-42-118 (1990)	direct life, health, annuity, and supplemental contracts	No	3: life, annuities, health	on one life: - $300,000 death benefits - $100,000 net cash surrender/ withdrawal - $100,000 health - $100,000 present value annuity - $300,000 all benefits	2%	10% for 10 yrs. beginning year after assessment paid	Yes	No

Every effort has been made to make this information as correct and complete as possible. For questions about specific state law, you should consult the statutes.

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INSURERS REHABILITATION AND LIQUIDATION MODEL ACT

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ARTICLE I. GENERAL PROVISIONS

Section 1. Construction and Purpose

A. This Act shall be cited as the Insurers Rehabilitation and Liquidation Act.

B. This Act shall not be interpreted to limit the powers granted the Commissioner by other provisions of the law.

C. This Act shall be liberally construed to effect the purpose stated in Subsection D.

D. The purpose of this Act is the protection of the interests of insureds, claimants, creditors and the public generally; with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(1) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

(2) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(3) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) Equitable apportionment of any unavoidable loss;

(5) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(6) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business: and

(7) Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this Act as part of the regulation of the business of

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insurance, insurance industry and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

Section 2. Persons Covered

The proceedings authorized by this Act may be applied to:

A. All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

B. All insurers who purport to do an insurance business in this state.

C. All insurers who have insureds resident in this state.

D. All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

E. All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to [insert statute identification if desired].

F. All title insurance companies subject to [insert statute identification if desired].

G. All prepaid health care delivery plans.

H. [Any other speciality type insurer not covered by the general law which should be subject to this Act].

Drafting Note: In considering other specialty type insurers, special attention should be given to surety companies. They are intended to be included under this Act; but, because of the enacting state's law, may not be included in the general provisions related to the business of insurance.

Section 3. Definitions

For the purposes of this Act:

A. "Ancillary state" means any state other than a domiciliary state.

B. "Commissioner" means the Insurance Commissioner [or the equivalent title, such as Director or Superintendent, utilized by the enacting state] of this state.

C. "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

D. "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under Section 9. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

E. "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(1) The issuance or delivery of contracts of insurance to persons resident in this state;

(2) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

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(3) The collection of premiums, membership fees, assessments, or other consideration for such contracts;

(4) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(5) Operating under a license or certificate of authority, as an insurer, issued by the Insurance Department.

F. "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

G. "Fair consideration" is given for property or obligation:

(1) When in exchange for such property or obligation, as a fair equivalent therefore, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(2) When such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

H. "Foreign country" means any other jurisdiction not in any state.

I. "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

J. "Guaranty association" means the [insert state] Insurance Guaranty Association created by Act [insert applicable cite] as amended, the Workmen's Compensation Security Fund created by [insert applicable cite] as amended, the Life and Health Insurance Guaranty Association Act created by Act [insert applicable cite] as amended, and any other similar entity now or hereafter created by the legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

K. "Insolvency" or "insolvent" means:

(1) For an insurer issuing only assessable fire insurance policies:

(a) The inability to pay any obligation within thirty (30) days after it becomes payable; or

(b) If an assessment be made within thirty (30) days after such date, the inability to pay such obligation thirty (30) days following the date specified in the first assessment notice issued after the date of loss pursuant to [add identification of act if applicable].

(2) For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

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(a) Any capital and surplus required by law for its organization; or

(b) The total par or stated value of its authorized and issued capital stock.

(3) As to any insurer licensed to do business in this state as of the effective date of this Act which does not meet the standard established under Paragraph (2), the term "insolvency" or "insolvent" shall mean, for a period not to exceed three (3) years from the effective date of this Act, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the Commissioner under provisions of the insurance law.

Drafting Note: This paragraph is intended only as a short term "grandfather" provision applicable for the three (3) years immediately following the effective date of this Act.

(4) For purposes of this subsection "liabilities" shall include but not be limited to reserves required by statute or by insurance department general regulations or specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto.

L. "Insurer" means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any Insurance Commissioner. For purposes of this Act, any other persons included under Section 2 shall be deemed to be insurers.

M. "Preferred claim" means any claim with respect to which the terms of this Act accord priority of payment from the general assets of the insurer.

N. "Receiver" means receiver, liquidator, rehabilitator or conservator as the context requires.

O. "Reciprocal state" means any state other than this state in which in substance and effect Sections 17A, 51, 52 and 54 through 56 are in force, and in which provisions are in force requiring that the Commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

P. "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

Q. "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

R. "State" means any state, district, or territory of the United States and the Panama Canal Zone.

S. "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Drafting Note: If "person" is not defined broadly in the insurance code of the enacting state to include corporations, partnerships, associations, trusts, etc., in addition to natural persons, an appropriate definition to include such entities should be added.

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Section 4. Jurisdiction and Venue

A. No delinquency proceeding shall be commenced under this chapter by anyone other than the Commissioner of this state and no court shall have jurisdiction to entertain, hear or determine any proceeding commenced by any other person.

Drafting Note: States may wish to consider the advisability of permitting one or more judgment creditors to commence proceedings under this Act. Some states already have similar provisions.

B. No court of this state shall have jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter.

C. In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the [insert applicable cite] Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(1) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(2) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(3) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(4) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

D. If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

E. All action herein authorized shall be brought in the [identify proper court].

Drafting Note: Each state will need to consider the appropriate court and county for delinquency proceedings under this Act. In general, the venue is more appropriate if it is in the county where the office of the Insurance Commissioner is located. This assures expeditious and expert handling by concentrating such cases in the court with the most experience with regulatory affairs of all kinds, including insurance. An option could also be provided in the county where the principal office of the insurer is located.

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Section 5. Injunctions and Orders

A. Any receiver appointed in a proceeding under this Act may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) The transfer of property;

(3) Interference with the receiver or with a proceeding under this Act;

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

(6) The institution or further prosecution of any actions or proceedings;

(7) The obtaining of preferences, judgements, attachments, garnishments or liens against the insurer, its assets or its policyholders;

(8) The levying of execution against the insurer, its assets or its policyholders;

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors or shareholders, or the administration of any proceeding under this Act.

B. The receiver may apply to any court outside of the state for the relief described in Subsection A.

Drafting Note: Injunctions which are necessary to liquidate an insurer should be included as part of the order to liquidate under Section 17 rather than separately applied for under this section.

Section 6. Cooperation of Officers, Owners and Employees

A. Any officer, manager, director, trustee, owner, employee or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the Commissioner in any proceeding under this Act or any investigation preliminary to the proceeding. The term "person" as used in this section, shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(1) To reply promptly in writing to any inquiry from the Commissioner requesting such a reply; and

(2) To make available to the Commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody or control.

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B. No person shall obstruct or interfere with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

C. This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

D. Any person included within Subsection A who fails to cooperate with the Commissioner, or any person who obstructs or interferes with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the Commissioner issued validly under this Act may:

(1) Be sentenced to pay a fine not exceeding $10,000 or to undergo imprisonment for a term of not more than one year, or both; or

(2) After a hearing, be subject to the imposition by the Commissioner of a civil penalty not to exceed $10,000 and shall be subject further to the revocation or suspension of any insurance licenses issued by the Commissioner.

Section 7. Continuation of Delinquency Proceedings

Every proceeding heretofore commenced under the laws in effect before the enactment of this Act shall be deemed to have commenced under this Act for the purpose of conducting the proceeding henceforth, except that in the discretion of the Commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this Act not been enacted.

Drafting Note: This section permits immediate application of the new law when the Commissioner deems it desirable and practicable. There might be circumstances under which application to old transactions of one or another of the new rules would be unconstitutional. It can be assumed that the Commissioner will then not apply the new law, or at least that portion of it, and that if he did, the court would simply treat the application of the new law as inappropriate and would correct the error, without invalidating the entire proceeding. For the most part, however, the changes are merely remedial and will not affect substantive rights in any way that would open the door to constitutional challenge. Discretion seems more appropriately lodged in the Commissioner than in the court, since the decision should ordinarily turn on considerations of practicability and administrative convenience.

Section 8. Condition on Release from Delinquency Proceedings

No insurer that is subject to any delinquency proceedings, whether formal or informal (administrative or judicial), shall:

A. Be released from such proceeding, unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

B. Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

C. Be returned to the control of its shareholders or private management; or

D. Have any of its assets returned to the control of its shareholders or private management

until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

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ARTICLE II. SUMMARY PROCEEDINGS

Section 9. Court's Seizure Order

A. The Commissioner may file in the [insert proper court] Court of this state a petition alleging, with respect to a domestic insurer:

(1) That there exists any grounds that would justify a court order for a formal delinquency proceeding against an insurer under this Act;

(2) That the interests of policyholders, creditors or the public will be endangered by delay; and

(3) The contents of an order deemed necessary by the Commissioner.

B. Upon a filing under Subsection A, the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the Commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the Commissioner.

C. The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the Commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the Commissioner fails to commence a formal proceeding under this Act after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this Act shall ipso facto vacate the seizure order.

D. Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

E. An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen (15) days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

F. If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

Section 10. Confidentiality of Hearings

In all proceedings and judicial reviews thereof under Section 9, all records of the insurer, other documents, and all Insurance Department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the [insert proper court] Court, after hearing arguments from the parties in chambers, shall order otherwise; or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the [insert proper court] Court shall be held by him in a confidential file.

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ARTICLE III. FORMAL PROCEEDINGS

Section 11. Grounds for Rehabilitation

The Commissioner may apply by petition to the [insert proper court] Court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

A. The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors or the public.

B. There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

C. The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person; if the person has been found after notice and hearing by the Commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

D. Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

E. Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the Commissioner concerning its affairs, whether in this state or elsewhere; and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

F. After demand by the Commissioner under Section [examination law] or under this Act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

G. Without first obtaining the written consent of the Commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to Sections [holding company law] or [bulk reinsurance law], substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsurer substantially its entire property or business in or with the property or business of any other person.

H. The insurer or its property has been or is the subject of an application for the appointment or a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this Act.

I. Within the previous four (4) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the Commissioner.

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Drafting Note: The time limit of four (4) years has been selected to coordinate with normal periodic examinations. A different time limit may be more appropriate depending on the state. The focus of this ground is upon continuing violations of a willful nature.

J. The insurer has failed to pay within sixty (60) days after due date any obligation to any state or any subdivision thereof or any judgement entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the Commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

K. The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the Commissioner, has failed to give an adequate explanation immediately.

L. The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in Section [insert application section], request or consent to rehabilitation under this Act.

Section 12. Rehabilitation Orders

A. An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the Commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the [insert proper court] Court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

B. Any order issued under this section shall require accountings to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order, but no less frequently than semi-annually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under Section 13D will be prepared by the rehabilitator and the timetable for doing so.

C. Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to Section 13.

Section 13. Powers and Duties of the Rehabilitator

A. The Commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the Commissioner may employ such counsel, clerks and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the Commissioner, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the Commissioner. The Commissioner, as rehabilitator, may, with the approval of the court,

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appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in rehabilitation proceedings conducted under this Act.

B. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the insurance department out of the first available money of the insurer.

C. The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

D. If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

E. If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

F. The rehabilitator shall have the power under Sections 25 and 26 to avoid fraudulent transfers.

Section 14. Actions By and Against Rehabilitator

A. Any court in this state before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for ninety (90) days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

B. No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the

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insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

C. Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

Section 15. Termination of Rehabilitation

A. Whenever the Commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the Commissioner may petition the [insert proper court] Court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under Section 16. The [insert proper court] Court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

B. The protection of the interests of insureds, claimants and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six (6) months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under Section 13D, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

C. The rehabilitator may at any time petition the [insert proper court] court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the [insert proper court] Court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Section 11 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The [insert proper court] Court may also make that finding and issue that order at any time upon its own motion.

Section 16. Grounds for Liquidation

The Commissioner may petition the [insert proper court] Court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

A. Of any ground for an order of rehabilitation as specified in Section 11, whether or not there has been a prior order directing the rehabilitation of the insurer;

B. That the insurer is insolvent; or

C. That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public.

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Section 17. Liquidation Orders

A. An order to liquidate the business of a domestic insurer shall appoint the Commissioner and his successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the Clerk of the [insert proper court] Court and the recorder of deeds of the county in which its principal office or place or business is located; or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

Drafting Note: Filing requirements should conform to existing state law.

B. Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in Sections 18 and 36.

C. An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

D. At the time of petitioning for an order of liquidation, or at any time thereafter, the Commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

E. Any order issued under this section shall require financial reports to the court by the liquidator. Financial reports shall include (at a minimum) the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one year of the liquidation order and at least annually thereafter.

F. (1) Within five (5) days of the effective date of this section, or, if later, within five (5) days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the Commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the defendant company's financial condition will not, in the judgment of the Commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the Commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the Commissioner and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the Commissioner or any of his deputies, agents, clerks, assistants or attorneys by any party based on preference in an appeal pendency plan approved by the court.

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(2) The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

(3) Any such plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, in the event an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses in connection therewith relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

Section 18. Continuance of Coverage

A. All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(1) A period of thirty (30) days from the date of entry of the liquidation orders;

(2) The expiration of the policy coverage;

(3) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(4) The liquidator has effected a transfer of the policy obligation pursuant to Section 20A(9); or

(5) The date proposed by the liquidator and approved by the court to cancel coverage.

B. An order or liquidation under Section 17 shall terminate coverages at the time specified in Subsection A for purposes of any other statute.

C. Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

D. Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under Subsections A and B.

Section 19. Dissolution of Insurer

The Commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the Commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

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Section 20. Powers of Liquidator

A. The liquidator shall have the power:

(1) To appoint a special deputy or deputies to act for him under this Act, and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator.

(2) To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation.

(3) To appoint, with the approval of the court, an advisory committee of policyholders, claimants or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in liquidation proceedings conducted under this Act.

(4) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court.

(5) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the insurance department out of the first available moneys of the insurer.

(6) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry.

(7) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

(8) To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(a) To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

(b) To do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as he deems best; and

(c) To pursue any creditor's remedies available to enforce his claims.

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(9) To conduct public and private sales of the property of the insurer.

(10) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 41.

(11) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(12) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution.

(13) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(14) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under Section 19, he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff.

(15) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person.

(16) To remove any or all records and property of the insurer to the offices of the Commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

(17) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions.

(18) To invest all sums not currently needed, unless the court orders otherwise.

(19) To file any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located.

(20) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations.

(21) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member; including any power to avoid any transfer or lien that may be given by the general law and that is not included with Sections 25 through 27.

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(22) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

(23) To enter into agreements with any receiver or Commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(24) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this Act.

Drafting Note: OPTIONAL SECTION: The following subsection may be added to provide for the optional extended reporting period of a claims-made policy. It gives the liquidator authority to sell a limited extended reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator and with the guaranty fund.

If this subsection is included, the regular Subsection B should be relettered C.

[B. (1) If a company placed in liquidation issued liability policies on a claims-made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims as stated herein. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen (18) months from the order of liquidation.

(2) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty (60) days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety (90) days after the order of liquidation. No commissions, premium taxes, assessments or other fees shall be due on the charge pertaining to the extended period to reports claims.]

B. The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

C. Notwithstanding the powers of the liquidator as stated in Subsections A and B above, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

Section 21. Notice to Creditors and Others

A. Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) By first class mail and either by telegram or telephone to the Insurance Commissioner of each jurisdiction in which the insurer is doing business;

(2) By first class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

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(3) By first class mail to all insurance agents of the insurer;

(4) By first class mail to all persons known or reasonably expected to have claims against the insurer including all policyholders, at their last known address as indicated by the records of the insurer; and

Drafting Note: Notice under this paragraph should include notices to various state agencies.

(5) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

B. Except as otherwise established by the liquidator with approval of the court, notice to potential claimants under Subsection A shall require claimants to file with the liquidator their claims together with proper proofs thereof under Section 35, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

Drafting Note: OPTIONAL SECTION: The following Subsection B should replace the above if the state has elected to include the optional Subsection B in Section 20.

[B. Notice to potential claimants under Subsection A shall require claimants to file with the liquidator their claims together with proper proofs thereof under Section 35, on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be no later than eighteen (18) months following the order of liquidation. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.]

C. (1) Notice under Subsection A to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(2) The liquidator shall promptly provide to the guaranty associations such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control, and otherwise cooperate with guaranty associations to assist them in providing to such policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

D. If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

Drafting Note: It is intended that under this subsection, notice required by mail shall be sufficient when the liquidator has deposited such notice in the United States Postal System. This is in conformity with federal bankruptcy law.

Section 22. Duties of Agents

A. Every person who receives notice in the form prescribed in Section 21 that an insurer which he represents as an agent is the subject of a liquidation order, shall within thirty (30) days of such notice provide to the liquidator (in addition to the information he may be required to provide pursuant to Section 6) the information in the agent's records related to

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any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to him, including the name and address of such sub-agent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

B. Any agent failing to provide information to the liquidator as required in Subsection A may be subject to payment of a penalty of not more than $1,000 and may have his licenses suspended, said penalty to be imposed after a hearing held by the Commissioner.

Section 23. Actions By and Against Liquidator

A. Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

B. The liquidator may, upon or after an order for liquidation, within two (2) years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition; the liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of 180 days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

C. No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the petition is denied.

D. Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

Section 24. Collection and List of Assets

A. As soon as practicable after the liquidation order but not later than 120 days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended

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or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the Clerk of the [insert proper court] Court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

B. The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

C. A submission to the court for disbursement of assets in accordance with Section 33 fulfills the requirements of Subsection A of this section.

Section 25. Fraudulent Transfers Prior to Petition

A. Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this Act is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this Act, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, leinor or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, leinor, or obligee.

B. (1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under Section 27C.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

C. Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under Subsection A if:

(1) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

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D. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under Subsection A shall be personally liable therefore and shall be bound to account to the liquidator.

Section 26. Fraudulent Transfer After Petition

A. After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

B. After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

C. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under Subsection A shall be personally liable therefore and shall be bound to account to the liquidator.

D. Nothing in this Act shall impair the negotiability of currency or negotiable instruments.

Section 27. Voidable Preferences and Liens

A. (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this Act, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is

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entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(a) The insurer was insolvent at the time of the transfer; or

(b) The transfer was made within four (4) months before the filing of the petition; or

(c) The creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(d) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding directly or indirectly more than five percent (5%) of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

B. (1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

C. (1) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

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(2) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of Subsection B, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of Subsection B through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

D. A transfer of property for or on account of a new and contemporaneous consideration which is deemed under Subsection B to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to prefect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

E. If any lien deemed voidable under Subsection A(2) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this Act which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

F. The property affected by any lien deemed voidable under Subsections A and E shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

G. The [insert proper court] Court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien; the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less that the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

H. The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under Subsection G to the extent of the amount paid to the liquidator.

I. If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

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J. If an insurer shall, directly or indirectly, within four (4) months before the filing of a successful petition for liquidation under this Act, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate thereof payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of Subsection A(2)(d).

K. (1) Every officer, manager, employee, shareholder, member, subscriber, attorney or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four (4) months before the date of filing of this successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under Subsection A shall be personally liable therefor and shall be bound to account to the liquidator.

(3) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

Section 28. Claims of Holders of Void or Voidable Rights

A. No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this Act; shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty (30) days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

B. A claim allowable under Subsection A by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance, may be filed as an excused last filing under Section 34 if filed within thirty (30) days from the date of the avoidance, or within the further time allowed by the court under Subsection A.

Section 29. Setoffs

A. Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this Act, shall be set off and the balance only shall be allowed or paid, except as provided in Subsections B, C and D and Section 32.

B. No setoff shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer; or

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(2) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(3) The obligation of the insurer is owed to an affiliate of such person, or any other entity or association other than the person; or

(4) The obligation of the person is owed to an affiliate of the insurer, or any other entity or association other than the insurer; or

(5) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(6) The obligations between the person and the insurer arise from business which is both ceded to and assumed from the insurer except that the rehabilitator may, with regard to such business, allow certain setoffs in rehabilitation if he/she shall find the allowance of said setoffs appropriate.

C. The liquidator shall provide persons that assumed business from the insurer with accounting statements identifying debts which are currently due and payable. Such persons may set off against such debts only mutual credits which are currently due and payable by the insurer to such persons for the period covered by the accounting statement.

D. A person that ceded business to the insurer may set off debts due the insurer against only those mutual credits which the person has paid or which have been allowed in the insurer's delinquency proceeding.

E. Notwithstanding the foregoing, a setoff of sums due on obligations in the nature of those set forth in Subsection B(6) shall be allowed for those sums accruing from business written where: the contracts were entered into, renewed or extended with the express written approval of the Commissioner of Insurance of the state of domicile of the now insolvent insurer, when in the judgment of such Commissioner it was necessary to provide reinsurance in order to prevent or mitigate a threatened impairment or insolvency of a domiciliary insurer in connection with the exercise of the Commissioner's regulatory responsibilities.

F. These amendments shall become effective six (6) months from the date of enactment and shall apply to all contracts entered into, renewed, extended or amended on or after that date, and to debts or credits arising from any business written or transactions occurring after the effective date pursuant to any contract including those in existence prior to the effective date, and shall supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer. For purposes of this section any change in the terms of, or consideration for, any such contract shall be deemed an amendment.

Drafting Note: The primary objective of Paragraph B(6) is to prohibit setoffs by reinsurers where the reinsurer both assumed from the insolvent and ceded to the insolvent. No contractual language or intent of the party should be allowed to override any of these objectives. Further, Subsection F's prospective nature shall not be construed as a comment one way or the other on the interpretation of the current law. It is not intended to suggest that the current law allows such setoffs or prohibits such setoffs as are dealt with in these amendments. Further, it is the intent of the drafters, with respect to B(3) and B(4), to deny setoffs between companies who are affiliated so as to not allow one company to use setoffs of another affiliate. Contractual provisions contrary to this intent would not be effective.

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Section 30. Assessments

A. As soon as practicable but not more than two (2) years from the date of an order of liquidation under Section 17 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable total liabilities;

(3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) A recommendation as to whether or not an assessment should be made and in what amount.

B. (1) Upon the basis of the report provided in Subsection A, including any supplements and amendments thereto, the [insert proper court] Court may levy one or more assessments against all members of the insurer who are subject to assessment.

(2) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

C. After levy of assessment under Subsection B, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

D. The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least twenty (20) days before the return day of the order to show cause.

E. (1) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to who cause under Subsection C, the court shall make an order adjudging the member liable for the amount of the assessment against him pursuant to Subsection C, together with costs, and the liquidator shall have a judgment against the member therefor.

(2) If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the Commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the Commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

F. The liquidator may enforce any order or collect any judgment under Subsection E by any lawful means.

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Section 31. Reinsurer's Liability

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

Section 32. Recovery of Premiums Owed

A. (1) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(2) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

B. Upon satisfactory evidence of a violation of this section, the Commissioner may pursue either one or both of the following courses of action:

(1) Suspend or revoke or refuse to renew the licenses of such offending party or parties.

(2) Impose a penalty of not more than $1,000 for each and every act in violation of this section by said party or parties.

C. Before the Commissioner shall take any action as set forth in Subsection B, he shall give written notice to the person, company, association or exchange accused of violating the law, stating specifically the nature of the alleged violation; and fixing a time and place, at least ten (10) days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing; the Commissioner, if he shall find such violation, shall impose such of the penalties under Subsection B as he deems advisable.

D. When the Commissioner shall take action in any or all of the ways set out in Subsection B, the party aggrieved may appeal from said action to the [insert proper court] Court.

Drafting Note: The enforcement provisions of this section may be redundant of existing law and if so may be deleted.

Section 33. Domiciliary Liquidator's Proposal to Distribute Assets

A. Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

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B. Such proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in Section 41, classes 1 and 2;

(2) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(3) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(4) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in Section 41 in accordance with such priorities. No bond shall be required of any such association; and

(5) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements mad therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

C. The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

D. The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming or guaranteeing policies or contracts of insurance under the acts creating such associations.

E. Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with Subsection B(1) and B(2).

Section 34. Filing of Claims

A. Proof of all claims shall be filed with the liquidator in the form required by Section 35 on or before the last day for filing specified in the notice required under Section 21, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

B. The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

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B. The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(2) A transfer to a creditor was avoided under Section 26 through 28, or was voluntarily surrendered under Section 29, and that the filing satisfies the conditions of Section 29;

(3) The valuation under Section 41, of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation; and

C. The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

D. The liquidator may consider any claim filed late which is not covered by Subsection B, and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

Section 36. Proof of Claim

A. Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

(2) The identity and amount of the security on the claim;

(3) The payments made on the debt, if any;

(4) That the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(5) Any right of priority of payment or other specific right asserted by the claimants;

(6) A copy of the written instrument which is the foundation of the claim; and

(7) The name and address of the claimant and the attorney who represents him, if any.

B. No claim need be considered or allowed if it does not contain all the information in Subsection A which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

C. At any time the liquidator may request the claimant to present information or evidence supplementary to that required under Subsection A and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

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liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four (4) months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

E. All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

Section 36. Special Claims

A. The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

B. A claim may be allowed even if contingent, if it is filed in accordance with Section 34. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

C. Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

D. Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under Section 12 or 17.

Section 37. Special Provisions for Third Party Claims

A. Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

B. Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty (60) days after mailing of the notice required by Section 21, whichever is later, he is an unexcused late filer.

C. The liquidator shall make his recommendations to the court under Section 41, for the allowance of an insured's claim under Subsection B after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of a) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or b) the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

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D. If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in Subsection C. If any insured's claim is subsequently reduced under Subsection C, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

E. No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

Section 38. Disputed Claims

A. When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first class mail at the address shown in the proof of claim. Within sixty (60) days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

B. Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected, not less than ten (10) nor more than thirty (30) days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

Section 39. Claims of Surety

Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim; the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution; however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person, the term "other person", as used in this section is not intended to apply to a guaranty association or foreign guaranty association.

Section 40. Secured Creditor's Claims

A. The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(2) By agreement, arbitration, compromise or litigation between the creditor and the liquidator.

B. The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the

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claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

Section 41. Priority of Distribution

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

A. Class 1. The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(1) The actual and necessary costs of preserving or recovering the assets of the insurer;

(2) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(3) Any necessary filing fees;

(4) The fees and mileage payable to witnesses;

(5) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation;

(6) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

B. Class 2. Reasonable compensation to employees for services performed to the extent that they do not exceed two (2) months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

C. Class 3. All claims under policies including such claims of the federal or any state or local government for losses incurred, ("loss claims") including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

D. Class 4. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors including claims of ceding and assuming companies in their capacity as such.

E. Class 5. Claims of the federal or any state or local government except those under Class 3 above. Claims, including those of any governmental body for a penalty or forfeiture, shall

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be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under Subsection H.

F. Class 6. Claims filed late or any other claims other than claims under Subsection G and H.

G. Class 7. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

H. Class 8. The claims of shareholders or other owners in their capacity as shareholders.

Section 42. Liquidator's Recommendations to the Court

A. The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under Section 38. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

B. The court may approve, disapprove or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty (60) days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to Section 38. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

Section 43. Distribution of Assets

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

Section 44. Unclaimed and Withheld Funds

A. All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with Section 41 to the person entitled thereto or his legal representative upon proof satisfactory to the state treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the General Fund.

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B. All funds withheld under Section 36 and not distributed shall upon discharge of the liquidator be deposited with the state treasurer and paid by him in accordance with Section 41. Any sums remaining which under Section 41 would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under Subsection A, unless the Commissioner in his discretion petitions the court to reopen the liquidation under Section 46.

Drafting Note: The escheat laws of the particular state should be examined and applied in this section if they differ from the above language.

Section 45. Termination of Proceedings

A. When all assets justifying the expense of collection and distribution have been collected and distributed under this Act, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

B. Any other person may apply to the court at any time for an order under Subsection A. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

Section 46. Reopening Liquidation

After the liquidation proceeding has been terminated and the liquidator discharged, the Commissioner or other interested party may at any time petition the [insert proper court] Court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

Section 47. Disposition of Records During and After Termination of Liquidation

Whenever it shall appear to the Commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

Drafting Note: The recommendation should conform to whatever general record destruction laws exist in the particular state.

Section 48. External Audit of the Receiver's Books

The [insert proper court] Court may, as it deems desirable, cause audits to be made of the books of the Commissioner relating to any receivership established under this Act, and a report of each audit shall be filed with the Commissioner and with the court. The books, records and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

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ARTICLE IV. INTERSTATE RELATIONS

Section 49. Conservation of Property of Foreign or Alien Insurers Found in This State

A. If a domiciliary liquidator has not been appointed, the Commissioner may apply to the [insert proper court] Court by verified petition for an order directing him to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(1) Any of the grounds in Section 11;

(2) That any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(4) (a) That its certificate of authority to do business in this state has been revoked or that none was ever issued; and

(b) That there are residents of this state with outstanding claims or outstanding policies.

B. When an order is sought under Subsection A, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

C. The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of [insert proper court] Court or the recorder of deeds of the county in which the principal business of the company is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

D. The conservator may at any time petition for and the court may grant an order under Section 50 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under Section 52, to be appointed ancillary receiver.

E. The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

Section 50. Liquidation of Property of Foreign or Alien Insurers Found in This State

A. If no domiciliary receiver has been appointed, the Commissioner may apply to the [insert proper court] Court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(1) Any of the grounds in Section 11 or 16; or

(2) Any of the grounds specified in Section 49A(2) through (4).

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B. When an order is sought under Subsection A, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

C. If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the [insert proper court] Court or the recorder of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

D. If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under Section 52. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under Section 52.

E. On the same grounds as are specified in Subsection A, the Commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the Commissioner deems desirable for the protection of the policyholders and creditors in this state.

F. The court may order the Commissioner, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this Act as are otherwise compatible with the provisions of this section.

Section 51. Domiciliary Liquidators in Other States

A. The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under Section 52C, be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to Section 52.

B. If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the Commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The Commissioner of this state may petition for a conservation or liquidation order under Section 49 or 50, or for an ancillary receivership under Section 52, or after approval by the [insert proper court] Court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

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C. Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

Section 52. Ancillary Formal Proceedings

A. If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the Commissioner may file a petition with the [insert proper court] Court requesting appointment as ancillary receiver in this state:

(1) If he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver;

(2) If the protection of creditors or policyholders in this state so requires.

B. The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds in this state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds.

C. When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

D. When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in Subsection C for ancillary receivers appointed in this state.

Section 53. Ancillary Summary Proceedings

The Commissioner in his sole discretion may institute proceedings under Sections 9 through 10 at the request of the Commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

Section 54. Claims of Nonresidents Against Insurers Domiciled in This State

A. In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

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B. Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this Act, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in Section 55B with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under Section 41.

Section 55. Claims of Residents Against Insurers Domiciled in Reciprocal States

A. In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

B. Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in Sections 34 and 35. The ancillary receiver shall make his recommendation to the court as under Section 42. He shall also arrange a date for hearing if necessary under Section 38 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty (40) days prior to the date set for hearing. If the domiciliary liquidator, within thirty (30) days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

C. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

Section 56. Attachment, Garnishment and Levy of Execution

During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

Section 57. Interstate Priorities

A. In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

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B. The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

C. The owner of a secure claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with Section 40, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

Section 58. Subordination of Claims for Noncooperation

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under Section 41G.

Section 59. Separability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 60. Effective Date

This Act shall take effect immediately.

Legislative History (all references are to the Proceedings of the NAIC).

1936 Proc. I 29, 30-32, 33 (adopted first liquidation statute).
1969 Proc. I 168, 241, 271 (recommended the adoption of the Wisconsin Liquidation Act by states).
1978 Proc. I 13, 15, 211, 238-241, 242-275 (adopted new model).
1986 Proc. II 410-411 (amendments adopted later are printed here).
1987 Proc. I 11, 18, 161, 420-421, 423-424 (amended).
1989 Proc. II 13, 23, 227-228, 338, 379-381 (amended).
1990 Proc. I 6, 26, 172, 398, 407-410 (amended).
1990 Proc. II 7, 14-15, 202-204; 224-251, 529-531 (amended and reprinted).

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ADMINISTRATIVE SUPERVISION MODEL ACT

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Section 1. Definitions

As used in this Act:

A. "Insurer" means and includes every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuities as limited to:

(1) Any insurer who is doing an insurer business, or has transacted insurance in this State, and against whom claims arising from that transaction may exist now or in the future;

(2) Any fraternal benefit society which is subject to the provisions of [insert applicable statute];

(3) [List any other specialty type insurer not covered by the general law which should be covered by this Act].

B. "Exceeded its Powers" means the following conditions:

(1) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the Commissioner, his or her deputies, employees or duly commissioned examiners;

(2) A domestic insurer has unlawfully removed from this State books, papers, accounts or records necessary for an examination of the insurer;

(3) The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto;

(4) The insurer has neglected or refused to observe an order of the Commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus;

(5) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the Commissioner;

(6) The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the Commissioner or has without first having obtained written approval of the Commissioner if approval is required by law:

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(a) Totally reinsured its entire outstanding business, or

(b) Merged or consolidated substantially its entire property or business with another insurer.

(7) The insurer engaged in any transaction in which it is not authorized to engage under the laws of this State;

(8) The insurer refused to comply with a lawful order of the Commissioner.

C. "Consent" means agreement to administrative supervision by the insurer.

D. [The terms "Commissioner" and "Department" may need definitions].

Drafting Note: States may wish to compare these definitions with other definitions in their statutes and resolve any conflict.

Section 2. Applicability

The provisions of this Act shall apply to:

A. All domestic insurers, and

B. Any other insurer doing business in this State whose state of domicile has asked the Commissioner to apply the provisions of this Act as regards such insurer.

Section 3. Notice to Comply with Written Requirements of Commissioner; Noncompliance; Administrative Supervision

A. An insurer may be subject to administrative supervision by the Commissioner if upon examination or at any other time it appears in the Commissioner's discretion that:

(1) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

(2) The insurer ["has" or "appears to have"] exceeded its powers granted under its certificate of authority and applicable law;

(3) The insurer has failed to comply with the applicable provisions of the insurance code;

(4) The business of the insurer is being conducted fraudulently; or

(5) The insurer gives its consent.

B. If the Commissioner determines that the conditions set forth in Subsection A of this section exist, the Commissioner shall:

(1) Notify the insurer of his or her determination;

(2) Furnish to the insurer a written list of the requirements to abate this determination; and

(3) Notify the insurer that it is under the supervision of the Commissioner and that the Commissioner is applying and effectuating the provisions of the Act. Such action by the Commissioner shall be subject to review pursuant to applicable State administrative procedures under [insert state's appropriate administrative appeals procedure statute].

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C. If placed under administrative supervision, the insurer shall have sixty (60) days, or another period of time as designated by the Commissioner, to comply with the requirements of the Commissioner subject to the provisions of this Act.

D. If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the Commissioner may extend such period.

E. If it is determined that none of the conditions giving rise to the supervision exist, the Commissioner shall release the insurer from supervision.

Section 4. Confidentiality of Certain Proceedings and Records

A. Notwithstanding any other provision of law and except as set forth in this section; proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the supervision of any insurer are confidential except as provided by this section.

B. The personnel of the Department shall have access to these proceedings, hearings, notices, correspondence, reports, records or information as permitted by the Commissioner.

C. The Commissioner may open the proceedings or hearings or disclose the notices, correspondence, reports, records or information to a department, agency or instrumentality of this or another State or the United States if the Commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another State of the United States.

D. The Commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records or other information if the Commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors or the general public.

E. This section does not apply to hearings, notices, correspondence, reports, records or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

Drafting Note: States may want to consider changing this section to require proceedings and records to be public record unless the Commissioner deems otherwise. Confidentiality of orders is not included in this section. Some states may want to protect orders from disclosure by including them in this section.

Section 5. Prohibited Acts During Period of Supervision

During the period of supervision, the Commissioner or his designated appointee shall serve as the administrative supervisor. The Commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the Commissioner or his appointed supervisor:

A. Dispose of, convey or encumber any of its assets or its business in force;

B. Withdraw any of its bank accounts;

C. Lend any of its funds;

D. Invest any of its funds;

E. Transfer any of its property;

F. Incur any debt, obligation or liability;

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G. Merge or consolidate with another company;

H. Approve new premiums or renew any policies;

I. Enter into any new reinsurance contract or treaty;

J. Terminate, surrender, forfeit, convert or lapse any insurance policy, certificate or contract, except for nonpayment of premiums due;

K. Release, pay or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate or contract;

L. Make any material change in management; or

M. Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

Section 6. Review and Stay of Action

During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to request a proceeding under [insert state's appropriate administrative appeals procedure statute].

Section 7. Administrative Election of Proceedings

Nothing contained in this Act shall preclude the Commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation or liquidation proceedings or other delinquency proceedings, however designated under the laws of this State, regardless of whether the Commissioner has previously initiated administrative supervision proceedings under this Act against the insurer.

Section 8. Rules

The Commissioner is empowered to adopt reasonable rules necessary for the implementation of this Act.

Section 9. Other Laws; Conflicts; Meetings Between the Commissioner and the Supervisor

Notwithstanding any other provision of law, the Commissioner may meet with a supervisor appointed under this Act and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of this Act to carry out the Commissioner's duties under this Act or for the supervisor to carry out his or her duties under this Act.

Section 10. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Insurance Commissioner or the Department or its employees or agents for any action taken by them in the performance of their powers and duties under this Act.

Legislative History (all references are to the Proceedings of the NAIC*).*

1990 Proc. I 6, 26, 173, 175-178 (adopted).

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MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

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Section 1. Authority

This regulation is adopted and promulgated by (title of supervisory authority) pursuant to Section (insert reference to Section authorizing Commissioner to adopt rules and regulations and a reference to Section 9 of the NAIC Model Insurer's Supervision, Rehabilitation and Liquidation Act and any other section where the term hazardous financial condition or a similar term is used) of the (insert state) Insurance Code.

Section 2. Purpose

The purpose of this regulation is to set forth the standards which the Commissioner may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

This regulation shall not be interpreted to limit the powers granted the Commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supercede any laws or parts of laws of this state.

Section 3. Standards

The following standards, either singly or a combination of two or more, may be considered by the Commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public. The Commissioner may consider:

1. adverse findings reported in financial condition and market conduct examination reports;

2. the National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports;

3. the ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus;

4. the insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;

5. the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

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6. the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than 50% of such insurer's remaining surplus as regards policyholders in excess of the minimum required;

7. whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation;

8. contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the insurer;

9. whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;

10. the age and collectibility of receivables;

11. whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

12. whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

13. whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

14. whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; or

15. whether the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

Section 4. Commissioner's Authority

A. For the purposes of making a determination of an insurer's financial condition under this regulation, the Commissioner may:

1. disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding;

2. make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

3. refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

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4. increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

B. If the Commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the Commissioner may, upon his determination, issue an order requiring the insurer to:

1. reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. reduce, suspend or limit the volume of business being accepted or renewed;

3. reduce general insurance and commission expenses by specified methods;

4. increase the insurer's capital and surplus;

5. suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

6. file reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

7. limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

8. document the adequacy of premium rates in relation to the risks insured; or

9. file, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the Commissioner.

If the insurer is a foreign insurer the Commissioner's order may be limited to the extent provided by statute.

C. Any insurer subject to an order under Subsection B may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant (cite the applicable rules of civil or administrative procedure). The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the Commissioner based the order. Unless mutually agreed between the Commissioner and the insurer, the hearing shall occur not less than 10 days nor more than 30 days after notice is served and shall be either in (insert proper county) or in some other place of convenience to the parties to be designated by the Commissioner. The Commissioner shall hold all hearings under this subsection privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

Section 5. Judicial Review

Any order or decision of the Commissioner shall be subject to review in accordance with (cite applicable provision of the State Administrative Code) at the instance of any party to the proceedings whose interests are substantially affected.

Note: Consideration should be given to the practice and procedure in each state.

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Section 6. Separability

If any provisions of this regulation be held invalid, the remainder shall not be affected.

Section 6. Effective Date

This regulation shall become effective (insert date).

Legislative History (all references are to the Proceedings of the NAIC).

1986 Proc. II 11, 23, 243, 244-247 (adopted).

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CREDIT FOR REINSURANCE MODEL REGULATION

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Section 1. Authority

This regulation is promulgated pursuant to the authority granted by Sections [insert applicable section number] and [insert applicable section number] of the Insurance Code.

Section 2. Purpose

The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of the [NAIC Model] Law on Credit for Reinsurance, Section [insert applicable section number] of the Insurance Code ("the Act"). The actions and information required by this regulation are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state.

Section 3. Severability

If any provisions of this regulation, or their application to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this regulation which can be given effect without the invalid provision or application, and to that end the provisions of this regulation are separable.

Section 4. Credit for Reinsurance—Reinsurer Licensed in this State

Pursuant to Section [1A or appropriate section number] of the Act, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this state as of the date of the ceding insurer's statutory financial statement.

Drafting Note: Statutory financial statement shall mean financial statements filed on either a quarterly or annual basis.

Section 5. Credit for Reinsurance—Accredited Reinsurers

A. Pursuant to Section [1B or appropriate section number] of the Act, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which:

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(1) Files a properly executed Form AR-1 (attached as an exhibit to this regulation) as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records; and

(2) Files with the commissioner a certified copy of a letter or a certificate of authority or of compliance as evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state; and

(3) Files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

(4) Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the commissioner within ninety (90) days of its submission or, in the case of companies with a surplus as regards policyholders of less than $20,000,000, whose accreditation has been approved by the commissioner.

B. If the commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, he may upon written notice and hearing revoke the accreditation. No credit shall be allowed a domestic ceding insurer with respect to reinsurance ceded after [insert date] if the assuming insurer's accreditation has been denied or revoked by the commissioner after notice and hearing.

Section 6. Credit for Reinsurance—Reinsurer Domiciled and Licensed in Another State

A. Pursuant to Section [1C or appropriate section number] of the Act the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which as of the date of the ceding insurer's statutory financial statement:

(1) Is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed in) a state which employs standards regarding credit for reinsurance substantially similar to those applicable under the Act and this regulation;

(2) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(3) Files a properly executed Form AR-1 with the commissioner as evidence of its submission to this state's authority to examine its books and records.

B. The provisions of this section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this section, "substantially similar" standards means credit for reinsurance standards which the commissioner determines equal or exceed the standards of the Act and this regulation.

Section 7. Credit for Reinsurance—Reinsurers Maintaining Trust Funds

A. Pursuant to Section [1D or appropriate section number] of the Act, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in Section [3B or appropriate section number] of the Act, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

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B. The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to business written in the United States, and in addition, a trusteed surplus of not less than $20,000,000.

(2) The trust fund for a group of individual unincorporated underwriters shall consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the commissioner annual certifications by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter member of the group.

(3) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners) and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the assuming insurers' liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the commissioner annual certifications by the members' domiciliary regulators and their independent public accountants of the solvency of each member of the group.

C. The trust shall be established in a form approved by the commissioner and complying with Section [1 or other appropriate section number] of the Act and this section. The trust instrument shall provide that:

(1) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States.

(2) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in interest.

(3) The trust shall be subject to examination as determined by the commissioner.

(4) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

(5) No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(6) No amendment to the trust shall be effective unless reviewed and approved in advance by the commissioner.

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Section 8. Credit for Reinsurance Required by Law

Pursuant to Section [1E or other appropriate section number] of the Act, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section [1A, B, C or D or other appropriate section number] of the Act, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

Drafting Note: Examples of assuming insurers for which credit may be allowed under this section include state owned or controlled insurance or reinsurance companies or ceding company participation in pools, guaranty funds or joint underwriting associations required by statute, regulation or administrative order.

Section 9. Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer

Pursuant to Section [2 or other appropriate section number] of the Act, the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section [1 or other appropriate section number] of the Act in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in Section [3B or other appropriate section number] of the Act. This security may be in the form of any of the following:

A. Cash.

B. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets.

C. Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in Section [3A or other appropriate section number] of the Act, effective no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

D. Any other form of security acceptable to the Cmmissioner.

An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to Section 9A, B and C shall be allowed only when the requirements of Sections 10, 11 or 12 of this regulation are met.

Section 10. Trust Agreements Qualified under Section 9

A. As used in this section:

(1) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

Drafting Note: The NAIC has adopted the above definition as part of the "Uniform Letter of Credit." However, the state may choose to utilize the following definition: "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator.

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(2) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

(3) "Obligations", as used in Subsection B(11) of this section, means:

(a) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(b) Reserves for reinsured losses reported and outstanding;

(c) Reserves for reinsured losses incurred but not reported; and

(d) Reserves for allocated reinsured loss expenses and unearned premiums.

B. Required conditions.

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in Section [3B or other appropriate section number] of the Act.

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the Commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in Subsection B(4)(a) of this section must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

(4) The trust agreement shall provide that:

(a) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(b) No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(c) It is not subject to any conditions or qualifications outside of the trust agreement; and

(d) It shall not contain references to any other agreements or documents except as provided for under Paragraph (11) of this subsection.

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

(a) Receive assets and hold all assets in a safe place;

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(b) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(c) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(d) Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account;

(e) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(f) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(10) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

(11) Notwithstanding other provisions of this regulation, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this regulation, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

(a) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(b) To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(c) Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial

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institution as defined in Section [3B or appropriate section number] of the Act apart from its general assets, in trust for such uses and purposes specified in Subparagraphs (a) and (b) above as may remain executory after such withdrawal and for any period after the termination date.

(12) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by Subsection D(1)(b) of this section, so long as these required conditions are included in the trust agreement.

C. Permitted conditions.

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in Subsection D(1)(b) of this section.

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Additional conditions applicable to reinsurance agreements.

(1) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

(a) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(b) Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by the Insurance Code or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance

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agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

(c) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(d) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(e) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses and unearned premium reserves; and

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(2) The reinsurance agreement may also contain provisions that:

(a) Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(i) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

(ii) After withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount.

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

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(b) Provide for:

(i) The return of any amount withdrawn in excess of the actual amounts required for Subsections D(1)(e)(i), (ii) and (iii), or in the case of Subsection D(1)(e)(iv), any amounts that are subsequently determined not to be due; and

(ii) Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Subsection D(1)(e)(iii).

(c) Permit the award by any arbitration panel or court of competent jurisdiction of:

(i) Interest at a rate different from that provided in Subparagraph (b)(ii),

(ii) Court of arbitration costs,

(iii) Attorney's fees, and

(iv) Any other reasonable expenses.

(3) Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to [insert date] will continue to be acceptable until [insert date], at which time the agreements will have to be in full compliance with this regulation for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in Subsection A of this section shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

Section 11. Letters of Credit Qualified under Section 9

A. The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution as defined in Section [3A or appropriate section number] of the Act. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in Subsection I(1) below. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

Drafting Note: The NAIC has adopted the above definition as part of the "Uniform Letter of Credit." However, the state may choose to utilize the following definition: "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator.

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B. The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

C. The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

D. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than thirty (30) days' notice prior to expiry date or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

F. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

G. The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit, pursuant to Section [3A or appropriate section number] of the Act.

H. If the letter of credit is issued by a qualified United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in Subsection G of this section, then the following additional requirements shall be met:

(1) The issuing qualified United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts, and

(2) The "evergreen clause" shall provide for thirty (30) days' notice prior to expiry date for nonrenewal.

I. Reinsurance agreement provisions.

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

(a) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

(b) Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

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(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves); and

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(c) All of the foregoing provisions of Paragraph (1) of this subsection should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in Paragraph (1) of this subsection shall preclude the ceding insurer and assuming insurer from providing for:

(a) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Paragraph (1)(b)(iii) of this subsection; and/or

(b) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of Paragraph (1)(b)(iv) of this subsection, any amounts that are subsequently determined not to be due.

(3) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of Paragraph (1)(b) of this subsection, require that the parties enter into a "Trust Agreement" which may be incorporated into the reinsurance agreement or be a separate document.

J. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

Section 12. Other Security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Section 13. Reinsurance Contract

Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections 4, 5, 6, 7, or 9 of this regulation or otherwise in compliance with Section [1 or appropriate section number] of the Act after the adoption of this regulation unless the reinsurance agreement:

A. Includes a proper insolvency clause pursuant to Section [insert appropriate number] of the Insurance Code; and

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B. Includes a provision pursuant to Section [1F or appropriate section number] of the Act whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

Section 14. Contracts Affected

All new and renewal reinsurance transactions entered into after [insert date] shall conform to the requirements of the Act and this regulation if credit is to be given to the ceding insurer for such reinsurance.

Legislative History (all references are to the Proceedings of the NAIC*)*

1991 Proc. 19, 18, 908, 926-927, 930-939 (adopted)

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