

FEDERATION OF REGULATORY COUNSEL, INC.

FORC Journal: Vol. 19 Edition 1 - Spring 2008

SHOULD THE SUPERINTENDENT OF INSURANCE ALWAYS BE THE LIQUIDATOR?*

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Introduction

Insurance liquidation statutes throughout the country require that when a domestic insurance company is placed into liquidation, the Superintendent of Insurance must be appointed the Liquidator by the Court supervising the liquidation. ¹ That requirement has not always been in place in this country and is not the case in England, parts of Europe and other countries. This article addresses the question of whether it makes sense to allow persons other than the Superintendent of Insurance to be appointed Liquidator of an insolvent insurance company.

When I started considering the issue for this article, I thought I was well suited to provide an objective analysis of this question since in my thirty plus years of being an attorney, I was outside counsel to the Superintendent of Insurance for twenty years on several different insurance company liquidations, I was in-house counsel at the Ohio Department of Insurance at a time in which there were several very active insolvencies and liquidations, and, since my return to private practice, I have been counsel for more than a dozen clients with significant issues in a half dozen or more liquidations. Whether I am being objective, however, may be subject to question because my view after the research and working on this article is much more one-sided. That is, I believe that the Superintendent should not always be the insurance Liquidator and statutes should therefore be amended to allow private parties to become appointed the Liquidator by the court supervising the liquidation.

I will discuss briefly the history of the Liquidator of an insolvent insurance company below, point out a number of issues that commonly arise because the Superintendent is the Liquidator and address the pros and cons of the Superintendent having the dual role.

History of Appointment of the Liquidator

For an insurance company to be placed into liquidation, the domestic regulator of the insurance company must file a complaint in court alleging the company is insolvent or that some other grounds exist which warrant the company be liquidated. The complaint is filed at the trial court level and the trial court, by statute, must appoint the Superintendent of Insurance as the Liquidator. The role of the Liquidator, like the role of a court-appointed receiver of an insolvent non-insurance company, is to marshal the assets, wind-down the business and pay the liabilities.

The role of Liquidator has not always been filled by the state's Superintendent of Insurance. Prior to the Uniform Insurers Liquidation Act, a model act promulgated by the National Association of Insurance Commissioners in 1939, the role of Liquidator was filled by a private citizen.² At common law, "a receiver's

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only purpose was to provide a presumably neutral party to carry out a particular task or set of tasks pursuant to the supervision of a court. Such a receiver was not performing a regulatory function on behalf of the sovereign state, but acted on behalf of the particular court that appointed him." 3 Thus, Liquidators were private parties.

In 1944, the United States Supreme Court decided *United States v. South-Eastern Underwriters Association*, holding that insurance companies were subject to federal regulation under the Commerce Clause.⁴ Due to a backlash from the insurance industry and the state regulators, Congress passed the McCarran-Ferguson Act in 1945.⁵ The McCarran-Ferguson Act (the "Act")⁶ grants states the authority to control state systems for the regulation and taxation of the insurance business.⁷ "McCarran-Ferguson, therefore, permits the states to determine the rules of insurance regulation" ⁸

Under the Act, state laws regulating the business of insurance are not preempted by conflicting federal laws that do not relate to the business of insurance unless the federal law specifically provides otherwise.⁹ As the United States Supreme Court explained in *SEC v. National Securities, Inc.*, "The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation."¹⁰ In *United States Dept. of the Treasury v. Fabe*, the Supreme Court explicitly held that the receivership of insolvent insurance companies was subject to state control.¹¹

Pursuant to that authority under the Act, almost every state has adopted a version of the Uniform Insurers Liquidation Act. The Model Act provides that an order to liquidate the business of an insurer shall appoint the superintendent of insurance as the Liquidator.¹² "Accordingly, only an elected or appointed officer of the state acting in his official capacity may be appointed an insurance receiver . . . [and] [t]he [Superintendent] is the embodiment of the state's police power in the insurance insolvency context."¹³

Until recent years, liquidations of insurers were infrequent and there was little need to question the role of the Superintendent as Liquidator.¹⁴ With the more recent rate of insolvencies, and their increasing size and complexity, it is time to re-examine the mandatory nature of the Superintendent's dual role.

Issues Raised by Superintendent's Dual Role

The fact that the Superintendent is first the regulator of a company that becomes insolvent and then the Liquidator of that same company has been the subject of considerable litigation over the years. Although the issues have arisen in a number of different ways and contexts, they basically relate to the question of whether the Superintendent as regulator is a separate and distinct person or entity from the Superintendent as court-appointed Liquidator.

Although state courts agree that a counterclaim against a Liquidator for conduct that occurred while the Superintendent was functioning as the regulator will not be maintained, other issues are the subject of conflicting views. These issues include whether the actions or non-actions of the Superintendent as Regulator can be a defense to the Liquidator's claims, whether the Liquidator is an arm of the state, whether the Deliberative Process Privilege applies to Liquidators and whether the state or the Liquidator personally is the real party in interest.

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Defenses to Liquidator's Claim Based Upon Regulator's Conduct

In *In the Matter of the Liquidation of Ideal Mutual Insurance Co.*, the Superintendent of Insurance for the State of New York, acting in his capacity as Liquidator, charged various officers and directors of Ideal Mutual Insurance Co. with breach of their fiduciary duties and mismanagement, which allegedly led to the company's insolvency.¹⁵ The defendants asserted two affirmative defenses against the Liquidator's claims: contributory negligence and lack of proximate cause.

The New York court held that the Superintendent, as Liquidator of an insurance company, occupies "a legal personality separate and distinct from the Superintendent of Insurance as the public official charged with regulating the industry generally." Therefore, the court dismissed the contributory negligence defense because the allegedly negligent acts were committed while the Superintendent was exercising his regulatory function, prior to the time he became Liquidator of Ideal. However, the court did not dismiss the lack of proximate cause defense. The court held that "because that defense is predicated upon the thesis that a subsequent act of a third party interrupted the causal nexus between the defendant's initial negligence and the plaintiff's injury thereby relieving the defendant of liability, the defense should not be dismissed."

In *Covington v. Buckner*, an action brought by the Ohio Superintendent of Insurance in his role as Liquidator, the court dismissed various affirmative defenses asserted against the Superintendent for conduct that occurred while he was functioning as regulator.¹⁶ Two defendants asserted that the Liquidator's claims were barred for several reasons, including the doctrines of unclean hands and in pari delicto, lack of proximate cause, intervening and superseding cause, contributory negligence, assumption of risk, waiver, and estoppel.

The Ohio trial court held that the two positions of the Superintendent, that of the regulator and that of the Liquidator, are not interchangeable and that "any affirmative defense asserted against the Superintendent must relate to his conduct as Liquidator. The Liquidator cannot be held accountable for behavior which is attributed to the Regulator . . . who [is] not a [party]" Therefore, the court dismissed defendants' affirmative defenses, other than the intervening and superseding cause defense which related to the Liquidator's ability to show proximate cause.

Counterclaims Against Liquidator for Conduct While Acting as Regulator

Just as defenses based upon the Superintendent's conduct as regulator have been the subject of litigation, courts have been faced with counterclaims by defendants against Superintendents for their action or non-action in their role as Regulator. On this issue, the courts are in agreement as a number of states, including Pennsylvania,¹⁷ Ohio,¹⁸ North Carolina,¹⁹ and Illinois,²⁰ have applied the court's ruling in *Ideal* and held that because the Superintendent as court-appointed Liquidator is a legal personality separate and distinct from this Superintendent in his previous role as regulator, defendants cannot pursue counterclaims in lawsuits by the Liquidator based upon the Superintendent's role as regulator.

Applicability of Deliberative Process Privilege

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States have disagreed, however, as to whether the Superintendent of Insurance, when acting as Liquidator, may claim the deliberative process privilege to protect information pertaining to actions that occurred while the Superintendent was acting in his regulatory capacity. For those states that recognize a deliberative process privilege, the privilege permits the government to withhold documents from discovery that contain confidential deliberations of law or policymaking that reflect opinions, recommendations, or advice.²¹

In *Ario v. Deloitte & Touche*, Reliance Insurance Company was placed into liquidation in Pennsylvania and the Superintendent was appointed as Liquidator. When the defendants sought to discover certain information, the Liquidator asserted the deliberative process privilege.²² The Pennsylvania court held because a governmental entity acting in one capacity is treated as a separate entity when acting in another capacity, the privilege applied to information pertaining to events that occurred during the decision making process while the Superintendent was acting in her regulatory capacity and to information related to the Superintendent's regulatory conduct.

When faced with a similar issue, however, in the Integrity Insurance Company liquidation, the Supreme Court in New Jersey found that the Superintendent acting as Liquidator could not claim the deliberative process privilege to prevent discovery.²³ The New Jersey Supreme Court held that the deliberative process privilege is inapplicable if the person asserting it is not performing a governmental function. The court found that the Superintendent as Liquidator functions, at least in part, in a private role. His fiduciary responsibilities are to the creditors of the insolvent insurer, not to the public at large. Because the insurance business affects the public interest, the Superintendent "functions in a hybrid status, part public and part private, when he oversees the liquidation of an insolvent insurer." Therefore, the court found the Superintendent was not performing a purely governmental function and the deliberative process privilege was inapplicable.

Is the Superintendent or the State the Real Party In Interest?

States also disagree as to whether the State or the Superintendent is the real party in interest when the Superintendent brings a claim in his role as Liquidator. Resolution of the real party in interest issue often determines, among other issues, the availability of federal court jurisdiction, the application of estoppel principles, whether there is a bond requirement, and the applicability of public records laws.

In *Crawford v. Employers Reinsurance Corp.*, the Superintendent, in his capacity as Liquidator of MCA Insurance Co., brought an action against Employers Reinsurance Corp. asserting that the defendant breached treaties of reinsurance entered into between it and MCA, prior to MCA being placed into liquidation.²⁴ The Superintendent moved to remand the action to state court on the theory that diversity of citizenship was not present. The court held that the Superintendent initiated the action to enforce a contract against the defendant in his capacity as Liquidator for MCA, not as a state official seeking to assert or protect significant state interests. The court found that the Superintendent, as Liquidator, not the state of Oklahoma, was the real party in interest for purposes of determining diversity and therefore found that diversity was present.

Courts in Texas and Louisiana, however, have held that when the Superintendent brings a claim while functioning as the Liquidator, the state is the real party in interest. In *El Paso Electric Company v. Texas Dept of Ins.*, the issue was whether a claim prosecuted by the Liquidator was a claim by a state agency within the meaning of Chapter 105 of the Texas Civil Practice and Remedies Code which allows a litigant to recover fees and expenses when a state agency brings a frivolous claim.²⁵

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The court held that even assuming that the Liquidator assumes a separate legal identity upon being appointed receiver for an insolvent insurer, the Liquidator acted on behalf of the State, and therefore the Liquidator's conduct was subject to the Texas statutes. Key factors in making that determination were the lack of discretion a court has to appoint someone other than the Superintendent or the Superintendent's designated special deputy as Liquidator and the fact that the Superintendent controls the activities and compensation of any special deputy receivers that are appointed.

In *Louisiana v. Preferred Accident Insurance Co.*, the Louisiana Court held that proceedings against the Liquidator were against a state official, and therefore the Liquidator did not have to furnish bond on appeal.²⁶ The Louisiana court found that because the Superintendent alone may be appointed ancillary receiver or Liquidator of an insurance company, and the duties of the Liquidator are part of the duties of the Superintendent charged with the administration of the Insurance Code, that the Liquidator acts as an officer of the state in a public capacity, and therefore, that the proceedings were against a state official.

In many instances, the issues discussed above should be eliminated if the Superintendent of Insurance is not appointed the Liquidator and instead a private party takes over that function. On the other hand, that does not mean there will necessarily be less litigation. In fact, if the Liquidator is an independent third-party, we can probably expect a number of cases where a private party Liquidator will file a complaint against the Superintendent in his role as regulator based upon some variation of a theory of negligent regulation or otherwise causing or permitting the insurance company to become insolvent.

Analysis of Arguments Supporting the Dual Role

Although there are several arguments in favor of the Superintendent also being the Liquidator that appear to have merit on their face, upon analysis, most of them are not necessarily valid.

- The Superintendent of insurance is a public official, and therefore is accountable to the public. The fallacy of this argument is that once a company is placed into liquidation, while the liquidation may in theory occur "publicly," in reality, almost everything occurring after the liquidation order is beyond the public eye. Insurance liquidations are complicated, very slow moving and uninteresting, which means both the press and the public lose interest in following them.
- Insurance departments are well versed in the insurance business and have a lot of experience to draw upon. While that statement is hopefully true in every state, the liquidation of an insurance company is not the business of insurance. The Liquidator marshals and then liquidates assets, pays claims and pursues litigation against creditors and wrongdoers. The only aspect that has much to do with the insurance business is the payment of claims, which in most instances is actually done by the insurance guaranty associations, not the Liquidator. Running an insurance liquidation is a management and administrative process, not a regulatory function.
- The Superintendent does not receive any additional compensation for serving as the Liquidator, whereas utilizing a third-party would involve additional compensation, making the liquidation more expensive. That statement is true in part, but misleading since Superintendents are otherwise fully occupied and do not have time to run liquidations themselves. As a result, they must either hire additional state employees or subcontract with independent contractors. It is very unlikely there is any real cost savings by having the Superintendent be the Liquidator.
- A third-party Liquidator would have an incentive to drag out a liquidation to continue his own source of income. While this argument could be true not only in theory but also in fact, there are dozens of

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well respected and competent independent consultants to manage liquidations and, thus, there will be no shortage of finding "good people" who will perform their duties responsibly. At the same time, the fact is that most liquidations take many years to close. Based just on how long liquidations take, there appears to be very little incentive for Superintendents that are Liquidators to bring estates to a close as soon as possible.

Arguments Supporting Having an Independent Party Serve as Liquidator

The Superintendent may have a conflict of interest

In many situations there is an inherent conflict of interest between the Liquidator and the regulator if the same person has those separate and distinct roles, although, of course, at different times. It is unrealistic to expect that the same person acting in one capacity will act completely independent of his role in the other capacity. This conflict becomes obvious in situations where the Liquidator sues former directors and officers of the insurance company for negligence and they raise a defense based upon the regulator's own conduct. If the Superintendent is the Liquidator, then in his role as Liquidator, he has to defend his own conduct when he was acting in a different capacity, that of regulator.

Moreover, in states where sovereign immunity has been waived, conduct by the Superintendent as regulator may deserve scrutiny and justify a claim against the Superintendent. How can the Superintendent acting as Liquidator bring a claim against himself for action or non-action he should have taken when he was the regulator?

A large part of the Liquidator's responsibilities is pursuing claims for debts owed to the estate. In some instances, another insurance company is a large debtor of the estate. In situations where that insurance company debtor is a domestic insurance company, another conflict of interest situation may arise because, although in the role as Liquidator the Superintendent wants to vigorously pursue the claim, he is not going to want to put his own domestic insurance company in peril financially and maybe cause another domestic insurance company liquidation. Looking at another side of the same situation, will that company really want to take on its domestic regulator and aggressively defend its position?

Reinsurance is usually the main asset of an insurance company liquidation and pursuing reinsurance claims is a prime responsibility of the Liquidator. Many of the larger insurance companies act as reinsurers and thus may be a target of a Superintendent acting as Liquidator. Even in situations where the insurance company which is a reinsurer is not a domestic, the Superintendent as Liquidator can use his power and authority as regulator of that insurance company to directly, or indirectly, put undue pressure on the reinsurer to settle a claim.

In addition to the conflict of interest when the Superintendent serves in the dual role as regulator and Liquidator, there are a number of other arguments supporting using an independent third-party as the Liquidator. These include:

- Superintendents who serve many years are the exception. Liquidations take many years, often even more than a decade. Very few Superintendents serve in that position for more than a few years, particularly those that are appointed, and therefore, a new Superintendent and his senior staff must be brought up to speed before major decisions can be made, such as deciding whether to initiate lawsuits

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or settle those that are pending. This is inefficient and leads to many delays which means more expense.

- Potential economies of scale. In states that do not have many liquidations pending at the same time, the cost of staffing liquidations will generally be higher than it would be if the claims manager or the reinsurance expert in-house can be utilized on several liquidations at one time. Liquidations are almost always done within the state of domicile's boundaries. Permitting a private party with considerable experience in liquidations to handle a number of smaller liquidations in different states at the same time would be more efficient and less expensive.
- Limiting Political Considerations. Since Superintendents are public officials, it would be naive to think that politics do not play a role in many of the Liquidator's decisions. While liquidations generally operate in the dark, many a politician is going to try to make sure that if specific decisions do come to light, he, or the Governor that appointed him, will be perceived as having made good decisions. In contrast, an independent party serving as Liquidator should be making decisions about whether to bring litigation or settle litigation based upon a cost-benefit analysis, without regard to any political ramifications.
- Liquidations require different experience and skills than regulating insurance companies. The role of the Superintendent as regulator is to protect the public, particularly policyholders, by regulating the insurance industry. Insurance regulation involves primarily risk assessment of insurance companies' financial condition and monitoring the performance of insurance companies and insurance agents in the marketplace. In contrast, in a liquidation, the Liquidator's objective is to protect creditors of the estate, not the public. Therefore, the risk assessment relates to the assessment of claims, which is something the Superintendent does not do as a regulator. The functions of the Liquidator in marshalling and liquidating the assets are totally different from the actions of the Superintendent as regulator. There are no true consumer protection activities taken in liquidations. Instead, the guaranty associations established in each state are the ones that protect the policyholders.
- Acting as Liquidator distracts the Superintendent from his primary role as regulator. With some of the large insolvencies over the last several years, there is no doubt that some Superintendents and their staff have been spending an inordinate amount of time in their role as Liquidator, taking away from their time as regulator. Insurance department staffs have been taxed by some of the larger insolvencies or the number of insolvencies of domestic insurance companies, again taking time away from their roles as regulators.
- There is a large pool of excellent people that are experienced in this type of work. Although in some situations, it would still make sense for the Liquidator to be the Superintendent, depending upon a number of factors including the potential for conflicts of interests, the size of the estate, the issues likely to arise in the liquidation estate, the amount of time that appears necessary to handle the estate and the short-term and long-term staffing of the insurance department in terms of both experience and availability, in those instances where it makes sense to have someone other than the Superintendent be the Liquidator, there are a good number of experienced people working in the private sector that are very competent and experienced in insurance liquidation. They include accountants, actuaries, attorneys, former insurance company executives and former insurance department superintendents or liquidation bureau officials. Most of these people are very well known to the industry and particularly the trade associations such as the National Conference of Insurance Guaranty Funds and the International Association of Insurance Receivers.

Conclusion

The Superintendent of Insurance should not always be the Liquidator of an insolvent insurance company. Insurance liquidation statutes should be amended so that consideration can be given on a case-by-case basis to appointing an independent party with sufficient experience and expertise to manage the liquidation process.

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Courts should have the freedom to appoint an independent party as the Liquidator in the appropriate circumstances which should lead to increased efficiencies, better run liquidations and less expense for all parties involved.

* Thanks to Sarah Porter, Esq. for her assistance in the research and writing of this article.

Endnotes

1. Some states refer to the head of its insurance department as "Superintendent" while others use the term "Commissioner." Although the term "Superintendent" is used in this article, it is meant to be interchangeable with "Commissioner."
2. *In the Matter of the Liquidation of Integrity Insurance Company*, 165 N.J. 75, 90 (2000).
3. Rubinstein, Karl L., *The Legal Standing of an Insurance Insolvency Receiver: When the Shoe Doesn't Fit*, 10 Conn. Ins. L.J. 309, 319-20.
4. 322 U.S. 533, 548-39 (1944).
5. See Note 3, *supra*, at 316.
6. 15 U.S.C. § 1011 *et seq.*
7. See Note 3, *supra*, at 316.
8. See Note 3, *supra*, at 317.
9. 15 U.S.C. § 1012.
10. 393 U.S. 453 (1969).
11. 508 U.S. 491 (1993).
12. NAIC Model Laws, Regulations and Guidelines 555-1, § 501.
13. See Note 3, *supra*, at 317.
14. Bickford, Peter H., *Insurer Solvency Regulation; Destroying Myths That Now Surround the Solvency Issue*, Business Insurance, March 18, 1991.
15. 140 A.D.2d 62 (S. Ct. NY 1988).
16. *Covington v. Buckner*, Franklin County Court of Common Pleas, Case No. 98CVH-07-5242, Decision and Entry, June 1, 2000.
17. *Koken v. One Beacon Insurance Co.*, 911 A.2d 1021 (Commw. Ct. Pa. 2006); *Foster v. Monsour Med. Foundation*, 667 A.2d 18 (Commw. Ct. PA 1995).
18. *Benjamin v. Ernst & Young*, 167 Ohio App.3d 350 (Ohio Ct. App. 2006).

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19. *North Carolina v. Alexander & Alexander Services, Inc.*, 711 F.Supp 257 (E.D. N.C. 1989).
 20. *Williams v. Continental Stock Transfer & Trust Co.*, 1 F.Supp.2d 836 (N.D. Ill. 1998).
 21. *Ario v. Deloitte & Touche*, 934 A.2d 1290 (Commw. Ct. Pa. 2007).
 22. *Id.*
 23. *In the Matter of the Liquidation of Integrity Insurance Company*, 765 A.2d 1177 (S. Ct. N.J. 2000).
 24. 896 F.Supp 1101 (W.D. Okla. 1995).
 25. 937 S.W.2d 432 (S.Ct. Tex. 1996).
 26. 115 So. 2d 384 (S.Ct. LA 1959).
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NEW HAMPSHIRE EXTRA-TERRITORIAL AND EXPANDED APPLICATION OF GROUP HEALTH MANDATES

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The New Hampshire Insurance Law provides the basic framework for the Department's authority. The Insurance Law provides that no accident or health policy may be issued in New Hampshire until the policy form and rates have been filed with and approved by the Commissioner of Insurance. ¹The Commissioner has broad authority to disapprove filings that he determines to be inconsistent with the Insurance Law. Specifically, the Commissioner may disapprove any form if he finds that: (1) the benefits are unreasonable in relation to the premium charged; (2) it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation; or (3) it does not comply with the requirements of law. ²All accident and health policy forms, regardless of coverage, must meet certain requirements and include certain provisions. ³ Within the confines of these broad grants of power, however, the Department has significant discretion to determine the scope of its authority.

I. Accident, Travel and Other "Limited Benefit" Policies

New Hampshire Insurance Law requires the Commissioner of Insurance to establish minimum standards for benefits for accident and health policies, including accident only and limited benefits policies. ⁴ The Commissioner has adopted regulations that provide minimum standards for each type of policy. ⁵ An "accident only" policy is one that "provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident." ⁶ A "limited benefits" policy is one that provides coverage, other than specified disease coverage, whose minimum benefits are less than that provided by any other medical benefits coverage described in the regulation. ⁷ The minimum benefits regulation does not provide a standard for "travel insurance," but "travel insurance" has historically been regarded as a particular

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type of accident coverage. ⁸ These limited coverages are distinguished from more comprehensive medical coverages, such as basic medical or hospital, major medical, etc.

Notwithstanding the seemingly clear distinctions made in the regulation between accident policies, limited benefit policies, etc. and more comprehensive coverage, the Department has begun taking stances that blur the lines between these different coverages and, in some cases, erase the distinctions altogether. For example, the Department has taken the position that various types of accident-only coverage must include all of the mandates and benefits for comprehensive group coverage. This position appears to be inconsistent with the nature of accident-only coverage, which provides coverage for medical expenses only incidentally (i.e., coverage is provided only to the extent expenses are the result of an accident covered by the policy). Similarly, the Department has repeatedly denied that insurers have the authority to offer a medical benefits policy that offers less coverage than other basic or comprehensive policies, despite what appears to be express authority for this type of coverage in the insurance regulations.

These regulatory trends have potentially far-reaching consequences for New Hampshire insurers. If the Department continues to take the position that any policy containing medical benefits must include the group health mandates, it may be more difficult for insurers to get traditional non-medical policies approved or to get them approved without accepting significant new coverage burdens. In addition, this development could limit the flexibility of insurers to offer new types of policies in New Hampshire. Furthermore, the Department could theoretically take the position that existing policy forms, (i.e. travel, sports policies) need to be amended to include the required mandates. It is still unclear the extent to which the Department will impose the mandates, and to what degree the facts and circumstances of a specific case will be relevant; however, these changes could radically alter the landscape for these types of insurance in New Hampshire.

II. Extraterritorial Application of New Hampshire Insurance Laws

Group medical insurance policies often provide coverage to residents of more than one state. For example: (1) an employer with a place of business in one state employs individuals who reside in another state; (2) an employer who has offices in multiple states purchases a single group medical policy covering all of its employees, wherever located; or (3) an association obtains a group master health insurance policy that is available to the association's employer members and their employees, wherever located. Regulation of such policies by a state or states other than the one in which the policy was issued may impose various practical problems (e.g. competing, inconsistent requirements) on insurers and employers.

For many years, the Department did not seek to enforce New Hampshire group health insurance laws in any of the situations identified above. However, the Department has recently indicated its intent to begin applying the group health rules to policies issued in other states that insure New Hampshire residents whose principal place of business is also in New Hampshire. If the Department does in fact take this step, it will represent a significant change in enforcement policy. Because this represents a significant change, it seems unlikely that the Department would punish past conduct; but compliance in the future would be required.

The Department's authority to apply its rules extraterritorially stems largely from several statutory provisions. For example, RSA 415:18, which dictates the provisions that must be included in a group health insurance policy, provides as follows:

No policy of group or blanket accident or health insurance, or accident and health insurance affecting a resident of New Hampshire, whether such policy is delivered or issued for delivery in this state or any other state, and no certificate thereunder shall . . . be delivered or issued for delivery in this state unless the policy or certificate contains in substance each and all of the provisions set forth in the following subparagraphs or provisions which in the opinion of the commissioner are more favorable to the holders of such certificates or not less

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favorable to the holders of such certificates and more favorable to policyholders.

The italicized language above suggests that this provision applies to policies wherever issued so long as they "affect" a New Hampshire resident. This interpretation is supported by the legislative history, which indicates that this language was added to resolve any doubts regarding the Department's authority to regulate out-of-state group health policies. ⁹ Several provisions mandating certain types of coverage in group health policies also suggest authority for extraterritorial application; by indicating that the coverage shall be provided to the portion of any group that consists of New Hampshire residents principally employed in New Hampshire. ¹⁰

Although there is at least one provision of the New Hampshire Insurance Law that appears to undermine the authority of the Department to apply its rules extraterritorially¹¹, the caselaw in New Hampshire generally supports the application of New Hampshire law to out-of-state policies where there is some connection to New Hampshire. Specifically, in two cases decided on the same day, the New Hampshire Supreme Court upheld the application of New Hampshire's mental health parity law to policies issued in other states. ¹² In addition, the New Hampshire Supreme Court has held more generally that an agency interpretation of an ambiguous statute that the agency is charged with interpreting is entitled to substantial deference. ¹³ As such, the Department would be entitled to deference in interpreting its authority under the Insurance Law.

Despite the Department's apparent authority to apply its rules to out-of-state policies, the Department has not sought to apply the group health rules extraterritorially for at least a decade, and probably longer.¹⁴ As noted above, this then represents a significant shift in Department policy. This change could potentially have a significant impact on employers and associations who purchase a single policy to cover employees working in New Hampshire and other states, because those groups will now have to comply with the insurance laws in at least two states. The impact will likely be greater now than a decade ago, as single policies covering workers in multiple states have become more common. Furthermore, there is reason to believe that other states in the region might follow New Hampshire's lead. ¹⁵ Although the Department has yet to set forth a clear policy statement on this issue, there is no question that any change in this regard will present insurers with new challenges and will change the way in which employers insure employees who are employed both in New Hampshire and other states.

III. New Hampshire's Civil Union Law

The New Hampshire Legislature passed, and the Governor signed, the New Hampshire civil union law in 2007, which became effective on January 1, 2008. ¹⁶ The law allows same sex couples to enter into civil unions that confer the same rights and obligations on them as married couples. Although the statute itself is not detailed, the fact that it confers the same rights on civil unions as marriages has far-reaching consequences. One sphere that is affected is the insurance market, particularly health insurance.

As of the effective date of the law, all insurance policies were automatically amended to comply with the civil union law by providing the same benefits to partners in a civil union as to those that are married. ¹⁷ In other words, any policy that provides benefits to a spouse must now also provide the same benefits to a partner in a civil union. In addition, all new policy forms and all renewals must be amended to provide such equal benefits.¹⁸ COBRA coverage is also available to civil union partners on the same basis as married couples, and a partner terminating a civil union is entitled to the same benefits under law as a divorced spouse. ¹⁹ Civil union partners are allowed to enroll on a special basis, within 30 days of entering into the civil union.²⁰ These requirements do not apply to self-insured ERISA plans, but they do apply to civil unions entered into in other states as long as they comply with the New Hampshire civil union law. ²¹

Although the civil union law does not represent a regulatory shift at the Department level, it constitutes a significant regulatory expansion nonetheless. The law also incorporates some of the same themes as the first

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two categories discussed. First, the law requires insurers to include coverage that they were not previously required to offer. Second, the law requires New Hampshire insurers to recognize civil unions entered into in other states (and presumably would be interpreted to require out-of-state insurers offering policies or covering subscribers in New Hampshire to recognize New Hampshire civil unions). As such, the civil union law constitutes another example of the expanding regulatory role of the Department.

IV. Conclusion

The ultimate impact of the changes discussed above remains to be seen. With the exception of the civil union law, which imposes an express statutory mandate, much is dependent on the regulatory path that the Department chooses to follow. The Department has provided little, if any, guidance on how it interprets its authority in these areas or what insurers can expect in the future. Given the absence of Bulletins or other formal policy statements on these issues, it is not inconceivable that the Department could backtrack or reverse course entirely without notice. Even in the context of the civil union law, where a Bulletin has been issued, there remain questions about how some aspects of the law will be implemented (e.g., the application to out-of-state policies insuring New Hampshire residents).

However, notwithstanding the lack of guidance, in practice the Department has clearly demonstrated its intent to expand the scope of its regulatory authority in the ways discussed above. Therefore, barring indications from the Department to the contrary, insurers must prepare for the consequences of operating within this new regulatory framework.

Endnotes

1. N.H. Rev. Stat. Ann. ("RSA") § 415:1.
2. RSA § 415:2.
3. RSA §§ 415:5; 415:6.
4. RSA 415-A:3.
5. N.H. Code Admin R. Ann. Ins 1900 ("Ins 1900").
6. *Id.* at 1901.06(i).
7. *Id.* at 1901.06(l).
8. Couch on Insurance § 1:47 (3rd Ed.).
9. See Hearing on HB 361 Before the S. Comm. on Insurance, pg. 2 (1986) (indicating that the new language was added to clarify that the Department has the authority to regulate out-of-state policies to the extent they cover New Hampshire residents).
10. See, e.g., N.H. Rev. Stat. Ann. §§ 415:18-a; 415:18-c; 415:18-d (similar language is used in the corresponding HMO provisions).
11. RSA 415:23, I provides that any insurer doing business in New Hampshire is presumed to be subject to the jurisdiction of the Department unless it can show that while providing the services in question it is subject

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to the jurisdiction of another agency of New Hampshire, another state or the federal government (e.g., an insurer subject to the jurisdiction of a foreign state where the policy is issued).

12. *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894 (1979); *New Hampshire-Vermont Health Service v. Whaland*, 119 N.H. 886 (1979).

13. See, e.g., *In re Weaver*, 150 N.H. 254, 256 (2003); *New Hampshire Dep't of Rev. Admin. v. Public Employee Labor Relations Bd.*, 117 N.H. 976, 977 (1977).

14. The last concerted effort by the Department to do so was in the late 1970's and early 1980's when it sought to apply the mental health parity mandates extraterritorially, as evidenced in the *Metropolitan Life* and *New Hampshire-Vermont Health Service* cases at Note 12.

15. There is some evidence that Massachusetts is beginning to apply its insurance laws more broadly to out-of-state policies. In addition, other states may feel pressure to do so, even if not otherwise so inclined, in response to such a trend in a neighboring state.

16. RSA 457-A.

17. Insurance Department Bulletin, Docket No.: INS 07-088-AB.

18. Id.

19. Id.

20. Id.

21. Id.

TOP 10 INTERNET RESOURCES FOR INSURANCE REGULATORY COUNSEL

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A. Introduction

The Call. The call comes late Friday afternoon (as always). “We need to know by Monday which states require in house insurance adjusters to be licensed. You can do that, right?” We’ve all gotten that call or some version of it. The dreaded “50-State Insurance Survey” – both the boon and bane of the insurance regulatory attorney’s existence. The answer to the client is invariably “of course” (followed by a muttered “expletive deleted” after hanging up). The challenge, however, is how to efficiently and accurately answer a question that requires a review of at least 50 plus different sources of law. This article reveals some of the author’s favorite Internet websites to answer these multi-state insurance issues, some of which are otherwise good general sources of insurance regulatory information.

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The Challenge. Insurance, as most know, is regulated at the state level. While strides have been made over the past decade to improve uniformity among state insurance laws (e.g., producer licensing), there is still a wide disparity in how states regulate the business of insurance. This regulatory landscape presents a challenge to insurance regulatory counsel, both corporate and law-firm based, in advising clients on state regulatory requirements in particular on multi-state issues. While such multi-state issues can be answered by a traditional “hit the books” method, such an approach is often tedious and generally impractical – I for one do not have copies of Montana insurance statutes lying about my office – no offense to my Montana colleagues.

The Resources. The Internet is a wonderful resource for information – vast, vast amounts of information. Google “insurance adjuster licensing requirements” and you come up with 146,000 “hits.” None of us has the time to parse through that much information. Thankfully, over the years a number of websites have developed into good to excellent repositories of information in answering insurance regulatory issues as well as serving as general sources of news and information on the insurance industry. Below is my personal “Top 10” list, plus a couple of honorable mentions, of such sites.

B. The Top 10 List (drum roll please . . .)

Honorable Mention

The Site: National Conference of Insurance Legislators (NCOIL)

Link: <http://www.ncoil.org/>

Free or Pay Site: Free (but restricted access to certain content)

Critique: NCOIL, like the NAIC, develops model insurance legislation and monitors a variety of insurance issues. If you are looking for an NCOIL model, their website is a good place to start. The site also has some interesting reports on an array of insurance related subjects. On the down-side an increasing amount of information on this site is now restricted to NCOIL members.

Honorable Mention

The Site: National Association of Mutual Insurance Companies (NAMIC)

Link: <http://www.namic.org/>

Free or Pay Site: Free (but restricted access to certain content)

Critique: NAMIC's site includes a good array of position papers, updates, and state-specific legislative summaries. It also contains some 50-state analyses of insurance compliance matters. The best content is reserved for member companies.

Honorable Mention

The Site: State Insurance Department Websites

Link: http://www.naic.org/state_web_map.htm

Free or Pay Site: Free

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Critique: The link is actually to the National Association of Insurance Commissioner's (NAIC) website which, in turn, has a handy map with links to every state insurance department website. A 50-state survey is generally not complete without some reference to states' insurance department websites. Many Department websites include a host of potentially useful information (not found in statutes or regulations) for companies and counsel, including notices, filing checklists, holding company transaction requirement summaries, etc. The principal challenges with most state websites is hunting down the information (generally the site search engines are not very useful) and, of course, looking at 50 different websites that all have their own unique designs and layouts.

No. 10

The Site: Yahoo Insurance News

Link: <http://biz.yahoo.com/n/y/y0017.html>

Free or Pay Site: Free

Critique: Up to the minute insurance related stories. If you have a personal Yahoo home page, you can add insurance news as a module. More than once, I have seen an article concerning a client come across the wires before the client has seen or heard the news.

No. 9

The Site: Google

Link: <http://www.google.com/>

Free or Pay Site: Free

Critique: While "Googling" a subject generally results in a ton of "hits," many times you can hit pay dirt and find exactly what you are looking for among the first few sites listed. For example, Google "insurance capital and surplus requirements" and one of the first three hits is an excellent NAIC chart with the requirements for all 50 states.

No. 8

The Site: Advisen

Link: <http://fpn.advisen.com/>

Free or Pay Site: Digest Edition is free (requires registration); Pay for Professional Edition Access

Critique: Advisen is one of several insurance-dedicated services that can deliver daily email news updates concerning the industry. In addition, the Advisen site has an excellent "in-depth" briefing section on current hot insurance topics (e.g., sub-prime, finite re, etc.). The website also has a wealth of other insurance research tools. The Professional Edition is well-worth the modest cost.

No. 7

The Site: AM Best Insurance Law Digest

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Link: <http://www.ambest.com/legal/statelawdigest.html>

Free or Pay Site: Free

Critique: AM Best's Law Digest provides general summaries of the insurance laws for each state and the Canadian Provinces. The summaries are prepared by law firms and cover state law (including case annotations) on a large number of topics. Some of the summaries do not appear to have been updated recently.

No. 6

The Site: National Conference of Insurance Guaranty Funds (NCIGF)

Link: <http://www.ncigf.org/>

Free or Pay Site: Free (but restricted access to certain content)

Critique: If you have a multi-state issue relating to insurance insolvencies or guaranty funds laws, this is the site for you. The NCIGF has put together some excellent charts summarizing these various areas on a state-by-state basis.

No. 5

The Site: Legal Information Institute at Cornell Law School

Link: <http://www.law.cornell.edu/>

Free or Pay Site: Free

Critique: A solid, top-notch general source of legal resources, including laws and regulations for all 50 states. The site also has an insurance specific section. If you need to look at the law of another state and do not want to pay WestLaw or Lexis charges, then this is your site.

No. 4

The Site: NAIC Consumer Information/Company Search

Link: <http://www.naic.org/cis/>

Critique: A good source of basic information on insurance companies, including consumer complaints, market conduct reports, and financial information. You can download complete copies of a company's financial statements over the last five years (you get the first five statements for free; after that there is a charge). More than once, this site has proven to be a life-saver in tracking down the financial statement of an insurer in a short amount of time.

No. 3

The Sites: Westlaw and Lexis

Links: <http://web2.westlaw.com/>, <http://www.lexis.com/>

Free or Pay Sites: Pay

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Critique: Two well-known online legal research companies. In the last year, both Westlaw and Lexis have rolled out 50 State Regulatory Surveys which include a number of general insurance areas. Thus far, we have found the surveys to be well done and incredible time savers. As noted, the surveys cover some common insurance topics (e.g., licensing, advertising, policy grace periods, etc.). They don't include more esoteric issues – which invariably are the subject of the 4PM Friday call from the client. Another big note of caution, the surveys are generally pretty expensive.

No. 2

The Site: NAIC Uniform Certificate of Authority

Link: http://www.naic.org/industry_ucaa.htm

Free or Pay Site: Free

Critique: Buried within the NAIC's Uniform Certificate of Authority Application (UCAA) website are a number of 50-state charts, including capital and surplus requirements, statutory surplus requirements, name approval procedures, application fees, and other state-specific licensing requirements. If you are engaging in a multi-state licensing project of Form A filing, this site should definitely be reviewed.

No. 1

The Site: National Portal for Insurance Regulatory Information

Link: <https://external-apps.naic.org/NBP/Basic.jsp>

Free or Pay Site: Free

Critique: This is a relatively new search engine found within the NAIC's website. Think of it as a Google for insurance law. The search seems to pull primarily from the NAIC and state insurance websites. Using the search engine takes some practice, but overall this is a great source of insurance regulatory guidance on a wide array of issues and saves you the time and trouble of searching 50+ different websites.

REORGANIZATION OF MULTIPLE INSURANCE AGENCIES

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Since its adoption by the National Association of Insurance Commissioners, the Producer Licensing Model Act (PLMA) has been enacted in approximately three-quarters of the states. Although it has been adopted in various forms, it has influenced the way that insurance agents and agencies navigate the regulatory minefield.

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In addition, it has opened the way for many multiple agency organizations to reorganize their licensing in order to simplify their overall structure. The following article includes a general description of the background of the PLMA and offers a few suggested considerations for insurance agencies and holding companies that may be thinking about reorganizing their corporate structures and insurance licensing in a manner consistent with the PLMA.

I. The Producer Licensing Model Act - Background

Over the past half-century, state insurance departments have regulated insurance agency licensees in various ways. Early during this period, each state developed its own laws, regulations, and "desk drawer rules" that made each state's licensing unique. For insurance agencies carrying a book of business that stretched across the country, the rules were difficult to follow with any accuracy. In response, many holding companies and owners of insurance agencies formed or acquired a separate corporate agency within each desired jurisdiction in order to conduct business. Over time, these variances in state insurance laws underscored the fact that one of the only consistent characteristics of nationwide insurance agency licensing was that it was inconsistent. Adhering to these variances and many others created a regulatory maze that was unworkable.

In response, the NAIC sought to reduce the number of disparities among state insurance licensing laws by focusing its attention on the development of model legislation that would encourage greater uniformity among the states. The result was the PLMA, which the NAIC adopted in 2000. Aside from the development of uniform applications for insurance licensing, one of the principle innovations of the PLMA was the establishment of a system whereby an insurance producer (i.e., an individual agent or an agency) 1 could obtain a resident license in his/her/its home state 2 and a nonresident license in all other states in which he/she/it will first and foremost transact insurance business. This innovation had the effect of requiring an entity to conform only to the state licensing requirements of the state constituting its principal place of business rather than the full array of licensing requirements of all states in which it planned to conduct business. Accordingly, pursuant to the PLMA, an insurance agency could adopt a more typical corporate structure while still permitting it to do business on a nationwide basis.

Today, many licensed agency groups remain organized as if the PLMA had never been adopted. Oftentimes, a parent corporation (sometimes it may be an insurance company) serves as owner of several subsidiary corporate agencies that are legally incorporated in different states and with each corporate subsidiary agency holding a separate resident insurance license. This organization includes many different entities operating under various federal employer tax identification numbers (FEIN). As such, one can see the organizational complexities that come into play. The corporate annual filings are difficult to track and manage due to the wide array of FEIN numbers, and one can only imagine the undesired internal accounting issues presented by multiple subsidiary corporate agencies. Moreover, the insurance licensing is needlessly complicated by the fact that each FEIN must be matched to each agency license in order to perform license renewals and other record maintenance. In view of these complexities and the recent changes provided by the PLMA, corporate agencies increasingly are reorganizing their current corporate structure into a simpler and more workable organization.

Perhaps the biggest disincentive to undertaking such a reorganization is the specter of converting all company appointments and agent affiliations to a new FEIN and insurance license. However, there are ways to simplify this process. The following section offers a detailed analysis and description of a method for effecting a reorganization of a corporate structure involving wholly-owned corporate insurance agencies.

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II. A Suggested Plan for Reorganizing an Insurance Agency's Corporate Structure - A Hypothetical Scenario

As noted above, given the multi-jurisdictional nature of insurance regulation, a number of businesses have established myriad corporate agencies under varying FEIN's and legal domiciles over time. Pursuant to the new PLMA, however, these businesses now have the opportunity to consolidate their corporate agency structure in order to achieve greater corporate efficiency. While such reorganization is not required by the PLMA, it is a characteristic that most nationwide existing agencies should find worthy of welcome.

As one might suspect, agency licensing is multifaceted and an explanation of it can quickly spin out of control. Therefore, for the sake of this discussion, we will employ the use of a hypothetical scenario that explains the intricacies, lesser-known details, and observations pertaining to the world of producer licensing. Due to formatting limitations, we are unable to produce diagrams for the reader's use; however, we would entreat you to diagram the corporate structure involved in order for the discussion to remain cogent.

Let us assume that ABC Insurance Agency, Inc. was incorporated in 1962 under the laws of the State of X where its offices and principal place of business are also located. Its immediate parent and sole owner is Holding Company, Inc., and Holding Company, Inc. is wholly owned by Ultimate Parent, Inc. As its business developed and the value of ABC Insurance Agency, Inc.'s business activity grew in State X, Holding Company, Inc. determined that it should broaden the agency's focus and develop a regional marketing program encompassing seven additional states (State A, State B, State C, State D, State E, State F, and State G). Accordingly, Holding Company, Inc. began establishing and acquiring new corporations in the expanded region. In States A, B, C, and D, Holding Company, Inc. acquired Agency 1, Agency 2, Agency 3, and Agency 4, all of which were separate corporate entities. In States E, F, and G, Holding Company, Inc. utilized the existing FEIN for ABC Insurance Agency, Inc. and obtained a nonresident license in those states. By 1985, the goal of licensure in all eight states (including its home state of State X) was fully realized, and Holding Company, Inc. was then operating in its desired eight-state region (i.e., State X and States A, B, C, D, E, F, and G). However, the corporate structure was such that Holding Company, Inc. owned five corporate entities: ABC Insurance Agency, Inc., Agency 1, Agency 2, Agency 3, and Agency 4, which hold the eight insurance licenses among them as to each of the eight states.

In 2008, and in the wake of the adoption of the PLMA, Ultimate Parent, Inc. is now committed to streamlining its organizational structure. In so doing, it is committed to consolidating ABC Insurance Agency, Inc., Agency 1, Agency 2, Agency 3, and Agency 4, with the resulting entity being ABC Insurance Agency, Inc. In addition, it desires to place the resulting agency (ABC Insurance Agency, Inc.) under its immediate control, which will require the removal of Holding Company, Inc. from the organizational structure. In essence, Ultimate Parent, Inc.'s insurance operations will go from a complex, three-tiered structure to a simple two-tiered structure whereby the surviving agency (ABC Insurance Agency, Inc.) exists as a resident insurance licensee in State X (the home state) and with nonresident insurance licenses in States A, B, C, D, E, F, and G. Naturally, Ultimate Parent, Inc. intends to achieve this reorganization in a manner that allows all insurance operations to continue without interruption.

Step 1: Obtain Nonresident Licenses for ABC Insurance Agency, Inc. in All Desired Jurisdictions While Leaving All Other Licensing in Place. Assuming that Agency 1, Agency 2, Agency 3 and Agency 4 have adopted the DBA name of "ABC Insurance Agency, Inc." in order that they may do business collectively under that name, the first goal is to obtain nonresident licenses for ABC Insurance Agency, Inc. in States A,

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B, C, and D (Note: as noted above, ABC Insurance Agency, Inc. already holds licenses under its FEIN in States X, E, F, and G). Generally speaking, all states now accept the NAIC's "Uniform Application for Business Entity Insurance License/Registration" (available online at http://www.naic.org/documents/committees_d_plwg_busapp.doc). Each state will require ABC Insurance Agency, Inc. to submit the NAIC uniform agency application, a fee, proof that the entity is registered in its home state, and possibly supporting documentation reflecting that the name has been registered with that state's secretary of state. ³In so doing, ABC Insurance Agency, Inc. must list on each application the name and social security number of a designated insurance producer who is licensed in that state on an individual basis and in the same lines of authority for which the agency is applying.

Step 2: Advise the Appointing Carriers of the Consolidation Plan. Because commission flow is a significant factor in any sophisticated insurance agency operation, Holding Company, Inc. should give notice to the appointing carriers for ABC Insurance Agency, Inc., Agency 1, Agency 2, Agency 3 and Agency 4 that its subsidiary insurance agencies are being consolidated into one agency (ABC Insurance Agency, Inc.). If ABC Insurance Agency, Inc. does not already hold appointments that are identical to those held by Agency 1, Agency 2, Agency 3, and Agency 4, then ABC Insurance Agency, Inc. will first need to obtain those appointments in order to ensure proper and uninterrupted commission flow through the corporate reorganization process.

Insurance companies generally organize their commission payment systems by FEIN's and subproducer codes. Each agency is identified by its FEIN, and within each agency, each location might be assigned a subproducer code that facilitates commission flow directly to an agency's alternate locations. This system of compensation is particularly well-suited for agencies that operate multiple locations and desire a more targeted system of compensation that directly compensates each responsible producer's business location rather than requiring processing through a central agency clearinghouse. In view of these considerations, Holding Company, Inc. should include in its letters to the appointing carriers that the FEIN should be changed to that of ABC Insurance Agency, Inc. but that all subproducer codes previously on file for Agency 1, Agency 2, Agency 3, and Agency 4 should be maintained intact. ⁴As long as ABC Insurance Agency, Inc. ends up collectively holding all necessary appointments for the entire agency operation, then the above notice to the appointing carriers, if properly followed, will ensure that payments continue uninterrupted to Agency 1, Agency 2, Agency 3, and Agency 4. ⁵

Step 3: Affiliate Agents to ABC Insurance Agency, Inc. Affiliations are tracked by insurance departments in approximately half of the states. ⁶ An "affiliation" refers to the record kept by an insurance department of the fact that an individual agent represents, or works on behalf of, a particular insurance agency. The states have various procedures for affiliating such individuals, but generally this process requires the agency to submit a form signed by an officer requesting the affiliation of individuals and the payment of a fee.

In our hypothetical scenario, the agents affiliated to Agency 1, Agency 2, Agency 3, and Agency 4 need to be affiliated to ABC Insurance Agency, Inc.'s new nonresident licenses in those states in which he or she will transact business on behalf of the agency (i.e., States A, B, C, or D). Once complete, all of the agents formerly affiliated exclusively to Agency 1, Agency 2, Agency 3, and Agency 4 will be dually affiliated to ABC Insurance Agency, Inc. Accordingly, assuming these individuals are individually appointed where required by state law, they may continue transacting insurance business under either license without interruption.

Step 4: Merge Agency 1, Agency 2, Agency 3 and Agency 4 with and into ABC Insurance Agency, Inc.

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Generally speaking, as compared with dissolution, merger of an insurance agency is a simpler method of eliminating undesired insurance agencies. Merger allows an entity to take advantage of tax free reorganization provisions, which may avoid undesired tax obligations. In some states, it also avoids franchise tax and certain income tax requirements and the additional filings that accompany them. Finally, merger avoids the possibility that certain income distributions would need to be paid as a result of dissolution.

In our hypothetical case, Agency 1, Agency 2, Agency 3, and Agency 4 should now be merged with and into ABC Insurance Agency, Inc. The merger will affect only the corporate identity of the agencies and will not unilaterally affect the licensing aspect. In those states whose secretaries of state require notice of a merger or dissolution involving a foreign business entity that is registered to do business in that state, such notice must be given subsequent to each merger if required by law by both the surviving and nonsurviving entities to the relevant secretaries of state.

Step 5: Surrender Previous Licenses for Agency 1, Agency 2, Agency 3 and Agency 4. In view of the fact that ABC Insurance Agency, Inc. is now licensed in State X (the home state) on a resident basis and States A, B, C, D, E, F, and G on a nonresident basis, the prior resident licenses of Agency 1, Agency 2, Agency 3 and Agency 4, which reflect four separate FEIN's, should be surrendered to the relevant insurance departments in States A, B, C, and D.

Step 6: Merge Holding Company, Inc. with and into ABC Insurance Agency, Inc. As noted above, Ultimate Parent, Inc. desired the elimination of Holding Company, Inc. an intermediate holding company pursuant to the overall corporate reorganization; therefore, Holding Company, Inc. should subsequently be merged downstream with and into its subsidiary, ABC Insurance Agency, Inc. In those states requiring notice of a merger involving a foreign business entity that is registered to do business in that state, such notice must be given to such states' secretary of state or corresponding entity subsequent to the merger if required by law. Upon completion of this final step, ABC Insurance Agency, Inc. will be the sole insurance agency with Ultimate Parent, Inc. as its immediate parent and sole owner. Accordingly, ABC Insurance Agency, Inc. will be licensed and appointed in all desired jurisdictions.

In sum, the legal work involved in successfully accomplishing such a reorganization, without any interruption of business, is far more detailed and complex than one might imagine. Accordingly, such a project, depending on the number of agencies and states involved, could likely take anywhere from four to twelve months to achieve completion.

III. Conclusion

In conclusion, enactment of the PLMA has enabled insurance agencies that have been historically "cobbled together" for various reasons to streamline their corporate organizations in order to achieve greater efficiency. As more and more insurance agencies transacting insurance business nationwide realize the potential and value of such change, it is likely that they will choose to institute such reorganizations. The structure outlined in this article is a suggested reorganization model that achieves the desired change over a period of time without any interruption of business.

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Endnotes

1. "Producer" is the collective term under the PLMA to include agents and agencies. "Insurance producer" is defined as any "person required to be licensed under the laws of this state to sell, solicit or negotiate insurance." See PLMA § 2(D) (2007).
2. "Home state" is defined by the PLMA as "the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer." See PLMA § 2(B) (2007).
3. ABC Insurance Agency, Inc. should confirm that it is registered to conduct business on a foreign basis with the secretary of state of each state in which it plans to obtain a nonresident insurance agency license.
4. We have found that many carriers will require proof that the FEIN has changed. Generally speaking, they require the submission of an IRS W-9 and possibly a carrier-specific form signed by an officer of the agency.
5. It has been our experience that the agency must remain vigilant about maintaining contact with each appointing carrier during this process in order to confirm that each carrier properly effects the requested changes. Many carriers will require answers to follow-up questions. Therefore, in order to avoid confusion amidst these changes, it is imperative that the notice to the carriers be carefully and clearly expressed. We would suggest that such a notice be sent in the form of a letter on agency letterhead so that the recipient is not confused by the sender's request.
6. Some states have alternate terminology for affiliations such as "designations," "members," "associations," or "subagents."

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WTO/GATS Agreement

GATS is The World Trade Organisation General Agreement on Trade in Services. GATS was signed in 1995 and covers international trade in services including the provision of insurance and reinsurance. Signatories included all members of the WTO, which include the U.S. and the EEA Member States.¹

GATS allows services to be provided through a number of methods including "cross-border trade," which is defined as a service provided from the territory of one country into the territory of another. Each GATS signatory has been obliged to make commitments in relation to the relevant services in its jurisdiction that would be opened up to the other signatories. Within the EEA, it has been agreed under GATS that non-EEA insurers, e.g., U.S., Bermuda and Swiss insurers, could provide (as a principal, through an intermediary or as

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an intermediary) marine, aviation and transport insurance (MAT Insurance) and that non-EEA reinsurers could provide reinsurance throughout the EEA on a cross border trade basis.² Non-EEA insurers and reinsurers have also been given the right under GATS to establish a commercial presence in EEA Member States, subject to any terms, conditions and procedures for authorisation in each jurisdiction.

It is also obligatory for GATS signatories to state in their national law any limitations to those commitments. In other words, notwithstanding the principles of freedom of services enshrined in GATS, it remains permissible to apply national law to regulate services, e.g., insurance and reinsurance, for prudential reasons or to ensure the integrity and stability of the financial system, provided that such domestic regulation is administered "in a reasonable, objective and impartial manner."

In relation to the supply of MAT Insurance, a number of specific limitations have been imposed by some other EEA states that limit the ability of non-EEA insurers to provide MAT Insurance in accordance with the cross-border trade provisions of GATS. For example, in Austria, compulsory air insurance can only be provided by an EEA authorised subsidiary or an Austrian branch of a non-EEA insurer. Other Member States simply require notification that business is being conducted in that jurisdiction on a GATS basis.

At the time of GATS negotiations, reinsurance was not regulated in the vast majority of EEA Member States. There were, therefore, in those jurisdictions, very few specific limitations relating to the cross border supply of reinsurance. Some Member States, e.g., Germany, permitted the provision of reinsurance by non-EEA reinsurers on a "correspondence" basis only, that is, no presence or activity in Germany itself (including activity by brokers) and all communication only by correspondence. Other Member States, namely France, Spain and Portugal, imposed collateral requirements on all foreign (EEA and non-EEA) reinsurers.

Some jurisdictions, such as the UK, fully regulated reinsurance at the time of the GATS negotiations. The regulation of reinsurance in the UK (and in certain other EEA Member States) was imposed on the basis that this was permissible under GATS as such regulation is required for prudential reasons or to ensure the integrity and stability of the financial system.

Regulation of Insurance

The EU Insurance Directives³ implemented a regime throughout the EEA for the authorisation and supervision of direct/primary insurers and reinsurers who also carry on insurance business, setting out a minimum set of rules and standards aimed at protecting policyholders, e.g., through minimum solvency requirements. Each EEA Member State has implemented the directives so that an insurer must have authorisation to carry on business in that state or be exempt from the authorisation requirements. GATS provides exemptions to these requirements in respect of MAT insurance.

The insurance directives give insurance companies headquartered in an EEA Member State the freedom to establish a physical presence, e.g., a branch, in other EEA Member States and the freedom to provide services (without establishing a physical presence) in the territory of other EEA Member States where they wish to conduct insurance business. These principles of freedom of establishment and freedom to provide services are two of the so-called fundamental freedoms which are central to the EEA internal market. These freedoms are referred to as "passporting."

Procedures are in place relating to the notification and (in the case of establishing a branch) approval of passporting by the home state regulator. Passporting firms continue to be regulated by their home state regulator, but the host state is entitled to impose "general good" conditions in relation to their business in the host state, that is, domestic rules with which the passporting firm has to comply but which are justified on the basis that they are for the general good.

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Regulation of Reinsurance

The EU Reinsurance Directive applies to pure reinsurers and was required to be implemented by EEA Member States by 10 December 2007. However, not all have done so, including France and Italy. The key provisions include:

- requirement for every EEA reinsurer to be authorised and regulated in the EEA Member State in which it has its head office;
- implementation of an EEA-wide supervisory regime;
- permission for EEA authorised reinsurers to carry on business throughout the EEA under the freedom of establishment and freedom to provide services in the same way as insurers; and
- abolition of collateral requirements for EEA (but not non-EEA) reinsurers (from 10 December 2008).

Non-EEA Insurers and Reinsurers

Now that reinsurance is regulated throughout the EEA, all EEA Member States, although they must consider their obligations under GATS, will, when transposing the Reinsurance Directive, have to impose limitations on the cross border supply of reinsurance as the directive takes precedence over GATS. It is no longer possible for a non-EEA reinsurer to carry on business in an EEA Member State without ensuring that it is doing so in compliance with the local authorisation and regulatory requirements in that jurisdiction. For example, in the UK, the cross-border supply of reinsurance into the UK is only permissible if it does not constitute the carrying on of a regulated activity in the UK.

For those reinsurers operating in EEA Member States which before the Directive did not regulate reinsurance or which had minimal regulation of reinsurance, the impact is likely to be significant. The Directive prohibits non-EEA reinsurers receiving more favourable treatment than EEA reinsurers,⁴ which means that the regulatory burden for non-EEA reinsurers must at least be equivalent to those for EEA reinsurers. The passporting rights set out in the Directive will not be available to non-EEA reinsurers or to branches of non-EEA reinsurers. Furthermore EEA Member States may continue to impose collateral requirements on non-EEA reinsurers and are not required to permit insurance business transfers to or from non-EEA reinsurers (although the UK does permit this).

Regulated Activities in the UK

Carrying on reinsurance business has been regulated in the UK for many years in the same way as insurance business. The rules governing carrying on insurance or reinsurance business in the UK are set out in the Financial Services and Markets Act 2000 (FSMA). The Financial Services Authority (FSA) is the body responsible for the authorisation and supervision of insurance and reinsurance in the UK.

The fact that a policyholder or a risk is situated in the UK does not by itself mean that an insurer or a reinsurer requires FSA authorisation. Rather, the requirement for authorisation is based on the carrying on of a regulated activity by way of business in the UK (subject to any exclusions or exemptions).⁵ Breach of the authorisation requirement is a criminal offence and can result in fines and/or imprisonment.⁶

The principal regulated activities relevant to insurance and reinsurance are "effecting" or "carrying out" contracts of insurance or reinsurance as principal.⁷ There is no statutory definition in the UK of the activities which will constitute the effecting or carrying out of a contract of insurance or reinsurance, and so it has been left to the English Courts to determine the issue. The case law is summarised below:

- Effecting covers more than executing the contract. It includes the offering of insurance or reinsurance services (even if no contract is concluded) and negotiation of contractual terms.

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- Carrying out contracts of insurance or reinsurance includes receipt of premiums, payment of claims and other administrative functions.⁸
- The fact that a contract is executed or policy issued offshore or that underwriting decisions are taken offshore is not conclusive of business having been conducted offshore.⁹
- An offshore insurer or reinsurer may also be effecting or carrying out a contract of reinsurance in the UK if the contract is entered into or carried out through an agent in the UK.¹⁰ The Courts have held that each of the following activities of an agent in the UK can constitute the effecting or carrying out of contracts of reinsurance on behalf of its principal and that collectively they amount to overwhelming evidence that such regulated activities are being carried out:
 - ◆ deciding what risks to refer to the offshore insurers or reinsurers;
 - ◆ advising insurers and reinsurers on premium rates;
 - ◆ making recommendations to the insurers or reinsurers as to the acceptance of a risk;
 - ◆ receiving notification of claims within agreed guidelines;
 - ◆ instructing loss adjusters; or
 - ◆ directly settling claims below an agreed amount.
- Writing a single contract of insurance or reinsurance can lead to a breach of the general prohibition if it is done by way of business in the UK.¹¹

In addition to effecting or carrying out contracts of insurance or reinsurance as principal in the UK, the following activities set out in the EU Insurance Mediation Directive (IMD) are also regulated by the FSA. Although the IMD is intended to apply to insurance and reinsurance intermediaries, unlike other EEA jurisdictions, insurers and reinsurers in the UK must also be authorised in respect of the following regulated activities if any of them are being conducted:¹²

- arranging deals in contracts of insurance or reinsurance, where the arrangements bring about the deal to which the arrangements relate. This includes negotiation of the terms of a contract and the insurer or reinsurer entering into a contract as principal;
- making arrangements with a view to contracts of insurance or reinsurance being entered into. In this case, arranging will be regulated even if no contract is concluded; or
- advising a potential policyholder on contracts of insurance or reinsurance, where the advice relates to a particular contract and the merits of that person buying, selling, subscribing for or underwriting the contract.

EEA Insurers and Reinsurers in the UK

As noted above, EEA headquartered insurers and reinsurers can utilise passporting rights to enable them to carry on business in the UK on the basis of their home state licence without the need for additional authorisation by the FSA unless they are carrying on activities in the UK for which they are not authorised in their home state. If such activities are being carried on, an insurer can apply to the FSA for "top-up permission."

Non EEA Insurers and Reinsurers in the UK

Both insurance and reinsurance are regulated in the UK, and so any non-EEA insurer or reinsurer carrying on any of the regulated activities set out above in the UK will require FSA authorisation. This can be achieved by the establishment of a subsidiary or a branch of the non-EEA entity in the UK, which then applies for FSA authorisation. In order to avoid the requirement to be authorised in the UK, any activity that is regulated in the

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UK must be carried on wholly offshore.

Non-EEA insurers and reinsurers with a branch in the UK authorised by the FSA do not have the right to passport into other EEA jurisdictions and must conduct business in the relevant jurisdiction in accordance with host state rules. However, a subsidiary of a non-EEA insurer or reinsurer which is authorised by the FSA may take advantage of passporting rights to operate throughout the EEA.

Conclusion

In summary, non-EEA insurers (subject to any exemptions available in the relevant jurisdiction for MAT Insurance under GATS) and reinsurers may only operate within the EEA in the following ways:

- establishment of a subsidiary with authorisation in an EEA Member State
- establishment of an authorised branch of the non-EEA insurer or reinsurer in an EEA Member State (although passporting rights will not be available)
- provision of insurance or reinsurance into an EEA Member State (without actually carrying on regulated insurance or reinsurance business in the State), but only where permitted by the rules of the State. Most EEA Member States restrict the provision of insurance by non-EEA insurers at least to some extent. In the UK, for example, compulsory insurance classes, such as employers' and motor liability, must be provided by EEA insurers.

The Reinsurance Directive authorises the EU Commission to negotiate mutual recognition treaties in relation to reinsurance between the EU and third countries.¹³ Negotiation of such treaties may eventually make it easier for non-EEA (re)insurers to do business in the European market. At present the EU has treaties only with Norway, Iceland and Liechtenstein (which provide full mutual recognition) and Switzerland (which provides only for rights of establishment for insurers, subject to host state authorisation). Switzerland and Bermuda are known to be enthusiastic to negotiate treaties, but the U.S. position is bound up with the state-based regulatory system, which makes mutual recognition unlikely in the short to medium term.

Endnotes

1. EEA Member States include all member states of the European Union plus Norway, Iceland and Liechtenstein. EU member states are Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden and the UK. Switzerland is not a member of the EEA.
2. The commitments of the EC and its Member States in relation to insurance are found in the "Understanding on Commitments in Financial Services."
3. Directives 73/239/EEC, 88/357/EEC, 92/49/EEC
4. Article 49 of the Directive
5. Section 19 FSMA
6. Section 23 FSMA

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7. Regulation 10 and Schedule 1 of The Financial Services and Markets Act 2000 (Regulated Activities) Order 2001
 8. *Stewart v Oriental Fire and Marine Insurance Co Ltd* [1985] 1 QB 988.
 9. *DR Insurance Co v Seguros America Banamex* [1993] 1 Lloyd's Rep 120
 10. *Secretary of State for Trade and Industry v Great Western Assurance Co SA* [1999] 1 Lloyd's Rep 377
 11. *Bedford Insurance Company Ltd v Instituto de Resseguros Do Brasil* [1985] 1 QB 966.
 12. Articles 25 and 53 of the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001.
 13. Paragraphs 30 and 31, Preamble to Directive and Article 50 of the Directive.
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PUTTING A STOP TO THE PARADE OF HORRIBLES

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This past September, 2007, after three long years of claims handling and litigation chaos, the Florida Supreme Court put an end to the havoc wreaked by the 2004 appellate court decision in *Mierzwa v. Florida Windstorm Underwriting Ass'n*, 877 So.2d 774 (Fla. 4th DCA 2004), that shifted the burden of paying for non-covered flood damage to homeowner insurance companies. In *Florida Farm Bureau Casualty Insurance Co. v. Cox*, --- So. 2d ----, 2007 WL 2727072, at *5 (Fla. 2007), the Florida Supreme Court disapproved the decision in *Mierzwa*, and held that home insurers are not required to pay policy limits if the damage from a covered peril did not cause a total or constructive total loss,¹ even if the covered peril combined with a non-covered peril to cause such a loss.

Mierzwa had held that because of the state's Valued Policy 2 "VPL", insurance companies were required to pay claimants' policy limits when wind damage (a covered peril) combined with flood damage (a non-covered peril) to cause a total loss, even when the damage was minor.

The impact of *Mierzwa* on the insurance industry was immediate and huge. *Mierzwa* was decided in the summer of 2004, just as Florida started to experience an abnormally active and destructive hurricane season. As a result of *Mierzwa*, policyholders whose property had been rendered a total loss, mainly as a result of

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flooding by the four named hurricanes and one tropical storm that hit Florida in 2004, made claims for the full policy limits against their property carriers.

The wind damage to the home in the *Mierzwa* case was significantly greater than the flood damage, but it still wasn't enough to make the home a total loss by itself. In making its decision to require the property insurer wind carrier to pay policy limits, the 4th District refused to consider the effect of its ruling in cases where the wind damage was only a small fraction of the total damage and suggested that the insurance industry was exaggerating the situation by referring to such hypothetical claims as a "parade of horrors".

Unfortunately, however, with the devastating 2004 Florida hurricane season, the "parade of horrors" became a reality. On August 13, 2004, Hurricane Charley hit the state, causing an estimated \$6.75 billion in insured damage. A few weeks later, on September 5, 2004, Hurricane Frances damaged 15,000 homes and 2,400 businesses in Palm Beach County alone, with insured damage across the state totaling \$4.11 billion. Eleven days after that, on September 16, 2007, Hurricane Ivan brought strong waves and a 10 to 15 foot storm surge that severely damaged the Interstate 10 Bridge in Pensacola. The insured damage from Ivan totaled over \$4 billion. Then, on September 26, 2004, Hurricane Jeanne hit the southern portion of the state, very near where Frances had struck just three weeks earlier. The insured damage throughout the state as a result of Francis was estimated at \$3.44 billion.

Much of the damage caused by these four storms was a combination of wind and flood damage, with many coastal homes suffering primarily flood surge damage. Yet, very few coastal homeowners had more than \$250,000 in flood coverage, the maximum policy limits available under the National Federal Flood Insurance Program, ("NFIP"). As a result of *Mierzwa*, the insurance industry in Florida was forced to shoulder the liability damages, including damages attributable to flooding.

Windstorm insurers had not included the risk of flooding in calculating their insurance premiums. Nevertheless, *Mierzwa* exposed them to significant risk. A 2004 study by Applied Insurance Research Worldwide calculated the value of residential and commercial coastal property in Florida at \$1.94 trillion, which represented 79% of the state's total insured property values. As a result of *Mierzwa's* holding, the insurance industry did two things: first, they were able to have the Valued Policy Law amended in 2005 by the Florida Legislature to ensure that they would be responsible only for the *pro rata* share of the damage caused by the covered peril.³ Second, they aggressively fought the *Mierzwa* decision in court. Vindication came three years later in the *Cox* decision.

While the Supreme Court's decision in *Cox* is clearly a relief for the insurance industry, it will not solve all multi-causation scenarios and, unfortunately, will not prevent future litigation. The Florida Supreme Court decision in *Cox* specifically limits its holding to "only those cases in which a covered peril did not cause a total loss or constructive total loss." *Cox*, 2007 WL 2727072, at *5 n.6. This holding supports and concurs with the 2005 amendments to the Florida VPL. What constitutes a "constructive total loss", however, will continue to be hotly contested in the claims handling process and in the Florida court system. For example, whether a structure suffers "substantial damage", and must comply with local flood management regulations may depend on the amount of the damage as compared to the property's tax-assessed value. ⁴

As the tax-assessed value on a residence is generally much less than its market value, it is conceivable that a moderate amount of wind damage (damage that is less than fifty percent of the market value of the home) could require the rebuilding or relocation of the home, creating a "constructive total loss" scenario. In such cases, the wind carrier may be burdened with the lion's share of the cost of reconstruction due to the \$250,000 limits imposed by the federal flood coverage. In addition, the determination of whether a structure is a total loss or a constructive total loss will be determined by the trier of fact, which in most cases will be a jury.

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In the end, "wind vs. water" will continue to be difficult decisions for adjusters and insurers to evaluate and will continue to keep adjusters, engineers and lawyers very busy for years to come. As a result, clear guidance in claims handling should be provided to adjusters with special care to obtain necessary valuations, assessments and expert reports (i.e., structural engineers, etc) in any multi-peril loss.

Endnotes

1. The "constructive total loss" doctrine as developed in Florida holds that a loss will be considered a total loss when the requirements of an ordinance or law prevent the insured from rebuilding or repairing the damaged structure or require that the structure be demolished. *Citizens Insurance Co. v. Barnes*, 124 So. 722 (Fla. 1929).
 2. LawThe Valued Policy Law, Section 627.702, Florida Statutes (2004), provided, in pertinent part: "In the event of the total loss of any building, structure, mobile home as defined in s. 320.01(2), or manufactured building as defined in s. 553.36(12), located in this state and insured by any insurer as to a covered peril, in the absence of any change increasing the risk without the insurer's consent and in the absence of fraudulent or criminal fault on the part of the insured or one acting in her or his behalf, the insurer's liability, if any, under the policy for such total loss shall be in the amount of money for which such property was so insured as specified in the policy and for which a premium has been charged and paid." The Mierzwa court held the words "if any" applied only to "liability." Thus, the court concluded that any liability for damages meant liability for policy limits. In *Cox*, the Florida Supreme Court clarified that "if any", referred to whether the carrier had liability under the policy for a total loss. *Cox*, 2007 WL 2727072, at *4 (emphasis supplied). If a carrier had liability for a total loss, its liability was for the face amount of the policy. If a carrier did not have liability for a total loss, the valued policy law simply would not apply. In addition, the Florida Supreme Court correctly noted that the valued policy law was silent as to causation and provided that an insurer's liability for a total loss is "in the amount of money for which such property was so insured as specified in the policy and for which a premium has been charged and paid." *Id.* at *3 (emphasis supplied)
 3. Florida's Valued Policy Law has been on the books for over one hundred years. Originally, when it was first passed in 1889, it only dealt with losses arising from fire and lightning. In 1982, it was amended to cover all perils. The main purpose of the law was to make sure that once an insurance company and an insured agreed as to the value of a home and set the amount of the policy limits, that there would be no opportunity for the insurance company to argue with the insured as to how much the home was worth in the event of a total loss.
 4. As noted by the First District Court of Appeal in the case of *Citizens Property Insurance Co. v. Ueberschaer*, 956 So. 2d 483, 484 (Fla. 1st DCA 2007): "Under the [National Flood Insurance Program ('NFIP')] requirements 44 Code of Federal Regulations 59.1, structures located within the 100-year floodplain that receive damage of any origin, whereby the cost of restoring the structure would equal or exceed 50% of the structure value, must be brought into compliance with the NFIP requirements. For residential structures with more than 50% damage, the structures must be either removed from the floodplain or have the lowest floor (including basement) elevated to or above the 100-year flood elevation. Failure to comply with this requirement will result in fines and/or legal action by the County against the owner of the structure."
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CREDIT-BASED INSURANCE SCORES

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What determines how much a consumer will pay for automobile insurance? The usual considerations immediately come to mind: accident history, average miles driven each year, number of speeding tickets and location of insured are a few factors that are evaluated. In almost every state, however, the consumer's credit score also can play an important role in determining eligibility for coverage and the insured's monthly premium.

To many, this news comes as a surprise. A report released this summer by the National Consumer Law Center and the Center for Economic Justice found that only 36 percent of Americans are aware that their credit histories can impact their insurance rates and coverage. For a variety of reasons, awareness and scrutiny from consumer groups, state regulators and Congress is growing.

What Are Credit-Based Insurance Scores?

Insurers are constantly in search of new and more reliable ways to evaluate and price risk. In the mid-1990s, insurers began to consider consumers' credit histories as one factor in their risk analysis after studies showed a strong correlation between credit history and the likelihood of loss and the submission of a claim. The practice eventually became standard among automobile insurers, and today major automobile insurers in almost every state consider consumers' credit histories when underwriting and pricing policies.

Credit scores are formulated based on consumers' credit histories, which contain information about their borrowing, spending and repayment habits. This data is compiled by three national credit bureaus. These bureaus take certain information - such as the age of a credit card account or the number of late payments on a home equity loan - and plug the information into a formula that produces a credit score. This credit score may be used by other lenders to determine, for example, whether a consumer qualifies for a mortgage or what interest rate he or she receives on a department store charge card.

Insurers are not alone in their reliance on this information. Credit scores have become the modern financial benchmark by which consumers are judged. Banks, credit card companies, insurers and other financial institutions all rely on credit scores to gauge the level of risk a consumer poses in entering into any particular transaction in order to price that risk, with varying degrees of success.

Insurers, however, use consumers' credit histories somewhat differently than other financial institutions. Instead of relying solely upon credit scores to make underwriting or pricing decisions, insurers combine credit scores with other data to derive a new measure of risk: credit-based insurance scores. Insurers then use these scores to evaluate and price the risk associated with an application for coverage. Essentially, credit scores become one part of the formula used to determine whether to offer coverage or to set the premium.

Why Are Credit-Based Insurance Scores Important?

In simplest terms, insurance scores matter because they impact the bottom line. For insurers, insurance scores function as an actuarial tool, enabling them to evaluate their risk assessment and price risk accordingly. Insurers argue that better accuracy in the underwriting and rating of risks is achieved by use of credit scores,

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which in turn, allows them to reliably match price with risk and leads to lower premiums for many consumers who fall into the middle and upper credit score tiers.

In the wake of this summer's consumer credit crisis, national attention has focused on those consumers who do not fall into the higher tiers. This summer, the Federal Trade Commission (FTC) released a report that evaluated the role of insurance scores in the automobile insurer industry and, particularly, the effect those scores have on ethnic and racial minority groups.

The report found that the average predicted risk for African-Americans and Hispanics increased significantly when credit-based insurance scores were used - meaning they often pay more for automobile insurance and may have greater difficulty obtaining coverage than Asian-Americans and Caucasians. Despite these findings, the FTC report concluded that insurance scores generally did not serve as a proxy for racial discrimination and cited studies showing a strong correlation between credit history and the likelihood of loss.

At a congressional hearing held earlier this month, consumer advocates and state regulators attacked the FTC's findings. Critics argued that credit histories are notoriously incomplete and inconsistent, making them poor predictors of risk. They also rebuked the FTC for relying on data voluntarily submitted by insurers; one FTC commissioner even dissented from the report, stating that insurers should have been compelled to provide more comprehensive data.

The critics' main argument, however, focused on the impact of credit-based insurance scores on racial and ethnic minorities. Because African-Americans and Hispanics are significantly over-represented in the lowest credit score tiers, they tend to pay higher premiums. Consumer groups argued that this result was fundamentally inconsistent with public policy because it made insurance less available and less affordable to low-income groups - the segment of the population least able to absorb losses.

Outlook

To some extent, the federal government regulates insurers' use of credit-based insurance scores through the Fair Credit Reporting Act (FCRA). FCRA requires that insurers provide notice to consumers when they take "adverse action" - such as not offering the best available rates or coverages - based on the information contained in credit reports. However, the power of the federal government in this area is limited, as evidenced by a recent United States Supreme Court decision that found FCRA's protection inapplicable to first-time applicants.

Ultimately, the states will continue to bear primary responsibility for regulating insurers and their reliance on credit-based insurance scores. Currently, 48 states have enacted laws that regulate the use of insurance credit scores. Most of these states passed versions of the model law promulgated by the National Conference of Insurance Legislators, but some have gone even further. Hawaii banned the practice outright 20 years ago, and Florida is taking aggressive action by attempting to require that insurers affirmatively demonstrate their underwriting and pricing practices do not discriminate against protected classes, including racial and ethnic minorities.

Consumer advocates have urged states to take additional action, such as requiring insurers to improve the transparency of their insurance-scoring methodologies and registering their models with the applicable state regulators. Congress also has expanded its inquiry into the issue, ordering the FTC to produce another report on the role of credit-based insurance scores in homeowners' insurance. For now, the debate continues to rage as the insurance industry, consumer groups and state and federal officials attempt to strike a balance between actuarial principles of pricing risk and public policy.

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