

FEDERATION OF REGULATORY COUNSEL, INC.

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INCENTIVE-BASED COMPENSATION, CONTINGENT COMMISSIONS AND REQUIRED BROKER DISCLOSURES: IS THERE A MEETING OF THE MINDS?

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Although incentive-based compensation and contingent commissions are not prohibited across the entire insurance marketplace,¹ in most states, since 2004, they have been the subject of controversial debate at various state levels, as well as at the National Association of Insurance Commissioners (the "NAIC"). The concerns raised primarily relate to the disclosure of such compensation and so-called "contingent fee arrangement[s]" to insureds, as such disclosures tend to limit the possibility of insureds falling prey to deceptive practices that raise insurance prices above competitive levels.

Legal actions were launched by former New York Attorney General Eliot Spitzer and others addressing allegations of kickbacks and bid-rigging involving national brokerages and multiple insurance companies. American International Group ("AIG") ultimately paid \$125 million to settle with nine states and the District of Columbia over bid-rigging, price-fixing, and allegations regarding undisclosed contingent commissions.² While the NAIC formed an Executive Task Force on Broker Activities and ultimately adopted model legislation on disclosure requirements, relatively few states have adopted this model in its exact form.³ What guidance, therefore, can be provided to brokers and agents on compliance?

I. What Are Contingent Commissions and Other Incentive-Based Commissions?

Independent insurance producers (as opposed to captive agents for carriers who write business exclusively for that single insurer) generally receive two types of compensation. The first is a flat percentage commission based on premium volume paid at the time of sale. There may be different flat rates paid for new and renewal business. A second form of compensation considered common in the marketplace is a "contingent commission."

A. Contingent Commissions.

Contingent commissions may be paid in addition to flat percentage commissions and typically are based on profit, volume, retention and/or business growth. Contingent commissions, often loosely referred to as "bonus commissions," are not payable on a per-risk basis, but are allocated based on the performance of the entire portfolio of business placed with a particular insurer by a specific producer. Contingent compensation is derived from premium dollars, after being combined or pooled with the premium dollars of other insureds that have purchased similar types of coverage. The contingent commission schedule is often known to producers at the beginning of a given period of time (usually one year), but contingent commissions actually earned are calculated some time after business is placed and loss experience is observed and measured.

B. Supplemental Commissions.

Some insurers also pay so-called "supplemental commissions." These commissions are similar to contingent commissions in that an incentive structure based on profit, volume, retention and/or business growth is generally put in place at the beginning of a given year. However, under a supplemental system, rather than paying additional cash commissions at the end of the year, the incentive structure is used to reflect the flat

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percentage commission for the following year.

II. The Nature of the Disclosure Required and the NAIC Model Act 218, § 18.

With regard to contingent commissions, the nature of the disclosure required by the producer to his client and whether it needs to be documented as acknowledged by the insured depends on the particular law of the state in which the business will be placed. In order to develop a national compliance effort with regard to compensation arrangements, broker disclosures should be a thorough disclosure of the terms of the compensation arrangement in order to comply with the laws in a small number of states which strictly adhere to Producer Licensing Model Act 218, § 18 (*NAIC Model Regulation Service* (Jan. 2005 at 218-1, *et seq.*)), or, in the alternative, the most stringent state in which the producer does business.

Section 18 of the NAIC Model Act provides that where an insurance producer or an affiliate of the producer receives any compensation from the customer for the placement of insurance or represents the customer with respect to that placement, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for that placement of insurance unless the producer has, prior to the customer's purchase of insurance:

- (a) obtained the customer's documented acknowledgment that such compensation will be received by the producer or affiliate; and
- (b) disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of the disclosure, the producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

Although far less than one-third of the states appear to have adopted the NAIC Model Act in the precise form as set forth in existing Model Act 218, § 18, there are other states that may, through bulletin, regulation or other statutory provision beyond the Producer Licensing Act, impose similar restrictions. Some states, like New Jersey⁴ and Alaska, contain these detailed restrictions only with respect to "fees" as opposed to "commissions." *See, e.g. N.J.A.C. 11:17B-1.1 et seq.* and *N.J.A.C. 11:17B-3.3*. States which have adopted the restrictions substantially similar to the Model Act include:

Arkansas, Arizona, California, Connecticut, Georgia, Illinois, Indiana, Oregon, Pennsylvania, Rhode Island, Texas, Washington and Wisconsin.

III. New York.

A. The New York Investigations.

Not surprisingly, the City of New York seems to be at the core of the broker compensation controversy. The New York State Attorney General and the Superintendent of Insurance conducted investigations of a number of insurance brokers and insurers, including AIG, Marsh & McLennan, AON and Willis North America. The investigations focused upon whether the arrangements between the broker and his client contemplate adequate disclosure of compensation from the insurers who ultimately pay the brokerage commission. New York State authorities alleged that, at many companies, payment of contingent compensation led insurance producers to steer their clients to insurers paying the producers the most compensation, either in terms of volume or percentage of premium. New York's former Attorney General Eliot Spitzer and former Superintendent of Insurance Howard Mills also alleged that the 2004 then-current level of disclosure failed to properly inform insureds of the compensation to be received.

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As a result of the New York investigations, the Attorney General and Superintendent entered into a number of agreements and stipulations with some, but not all, producers doing business in New York that prohibited the receipt of contingent commissions by certain insurance brokers, prohibited the payment of contingent compensation by certain insurers for certain lines of business, provided a mechanism for expansion of the prohibition to additional lines, and required substantial improvements in disclosures to clients.⁵

In 2004, Willis North America was the first national brokerage to voluntarily enter into an agreement with New York and several other state regulators and enforcement authorities to stop using contingent commissions as a means of boosting business. This decision and the so-called "Spitzer Investigation" ultimately led to Marsh & McLennan and AON also agreeing to discontinue contingent commission arrangements.

B. The 2008 New York Public Hearings.⁶

In July and August 2008, the Superintendent of Insurance, Eric Dinallo, and the Attorney General of the State of New York, Andrew M. Cuomo, conducted joint public hearings in Buffalo, Albany, and New York City, respectively, to obtain the views of interested persons about the proposed addition of a new regulation to address permissible forms of insurance producer compensation and disclosure by insurance producers of all forms of compensation, not just contingent commissions. Specifically, these public hearings were intended to consider producer compensation for the market as a whole as the prior agreements and stipulations were not entered into by the New York Attorney General and the Superintendent with all of the producers doing business in New York. As a result of these long-awaited hearings, it was anticipated that proposed regulations would be developed, proposed and presumably promulgated into law so that brokers, insurers, and their clients would have clarity on these serious issues.

At the hearings, the Superintendent and the Attorney General expressly sought the views of interested parties on whether insurance producers in New York should be required to make full disclosure to the insured, and to obtain the insured's consent in writing, of any compensation from an insurer or other entity relating to the issuance, renewal or servicing of the insured's insurance policy or contract. The Superintendent and Attorney General also sought views about contingent commissions, and whether such compensation created an irreconcilable conflict of interest for producers, as is suggested by Willis. Having led the charge in 2004, it is likely that New York's direction will be followed by other states who, to date, have not yet established clear mandates for the insurance industry.

C. New York Law.

1. Existing Law.

New York currently provides clear legal guidance only with regard to broker disclosures to its clients in the context of fixed commissions. In at least three Opinions of the New York Office of the General Counsel (OGC Opinion # 08-01-10 (Jan. 30, 2008), OGC Opinion # 05-08-18 (Aug. 30, 2005), and OGC Opinion # 06-11-19 (Nov. 20, 2006)), the General Counsel concluded that neither the insurance law nor regulations promulgated thereunder require that a broker disclose to its clients the fixed commission it earns on the policies it places. However, in the January 30, 2008 Opinion, the General Counsel acknowledged that the Department intended to adopt a new part to 11 NYCRR to establish requirements regarding disclosure of all sources and amounts of compensation received by licensed insurance brokers and certain agents. This Opinion also interpreted a 1998 Circular Letter, Number 22 (Aug. 25, 1998), to provide guidance requiring broker disclosure of compensation to producers over and above fixed commission payments. Such compensation was stated in the 2008 Opinion to include "contingent commissions, which may be based upon business volume, profitability, new business generated, existing business retained, or loss experience of business placed with the insurer by the producer." OGC Opinion # 08-01-10.⁷ The New York draft

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regulations and the Superintendent of Insurance and Attorney General investigations, suits and settlements are more fully addressed below.

On January 29, 2009, Superintendent Dinallo circulated draft regulations to be codified at 11 NYCRR 30 to address the transparency of compensation paid to insurance producers and their role in insurance transactions. The regulations apply to the entire marketplace, including to the practices of insurers, insurance producers and other Insurance Department licensees. The rules are intended to establish the so-called "minimum disclosure requirements," which include:

- 1. the nature and amount of compensation to be received by the producer in connection with a sale of insurance;
- 2. a description of any material ownership interest the insurance producer has in the insurer issuing the insurance contract;
- 3. a description of any material ownership the insurer issuing the insurance contract has in the insurance producer; and
- 4. a prescribed notice as follows:

You are purchasing an [insurance policy, annuity contract, guaranty contract, surety bond] from an insurance producer.

An insurance producer is often paid by the insurance company based on the [insurance policies, annuity contracts, guaranty contracts, surety bonds] the producer sells.

The compensation that insurance companies pay to insurance producers varies from company to company and from [insurance policy to insurance policy, annuity contract to annuity contract, guaranty contract to guaranty contract, surety bond to surety bond]. Therefore, an insurance producer may have incentives to recommend a particular [insurance policy, annuity contract, guaranty contract, surety bond] to you based on the amount of compensation paid in connection with that [policy, contract, bond].

The insurance producer is required to provide you with information about his or her compensation in connection with the [insurance policy, annuity contract, guaranty contract, surety bond] you are purchasing. You may also have a right to receive information from the insurance producer about any quotes or alternative [policies, contracts, bonds] the insurance producer considered and the relative amounts of compensation the insurance producer would have received in connection with those quotes or alternatives.

If you would like such information about quotes and alternatives, just ask the insurance producer. If you are not satisfied with the information you receive, you may contact the New York State Insurance Department.

See §30.3(a), entitled "Disclosure of Producer Compensation, Ownership Interest and Role in Insurance Transaction."

If the amount or value of any compensation to be received by the producer is not known at the time of sale, then the producer is required to describe to the purchaser in writing the method of calculating the compensation, including factors on which compensation is based, such as volume, profitability and retention, and a reasonable estimate of the amount or value. The insurance producer may state the amount as a percentage of premium. *See* §30.3(b). At the purchaser's request, the new rules specifically require the producer to provide comprehensive information about quotes solicited and received and alternative insurance contracts considered, including, but not limited to, a description of coverage, the premium and the

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compensation the producer would have received in connection with those quotes or alternatives. If, at the initial issuance of an insurance contract, the disclosure provided pursuant to §30.3(a) expressly applies to future renewals of the insurance contract, then no additional disclosures are required upon renewal except if there has been a material change in the information required to be disclosed pursuant to subsection (a) at the time of renewal.

Section 30.4 of the New York draft rules requires an insurance producer to retain copies of the disclosures for not less than three years after the disclosure is given. There are a few notable exceptions to application of the disclosure rules, including: (a) the placement of reinsurance, (b) the placement of insurance with a captive insurance company, or (c) a producer that has no contacts with the purchaser, which may include wholesale brokers or managing general agents.

Violations of the regulations once they are promulgated into law will be deemed to be an unfair method of competition or an unfair or deceptive act and practice in the conduct of the business of insurance in New York, and shall be deemed to be a trade practice constituting a determined violation under Insurance Law § 2402(c), in violation of § 2403 of that law.⁸

IV. Other State Activity.

A. New Jersey.

Other state regulators have also investigated the practice of contingent commissions. For example, the New Jersey Department of Banking and Insurance ("NJDOBI") issued a bulletin, various press releases and two orders (one to insurance producers and one to carriers) reminding insurance producers and other interested parties of producer conduct requirements and regulatory sanctions for noncompliance. The orders requested copies of certain compensation plans from insurers and producers. Marsh & McLennan Companies, Inc. and its risk and industry subsidiary, Marsh, Inc., implemented significant reforms to its own business model in the wake of this controversy. The NJDOBI bulletin at issue, Bulletin No. 04-20, addressed producer conduct requirements and expressly referenced the producer's fiduciary obligations to its insured as follows:

- An insurance producer acts in a fiduciary capacity in the conduct of his or her business. *N.J.A.C.* 11:17A-4.10;
- Any insurance producer charging a fee to an insured or a prospective insured must first obtain from the insured or prospective insured a written agreement, which contains a clear statement in the amount of the fee and the nature of the service to be provided related to such fee and a statement whether the commission will be received from the insurer upon the purchase of insurance. *N.J.A.C.* 11:17B-3.1.

The unique fiduciary obligations that brokers have to their insureds is cited in support of the requirement that brokers disclose any potential conflicts in their fee arrangements to the consumers that hire them in the first place. *See* Oct. 22, 2004 press release from NJDOBI, quoting Director of Insurance Donald C. Bryan. It is this fiduciary capacity upon which regulators justify the need for disclosure of contingent fee arrangements to insureds.

Contingent fee arrangements routinely incentivized the producer to produce more business on behalf of an insurer or group of insurers to the benefit of the producer and the insurers. As currently defined under New Jersey law, a "commission" is:

Any payment from an insurer that is contingent upon the sale of a policy, contract or certificate of insurance, or is based on the total premium produced by the producer or written by the insurer. *See N.J.A.C.* 11:17B-1.3.

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Other states' statutes including those in states adopting NAIC model legislation (like Arkansas, Georgia, Texas, and Rhode Island), have expressly defined the term "commission" to include "contingent commissions." *See, e.g., Ark. Ins. Code* § 23-64-520(a)2(A); *Ga. Ins. Code* § 33-23-46(a)(2); *Tex. Ins. Code* § 4005.004(a)(3); and *R.I. Ins. Code* § 27-2.4-15.1(c)(2). New Jersey, New York and other states view compensation arrangements on a case-by-case basis and, depending upon the arrangement, have viewed them in the context of state Unfair Trade Practice Acts, as well as in the context of a broker's fiduciary obligation. *See, e.g.,* January 29, 2009 draft 11 NYCRR § 30.5.

Effective January 4, 2009, New Jersey law requires disclosure of compensation earned by a licensed producer to the purchaser of health insurance (the "Health Disclosure Law").⁹ This includes all commissions, fees, service fees and consulting fees. Among other things, § 25 of the Health Disclosure Law amends the New Jersey Producer Licensing Act of 2001¹⁰ by requiring licensed insurance producers to disclose to health insurance purchasers any compensation received from the sale of such policies or contracts.

Section 25 of the Health Disclosure Law provides as follows:

- a. An insurance producer licensed pursuant to P.L. 2001, c.210 (C. 17:22A-26, *et seq.*) who sells, solicits or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation, or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.
- b. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

N.J.S.A. 17:22A-28 defines an "insurance producer" as the person required to be licensed under the laws of this State to sell, solicit or negotiate insurance. The term includes insurance brokers, agents and consultants, and general agents. The scope of disclosure, on the face of the Health Disclosure Law, is quite broad, and disclosure is required for any insurance contract that meets the definition of "health insurance" at *N.J.S.A.* 17B:17-4, and for any contract sold by non-insurance health carriers, such as hospital, medical, health and dental service corporations, dental plan organizations, pre-paid prescription plans and health maintenance organizations. Disclosure, however, is expressly not required for health coverage that is an incidental part of a life or annuity contract.

What must be disclosed under the New Jersey law is any valuable consideration, including, but not limited to, commissions, consulting fees or service fees. Consideration must be disclosed even if its amount cannot be calculated or estimated. However, the nature of the compensation (*e.g.*, commission versus service fee) does not need to be disclosed. In the case of standard commission rates, the commission percentage or the per-employee amount of commission in connection with the rate proposal, binder or bill may be disclosed.

While the Health Disclosure Law requires that the producer provide the disclosure to the purchaser of insurance, in many cases, it may be more efficient for the carrier to provide the disclosure. However, producers should be aware that the obligation is theirs, not the carrier's. While the Law does imply that disclosure must be made at the time of proposal or prior to a contract becoming effective, certainly disclosure at the effective date is mandatory. Generally, disclosure at the earliest possible date is optimal.

In view of pending legislation to clarify the legislative intent regarding the scope of the producer compensation disclosure requirements described in Bulletin No. 08-16 and the Health Disclosure Law, for at least the first quarter of 2009, the NJDOBI reportedly will not take enforcement action against producers for

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failure to make the referenced disclosures for policies that do not constitute a "health benefit plan," *i.e.*, pre-paid prescription drug, accident only, and dental plans, among others. If it appears that new legislation may be enacted during this period, the NJDOBI will continue to wait before taking enforcement action. If the new Bill appears not to be moving, however, the NJDOBI expects to provide a short but reasonable time for the industry to come into compliance with the newly adopted law. The NJDOBI has provided this advice to impacted insurers and producers. To avoid confusion, the NJDOBI does not intend, at this time, to issue additional bulletins on this matter until the legislative process is complete.

There is also a regulatory proposal in New Jersey addressing "service fees" that may be charged to insureds. *See* 40 N.J.R. 6736.11 This proposal applies only in the case of commercial lines insurance where the products and issues involved in the provision of such coverage are more complex. The proposal clarifies that a producer should not be prohibited from providing additional services (such as analysis of a client's risk profile and development of a comprehensive insurance program, preparation of annual coverage reviews, enhanced customer services standards and claims services, appraisals and inspection, and loss control consulting and education) and charging appropriate fees for such services, provided the insured agrees to such additional fees and they otherwise comply with *N.J.A.C. 11:17B-3.1(b)* through (g).

B. Texas.

1. Texas Law.

As noted above, Texas has adopted a compensation disclosure law quite similar to the NAIC Model. In December 2005, at the time of the NAIC approval of the Model legislation for disclosure of agent and broker compensation, then Texas Insurance Commissioner Jose Montemayor and Texas Representative Craig Eland (D-Galveston), who was serving at the time as President of the National Conference of Insurance Legislatures ("NCOIL"), were instrumental in crafting the legislation. The Commissioner was on the NAIC Task Force, and Representative Eland filed the Bill in Texas as House Bill No. 2941. While the Model was not intended to apply to the placement of business in a secondary or residual market, such as the Automobile Assigned Risk Plan, and allowed exemption of nominal fees as defined in statutes in Texas, that provision might apply to fees that reimburse the agent for expenses and special charges. The Model legislation also included a drafting note suggesting the need for statutory standards that clarify the fiduciary duty of an agent or broker to a customer where the State's laws do not adequately address such duties. Texas, instead, relied upon common law which established a fiduciary duty for agents in special circumstances, and initially deemed no statutory obligation necessary.

Texas requires that a "documented acknowledgment: be obtained before the customer's purchase of an insurance product, as demonstrated by the customer's written or electronic signature or recorded voice," or by "other additional methods that the Commissioner may authorize by rule." *Tex. Ins. Code Ann. § 4005.004(a)1*. The written disclosure must include a description of the method and factors used by the insurer to compute the compensation to be received by the producer or other third party for that placement. *Tex. Ins. Code Ann. § 4005.004(a)2*.

2. Texas Investigations and Suits/Settlements.

Both the Commissioner of Insurance and the Attorney General sent requests for information to insurance companies in the State. Texas Attorney General Craig Abbott was also active in bringing suits against insurers for bid-rigging. In December 2006, the Texas Attorney General announced that Texas and ten other states had reached agreed final judgments with one of the world's largest insurers, Zurich American Insurance Co., requiring that company to implement a variety of business reforms and refund \$9 million to Texas commercial policyholders as a result of an anti-trust settlement which it had reached in March 2006. The settlement was the culmination of a multi-state investigation alleging that the company had participated in

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widespread, deceptive bid-rigging, price-fixing and other schemes in the commercial marketplace, also orchestrated by Marsh & McLennan and other large brokers. In the process, large and small companies, nonprofit organizations and government offices that purchased lines of insurance from Zurich were misled into believing that they were receiving the most competitive commercial premiums available.

Texas led the 15-month investigation, which revealed that Zurich had conspired with brokers at the center of the conspiracy in a "pay-to-play" scheme to overcharge policyholders for their commercial insurance policies. The scheme devised by Marsh & McLennan gave commercial policyholders the illusion of a legitimate competitive bidding process on policies, when in fact Marsh had pre-designated certain insurers to win bids. The results for the policyholders were actually inflated rates, not competitive bids. The scheme was successful because insurers such as Zurich failed to disclose to policyholders that they had paid these so-called secret "contingency commissions" to insurance brokers. Both Zurich and the brokers were deemed to have engaged in anticompetitive conduct. The brokers were steering contracts away from insurance companies that refused to participate in the scheme, and Zurich allegedly submitted fake quotes and was rewarded with protection from competition so it could set artificially high premiums and profits on other lucrative accounts.

The Texas Attorney General settlement eliminated the schemes, required the disclosure of all compensation paid to brokers and agents, and thereby assisted policyholders in making decisions on obtaining or renewing insurance with Zurich. The multi-state coalition supporting Texas included California, Florida, Hawaii, Maryland, Massachusetts, Oregon, Pennsylvania, Virginia and West Virginia.

In a companion settlement of a class action law suit in New Jersey, Zurich was required to distribute approximately \$122 million in refunds to commercial policyholders, including an estimated \$9.3 million to Texans. Texas, like Florida and a number of other states, has long since required the disclosure of broker's compensation in connection with a viatical settlement. ¹²

C. Florida.

1. Florida Attorney General Settlements.

In 2007 and 2008, Florida's Attorney General Bill McCollum, Chief Financial Officer Alex Sink, and Insurance Commissioner Kevin McCarty, announced that Florida had reached settlement with AON Corp., a large insurance broker that received undisclosed compensation in connection with the placement of insurance coverage on behalf of Florida policyholders. As part of the agreement, AON paid \$2.6 million to Florida to reimburse affected policyholders. The Florida settlement was particularly highly publicized, as some of the insurance consumers impacted were Florida public entities, such as the Hillsborough County School District and five other Tampa-area public entities, who received a total of \$1.48 million in refund checks.

In July 2007, the Attorney General's Office, the Florida Department of Financial Services, and the Office of Insurance Regulation obtained a \$2 million settlement with Willis, resolving allegations that the company improperly collected undisclosed fees or commissions from various public entity clients. The company's clients included more than a dozen public entities in Florida, including Economic Development Councils, city and county governments and school boards. A similar \$2.6 million settlement was reached with AON in May 2008. AON reportedly had over 45 public entities as clients.¹³ Under the terms of the 2007 agreements, AON and Willis agreed to make full written disclosure of commissions and to pay the costs of the investigation.

Florida, Hawaii, Maryland, Massachusetts, Michigan, Oregon, Texas, West Virginia, Pennsylvania, and the District of Columbia also joined in a settlement in December 2007 against The Travelers Companies. Travelers signed a consent agreement with the nine states and the District of Columbia, agreeing to pay \$6

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million to settle charges linked to its role in a nationwide bid-rigging scheme devised by insurance broker Marsh & McLennan. The purpose of the settlement was intended to ensure that brokers fairly represented their clients' interest by requiring greater transparency and disclosure of the types and ranges of compensation paid to insurance brokers on Travelers' policies.

According to the complaint, Travelers allegedly participated in an intricate bid-rigging scheme in which Marsh & McLennan pre-designated which company's bid would "win" a particular account. To create the appearance of a competitive bidding process, Marsh instructed certain insurers to submit inflated, intentionally uncompetitive bids. The schemes gave commercial policyholders, which included large and small companies, nonprofit organizations, and public entities the impression that they were receiving the most competitive commercial premiums available, when they were actually being overcharged.

Additionally, Travelers was involved with a "pay-to-play" arrangement centered on its payment of contingent commissions, in addition to standard commissions and fees, to insurance brokers. These contingent commission arrangements were often undisclosed to consumers, and provided an incentive for brokers to steer business to the insurer who offered the most lucrative contingent commissions, often in violation of their clients' best interest.

V. Should Contingent Commissions Be Prohibited?

As states are inconsistent with respect to when disclosure of contingent commission and broker compensation arrangements is required, insurance brokerages such as Willis, who voluntarily stopped using contingent commissions early in the investigatory stages, have encouraged regulators to end contingent commissions for all brokerages, stating that advising clients about contingent commissions as part of a transaction does not necessarily go far enough to protect consumers. "As important as transparency is, it still isn't enough. We do not believe that it is enough to just reveal a practice that you know is not in your clients' best interests. That's not honoring the spirit of making your clients' interests paramount . . ."14

Senior management at Willis has suggested that creating "a fair system" without contingent commissions could take place in several ways. First, at public hearings held by New York during the summer of 2008, Willis CEO Don Baley testified that New York regulators could force any broker renewing a license in the state to end the practice of accepting contingent commissions. Another option proposed was to challenge the insurance industry to resolve the issue. While Baley did not want contingent commissions terminated immediately, he suggested that they should be phased out over a reasonable period of time to allow brokers to adjust their business models.

Other critics of contingent commissions contend it creates a conflict for ostensibly independent producers because the size and structure of the contingent commissions that insurers offer to intermediaries and producers can vary significantly and lead to abuses, such as improper "steering" of clients to insurers that allegedly fail to provide coverage as beneficial as that covered by competitors. The defenders of contingent commissions, on the other hand, assert that competition in the marketplace can adequately address any such conflicts. They also argue that the conflicts of interest created by contingent commissions are also inherent in the payment of supplemental and flat percentage commissions.

While an absolute prohibition on contingent commissions may well be too draconian, full and complete disclosure of all compensation arrangements is advisable to assure transparency given recent developments and the trend in regulatory authority. Producers with a national scope are particularly advised to consider disclosure of all compensation (not just contingent compensation), as some states may well impose a broad requirement. *See e.g.*, the New York draft regulation. To ensure compliance in these more broadly regulated markets, a full and complete disclosure is prudent.

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VI. Recommendations For Compliance Procedures.

- 1. Include disclosure of contingent or bonus commissions on any website, and generally address compensation bases. If a state has a required written disclosure (such as the New York draft regulation), tailor the website disclosure accordingly.
- 2. Adopt a form Disclosure Statement that caters to the most restrictive state requirement.
- 3. Provide written disclosures to each insured or prospective insured. Such disclosure should include commissions, whether contingent or otherwise, fees and the source of payment, as well as that the contingent commission provides an incentive to the producers to produce more business on behalf of an insurer or group of insurers to the benefit of the producer and the insurers. Disclose the amount of fees and all commissions and clarify whether the producer will receive both fees from the insured and commissions from the insurer upon the purchase of insurance. If a precise fee is not known, include the calculation methodology in the disclosure.
- 4. The Disclosure Statement should advise the insured of his right to request and receive copies of all quotes or alternative policies, contracts and bonds the producer considered and relative amounts of the compensation the insurance producer would have received with those arrangements.
- 5. Have all written disclosures and all fee agreements signed and dated by the insured **before** the application for insurance is signed, at the onset of the business relationship.
- 6. The Disclosure Statement and all sales material should state that the individual or entity is an insurance producer, is paid commissions by the insurer, and should reference the producer's state insurance license number.
- 7. If an insured requests a more detailed disclosure of the precise fee structure on a particular contemplated transaction, make every effort to provide it.
- 8. Provide copies of all quotes or alternative policy, contract or bond forms to the insured, unless he states he does not want them.
- 9. Train all licensed personnel who interface with insureds and prospective insureds with regard to the producer's internal disclosure guidelines and each state's statutory and regulatory requirements.
- 10. If an insured requests that contingent commissions not be taken, unless they cannot be calculated on a given transaction, agree, or at the very least agree to request that the carrier not include the specific transaction in the contingent commission calculation.
- 11. Update internal guidelines and written disclosures periodically to keep up with changes in the law.

Endnotes

1. California law prohibits an admitted life insurer from paying contingent commissions on life or disability business. *See Cal. Ins. Code* § 10434.
2. States involved included: Florida, Hawaii, Maryland, Michigan, Oregon, Texas, West Virginia, and the Commonwealths of Massachusetts and Pennsylvania.
3. The NAIC model was publicly criticized as being insufficient. Then Connecticut Attorney General Richard Blumenthal called the NAIC Model "a shadow of what it should be," according to an article by Dan Haar, "Model Broker Rules Drafted," *Hartford Courant*, Business Section, page 1 (Nov. 17, 2004). Blumenthal, Eliot Spitzer and others testified on November 16, 2004 before a U.S. Senate panel, and also said that "this model simply fails to address the key defects in the current system," according to the *Courant*. *Id.*
4. New Jersey does have express disclosures regarding health insurance commissions.

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5. Marsh, Inc. entered into a similar agreement in January 2005. Yet on August 17, 2006, Marsh reportedly entered into an agreement with then New York Attorney General Spitzer and then New York Superintendent of Insurance Howard Mills to modify the 2005 agreement that banned all contingent commissions or profit sharing deals involving payments based on the volume of business Marsh placed with various insurers. The August 2006 agreement reportedly clarified that Marsh could be compensated as a Managing General Agent ("MGA") or underwriting manager, defining such activities as those where Marsh has been appointed by an insurer to be the insurer's representative in connection with the management of its book of business. See National Association of Professional Insurance Agents, *Insurance News* (Aug. 30, 2006).
6. The public hearings were held by the New York Attorney General and Superintendent of Insurance on July 14, 2008 in Buffalo, July 23, 2008 in Albany, and on July 25, 2008 in New York City. Representatives from Willis, United Insurance Agency, Inc., Plan Futures Financial Group, Henry Kay, as past President of the Professional Insurance Agents of New York, the Independent Insurance Agents and Brokers of New York, New York Insurance Association, New York Health Plan Association, Mercer Health and Benefits, LLP, Rutherford, Inc. and Russell Bonds, Inc., Marsh, Inc., Marsh & McClennan Companies, AON, American Risk and Insurance Management Society, Inc., Independent Insurance Agents and Brokers of America, the Insurance Information Institute, the Center for Economic Justice, the American Insurance Association, ACE, Fireman's Fund Insurance Company, Life Insurance Council of New York, the Excess Lines Association of New York, Allstate Insurance Company, CVS Coverage Group, Inc. and the Council of Insurance Brokers of Greater New York, all testified at one or more of these three public hearings.
7. The draft regulations recently prepared by the New York Superintendent of Insurance will, if adopted in their draft form, bring New York closer to the NAIC Model, but appear to be more comprehensive.
8. Compensation is defined quite broadly, consistent with the terms of the Model Act, to include anything of value, including money, credits, loans, interest on premium, forgiveness of principal or interest, vacations, prizes, gifts or the payment of employee salaries, benefits or expenses whether paid as commission or otherwise. See proposed §30.2(a). "Purchaser" is also broadly defined to include the person or entity to be charged under an insurance contract or a group policy and may include the named insured, policyholder, owner of a life insurance policy or annuity contract, principal under a bond, or other person to be charged, including any applicant for an insurance bond or annuity, but expressly does not include a certificateholder or member under a group or blanket insurance contract unless the certificateholder or member has direct contact with the insurance producer, or the certificateholder or member pays the entire premium. See §30.2(b).
9. See N.J.S.A. 17:22A-41.1 (P.L. 2008, c.38 (eff. January 4, 2009) and NJDOBI Bulletin No. 08-16 (October 1, 2008).
10. See N.J.S.A. 17:22A-26, et seq.
11. N.J.A.C. 11:17B-3.1 (now applicable to all permissible services fees) requires a written fee agreement containing a clear statement of the amount of the fee charged; the nature of the service provided; a statement that the fees are not part of the premium charged by the insurer; that such fees can only be charged if the insured or prospective insured consents in writing; a clear statement as to whether a commission will be received from the purchase of insurance; and the signature of the insured or prospective insured and the licensed insurance producer, as well as the date of execution of the agreement. Any fee charged by a producer shall bear a reasonable relationship to the services provided and shall not be discriminatory. A new written agreement shall be entered into for each fee charged and each time a fee is charged. An initial agreement shall not be used as the sole basis to charge a fee on a renewal policy. No insurance producer may pay or return, or offer to pay or return, all or a part of a fee charged as an inducement to purchase a specific policy, or coverage within a policy, or coverage from a particular insurer. No insurance producer may charge a service fee for services not actually performed, and finally, no insurance producer, except a duly authorized producer

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employed by and acting on behalf of his or her employer, may execute a written fee agreement on behalf of any other insurance producer or premium finance company.

12. See, e.g., 28 Tex. Admin. Code § 3.1711 and Fla. Admin. Code § 626.99181.

13. WMBB News-TV, February 9, 2009.

14. Insurance and Financial Advisor (powered by IFA Webnews.com, July 14, 2008), quoting Donald Baley, CEO of Willis North America.

ADMINISTRATIVE RULES IN ILLINOIS: WHO HAS THE FINAL SAY?

Is JCAR Unconstitutional?

As with "desk drawer rules," which seem to exist in every state, it is often judged more prudent to accept their existence and validity for a variety of reasons than to challenge them in a formal proceeding. Such it has been as well in Illinois with the constitutional issue of the authority of the Joint Committee on Administrative Rules (JCAR).

JCAR is a legislative body composed of twelve members, six from the House, six from the Senate, with three from each side of the aisle in their respective chambers. 25 ILCS 130/1-5(a)(3) (2006). It has the authority to reject administrative rules proposed by the executive branch with a vote of eight of the twelve members. 5 ILCS 100/5-120(a) (2006). When JCAR was originally enacted in 1981, it was vetoed by then Governor Thompson on the grounds that he believed it to be unconstitutional. His veto was subsequently overridden by the General Assembly, and JCAR came into being. Since then, Governors have grumbled on occasion but have complied with JCAR's decisions and have never raised the possible constitutional objections voiced by the Thompson veto in a court challenge. This has now changed.

Background

In March 2007, Governor Blagojevich delivered a combined Budget and State of the State address. One of the central themes was his call for a vast expansion of the state's health care program. The catch phrase for the multi-part initiative was "Illinois Covered."

To support this initiative and many others, the Governor proposed a Gross Receipt Tax. Neither proposal was ever passed nor even voted on by either chamber, a clear indication the proposals had little support in the legislature. The Governor, however, did not view this as an impediment to his proposals. On August 30, 2007, he was quoted in the *Chicago Tribune* saying:

"Because we couldn't get some legislators to support this, I'm acting unilaterally to expand health care."

Emergency and permanent rules were subsequently filed to implement portions of Illinois Covered. Both were rejected by JCAR with the necessary eight of twelve votes. The effect of JCAR's rejection of both the emergency and permanent rules under the Illinois Administrative Procedure Act should have been a prohibition on the implementation of the rules.

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However, in November 2007, the Department of Healthcare and Family Services (DHFS) began enrolling people into one of the programs included in the Illinois Covered proposal called "Family Care." In so doing, it took the position that the actions of JCAR were of no legal and binding effect and in effect, advisory only.

A preliminary injunction was sought by a tax payer and a business group and was granted on April 15, 2008. The decision of the Court was based entirely upon some technical aspects of the structure of the program. The JCAR issues were not addressed. *Caro, et al. v. Blagojevich, et al.*, 07 CH 034353, Circuit Court, Cook County, Illinois.

DHFS appealed the Circuit Court Order and on September 26, 2008, an Illinois Appellate Court issued an order upholding the injunction issued by the Circuit Court, only mentioning the JCAR issue in passing. *Caro, et al. v. Blagojevich, et al.*, 1-08-1061, Appellate Court of Illinois, First Judicial District, Fifth Division, Slip Opinion.

The question has been asked; the issue is now on the table. The Speaker of the House, a member of the same party but not an ally of the Governor, has reacted to the Governor's position of treating JCAR as merely advisory by requiring the addition of language similar to the example below on all bills brought before the General Assembly under which the Governor or an agency under him could propose rules.

Notwithstanding any other rulemaking authority that may exist, neither the Governor nor any agency or agency head under the jurisdiction of the Governor has any authority to make or promulgate rules to implement or enforce the provisions of this amendatory Act of the 95th General Assembly. If, however, the Governor believes that rules are necessary to implement or enforce the provisions of this amendatory Act of the 95th General Assembly, the Governor may suggest rules to the General Assembly by filing them with the Clerk of the House and the Secretary of the Senate and by requesting that the General Assembly authorize such rulemaking by law, enact those suggested rules into law, or take any other appropriate action in the General Assembly's discretion. Nothing contained in this amendatory Act of the 95th General Assembly shall be interpreted to grant rulemaking authority under any other Illinois statute where such authority is not otherwise explicitly given. For the purposes of this amendatory Act of the 95th General Assembly, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act, and "agency" and "agency head" are given the meanings contained in Sections 1-20 and 1-25 of the Illinois Administrative Procedure Act to the extent that such definitions apply to agencies or agency heads under the jurisdiction of the Governor.

This amendment encapsulates the unresolved question. The President of the Senate, an ally of the Governor, refuses to accept bills with this amendment. Thus, a stalemate has developed.

Governor's Position

The Governor's position is basically that of a separation of power under the Illinois Constitution. He concedes that while the General Assembly has originally delegated the authority, it can only be withdrawn by a legislative action. He contends that the suspension of a rule by the General Assembly is a legislative action that must comply with Article IV of the Illinois Constitution of 1970. Article IV requires an action by the legislature to be passed by both houses; presented to the Governor for approval or veto; and if necessary, returned to the legislators for consideration of a veto.¹² JCAR actions involve none of these elements because they are only acted upon by a committee and the Governor cannot veto or approve their action. Brief of Defendants-Appellants at 39, *Caro, et al. v. Blagojevich, et al.*, Appellate Court of Illinois, First Judicial District, Fifth Division (No. 08-1061)

In the briefs, he also notes that nine states and the United States have adopted a similar position: Alabama, Kansas, Kentucky, Michigan, Missouri, New Hampshire, New Jersey, Oregon and West Virginia. *Id.* at 37.

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Attorney General's Position

The Plaintiff and the Illinois Attorney General support the constitutionality of JCAR. They point out that the legal burden born by the Governor is quite high.

"All statutes are presumed to be constitutional, and the burden of rebutting that presumption is on the party challenging the validity of the statute to demonstrate clearly a constitutional violation." *People v. Wilson*, 214 Ill.2d 394, 398-99, 827 N.E.2d 416, 419-20 (2005). "Moreover, courts will construe statutes, if possible, to be constitutional." *Chicagoland Chamber of Commerce v. Pappas*, 378 Ill.App.3d 334, 345, 880 N.E.2d 1105, 1117 (1st Dist. 2007).

They further argue that this matter has been addressed by the Illinois Supreme Court in a similar situation when the constitutionality of the Compensation Review Board (25 ILCS 102/2) was upheld in *Quinn v. Donnewald*, 107 Ill.2d. 179, 483 N.E.2d 216 (1985). In that case, a board of twelve appointed individuals was given authority to recommend increases in salaries for legislators and some Executive Branch positions. If a recommendation was made, it was then up to both chambers of the General Assembly to reject the recommendations or they would go into effect. No action by the Governor is possible under this statute.

In *Quinn*, the court held Article IV was not violated because:

"Itself [the Compensation Review Board legislation] was, of course, passed by a majority of both houses of the General Assembly and was presented to the Governor for his possible veto." *Quinn*, 107 Ill. 2d at 190, 483 N.E.2d at 222. In addition, "the appropriation bill [which would fund the increases] was passed by a majority of both houses and presented to and approved by the Governor." *Id.* Thus, the Court held, "the requirements of article IV, section 8(c) [enactment clause], and Article IV, sections 9(a) and (b) [presentment clause], have been satisfied." *Id.* at 190-91, 483 N.E.2d at 222.

The Plaintiff and the Attorney General assert that if principles of the *Quinn* case are applied in this situation, any subsequent actions taken by JCAR must be held constitutional, since the authorization of the JCAR legislation was passed in accordance with Article IV. They further argue in support of JCAR that Illinois has a long history of legislative delegation to executive branch agencies.

"Highly complex and technical subjects . . . it simply is impractical for legislators to become and remain thoroughly apprised of the facts necessary to determine which aspects of that activity are harmful and how they might be modified." *Stofer v. Motor Vehicle Cas. Co.*, 68 Ill. 2d 361, 370, 369 N.E.2d 875, 878 (1977).

This delegation does not transfer rule making into an executive function, but rather it remains a quasi-legislative power, and thus, constitutional.

As of this writing, the appeals court has upheld the preliminary injunction and the issue is back before the Circuit Court for a hearing on the merits.

It is, of course, unknown if the court will again decide the matter without reaching the issue of the constitutionality of JCAR, or if so, what it will decide.

Until there is a final resolution, the best prediction is that the legislative language being inserted by the House, which in essence will prohibit the executive branch from promulgating any administrative rules to implement newly enacted laws without the prior permission of the General Assembly, will become part of every bill so long as the parties or their successors hold to their positions.

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Endnotes

1. SECTION 8. PASSAGE OF BILLS (c) No bill shall become a law without the concurrence of a majority of the members elected to each house. Final passage of a bill shall be by record vote.
 2. SECTION 9. VETO PROCEDURE (a) Every bill passed by the General Assembly shall be presented to the Governor within 30 calendar days after its passage. The foregoing requirement shall be judicially enforceable. If the Governor approves the bill, he shall sign it and it shall become law. (b) If the Governor does not approve the bill, he shall veto it by returning it with his objections to the house in which it originated. Any bill not so returned by the Governor within 60 calendar days after it is presented to him shall become law.
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CHAPTER 15 - BANKRUPTCY CODE APPLICATION TO INSURERS

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Bankruptcies are governed by federal law. The United States Constitution, article 1, Section 8, provides that "Congress shall have the power ... to establish uniform laws on the subject of bankruptcies throughout the United States...." Congress exercised this power in 1978 by enacting Title 11 of the United States Code (the "Bankruptcy Code").¹ The Bankruptcy Code has been amended several times since 1978. Most recently, it was amended pursuant to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA"). In addition to amending numerous provisions of the Bankruptcy Code, BAPCPA added a new Chapter 15. Chapter 15 permits a United States bankruptcy court to recognize and cooperate with a foreign proceeding in which the assets and affairs of the debtor are "subject to control or supervision by a foreign court, for the purpose of reorganization or liquidation."²

Insurance company insolvency proceedings are governed by state law. The Bankruptcy Code denied bankruptcy liquidation relief to insurance companies by providing that neither a domestic insurer nor "a foreign insurance company,³ engaged in such business in the United States" are eligible for relief under Chapter 7.⁴ Similarly, Congress denied insurers the ability to reorganize or liquidate as a going concern under Chapter 11 since (with few exceptions) only an entity that may be a Chapter 7 debtor is eligible for Chapter 11 relief.⁵

The amendments under BAPCPA continued the decades-old bar against insurance company bankruptcies, with one exception - a foreign insurance company may be the subject of a proceeding under the newly-created Chapter 15.⁶ As noted by one court:

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The status of a debtor in this [Chapter 15] case *as a foreign insurance company that is ineligible to be a debtor under the Bankruptcy Code by virtue of 11 U.S.C. § 109(b)(3) does not affect the availability of Chapter 15 relief.* Foreign insurance companies are eligible for Chapter 15 relief because § 1501(c)(1) provides that Chapter 15 does not apply to "a proceeding concerning an entity, other than a foreign insurance company, identified by exclusion in section 109(b)."⁷

Although foreign insurers may be the subject of Chapter 15 proceedings, the relief that can be granted in the Chapter 15 context is in some instances more limited than would otherwise be available in a "traditional" United States bankruptcy case. For example, the foreign representative cannot sue in the Chapter 15 case to set aside or avoid pre-bankruptcy transfers. Instead, a suit of that kind can only be brought if the foreign representative files or participates in a companion, plenary case under one of the other substantive chapters of the Bankruptcy Code (such as Chapter 7 or Chapter 11).⁸ Since Congress did not amend the Bankruptcy Code to allow foreign insurers to be subject to any chapter other than Chapter 15, the foreign representative of a foreign insurer will not have standing to file or participate in a "traditional" bankruptcy proceeding, thereby precluding the ability to set aside or avoid pre-bankruptcy transfers.

This limitation is illustrated by *In re Condor Insurance Limited (In Official Liquidation)*, Case No. 07-51045, filed in the United States Bankruptcy Court for the Southern District of Mississippi ("Bankruptcy Court"). In *Condor Insurance Limited*, the Eastern Caribbean Supreme Court in the High Court of Justice, St. Christopher and Nevis, Nevis Circuit ("Nevis Court"), ordered the winding up of Condor Insurance Limited, an entity primarily involved in the business of reinsurance. The joint liquidators appointed by the Nevis Court for Condor Insurance Limited filed a Chapter 15 proceeding in the Bankruptcy Court. After the Honorable Edward R. Gaines, United States Bankruptcy Judge, entered an order recognizing the Nevis foreign proceeding, the liquidators filed an adversary proceeding in the Chapter 15 case against Condor Guaranty, Inc. and others seeking to recover property valued at \$313 million as of 2005. The liquidators asserted that Nevis law entitled them to avoid or set aside transfers of the property or to obtain equivalent damages. Condor Guaranty, Inc. filed a motion to dismiss the adversary proceeding, alleging (among other things) that the Bankruptcy Court lacked subject matter jurisdiction since the adversary proceeding had not been filed in a related, plenary bankruptcy case under Chapter 7 or Chapter 11. The liquidators acknowledged during briefing that Chapter 15 prohibited them from using avoidance remedies under the Bankruptcy Code except in a related, plenary bankruptcy case. They further acknowledged that 11 U.S.C. § 109 prevented them from filing a related Chapter 7 or Chapter 11 case for Condor Insurance Limited because of its status as a foreign insurer. Nevertheless, they contended that nothing in Chapter 15 prohibited the use of foreign avoidance law in the Chapter 15 case.

Following briefing and oral argument, Judge Gaines took the motion to dismiss under advisement. On July 17, 2008, he rendered his Opinion⁹ and entered an Order dismissing the liquidators' complaint. In his Opinion, Judge Gaines acknowledged that foreign representatives have standing to avoid pre-petition transfers, but *only* in a separate Chapter 7 or Chapter 11 bankruptcy case that is related to the Chapter 15 proceeding. The Bankruptcy Court agreed with Condor Guaranty, Inc.'s argument that foreign representatives have no standing to avoid pre-petition transfers of property in a Chapter 15 context (citing 11 U.S.C. § 1521(a)(7) and 11 U.S.C. § 1523(a)). Because a related, non-Chapter 15 proceeding was not pending, the Bankruptcy Court found that subject matter jurisdiction was lacking. The Bankruptcy Court also agreed with Condor Guaranty, Inc. that the liquidators had not presented any authority in a Chapter 15 context to support the use of foreign avoidance law when United States avoidance law is not available.¹⁰

The worldwide economic downturn likely will generate many Chapter 15 proceedings. With BAPCPA, Congress opened the door of bankruptcy to foreign insurers, but only in a Chapter 15 context. As illustrated by *Condor Insurance Limited*, the relief available in such cases is limited. It remains to be seen how extensively Chapter 15 will be utilized for foreign insurers who are subject to foreign reorganization or

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liquidation proceedings.

Endnotes

1. The Bankruptcy Code replaced the Bankruptcy Act that had been in effect since 1898.
2. 11 U.S.C. § 101(23).
3. What the Bankruptcy Code calls a "foreign" insurance company is known in insurance regulatory law as an "alien" insurance company. Because this article quotes from the Bankruptcy Code, the bankruptcy nomenclature is used herein.
4. 11 U.S.C. § 109(b)(2)-(3).
5. 11 U.S.C. § 109(d).
6. 11 U.S.C. § 1501(c)(1) provides "This chapter does not apply to (1) a proceeding concerning an entity, *other than a foreign insurance company*, identified by exclusion in section 109(b)" (emphasis added).
7. *In re Tri-Continental Exchange, Ltd.*, 349 B.R. 627, 632 (Bankr. E.D. Cal. 2006) (emphasis added). *See also* House Report, Section 1501 ("Section 1501 contains an exception to the section 109(b) exclusions so that foreign proceedings of foreign insurance companies are eligible for recognition and relief under Chapter 15").
8. 11 U.S.C. §§ 1521(a)(7) and 1523(a).
9. The Opinion may be found at 2008 WL 2858943.
10. The liquidators have appealed the Bankruptcy Court's decision.

FULL DISCLOSURE OF PRODUCER COMPENSATION: THE CHEAPEST E&O INSURANCE

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1 Historically, insurance intermediaries did not disclose their compensation to their customers. The insurance intermediaries saw no problem with this lack of disclosure because they received their compensation from the insurers. Perilously, the insurance intermediary assumed there was no requirement to disclose the amount or nature of the compensation. Recent developments have spurred regulations requiring disclosure to the customer of all compensation an insurance intermediary may receive. 2

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Should an insurance intermediary disclose to the insurance consumer all potential compensation? Yes. The need to disclose potential compensation precedes the current regulatory mood and is rooted in the insurance intermediaries' common law duties to his or her clients. The statutes and regulations enacted across the nation following former New York Attorney General Eliot Spitzer's investigation of the insurance industry potentially subjects the insurance intermediary to regulatory penalties, such as fines. The real threat to the insurance intermediaries, though, is the potential civil liability from the codification of these duties as well as violations of the existing common law duties.

I. INSURANCE INTERMEDIARIES

This discussion first requires an overview of insurance intermediaries. An insurance intermediary is an individual or business firm that stands between the consumer and the seller of insurance.³ Generally speaking, there are three types of insurance intermediaries - brokers, exclusive agents and independent insurance agents.⁴ Brokers are insurance intermediaries who solely represent the consumer.⁵ Exclusive agents are employed by and represent only one insurer. Independent agents represent multiple insurers.⁶ Independent agents place the bulk of the property-casualty policies in the United States.⁷

The distinction between brokers and independent agents is subtle, as no absolute dichotomy exists between them.⁸ Textbooks state that insurance agents are, in the legal sense, agents of the insurer, while brokers are agents of the customer. ⁹ The textbook definition is far too simplistic for the real world insurance market because independent agents and brokers perform many of the same functions and services, including acting as advocates for the insured and providing services for claims management.¹⁰ In addition, many "brokers" operate under documents functionally indistinguishable from the "agency appointment" contracts that the independent agents enter into.¹¹ Even if acting in a "dual agency" role, the independent producer may be the agent of the insured, not the insurer.¹² The primary distinction between independent agents and brokers relates more to the size, range, and depth of services provided.¹³ Independent agents tend to be smaller and provide services to relatively small businesses and consumers in a localized market. In contrast, the broker's service area tends to be larger and involve more complicated business insurance needs. Therefore, while the labels "agent" and "broker" have a disarming simplicity, the economic reality is much more complex.

The structure of the market also complicates the distinction between insurance intermediaries. Insurance intermediaries act as gatekeepers between the insurance consumers and the insurance providers thereby creating confusion for the intermediaries as to who is actually the "customer." Is the "customer" the one to whom it is providing the good risks (the insurer) or the end user of the insurance policy (the consumer).¹⁴ The difficulty in distinguishing between agents and brokers in the marketplace is aptly illustrated in California's Consumer Guide to Automobile Insurance (Broker Fee Regulations), which only compounds the confusion between a broker and an agent with its definition of broker: "A broker will usually have the words 'insurance agency,' 'insurance brokers,' 'insurance brokerage,' or 'insurance services' in its business name."¹⁵ Because of the difficulty in distinguishing between agents and brokers, the National Association of Insurance Commissioners (NAIC) Model Rules¹⁶ and the laws of many states ¹⁷ classify all insurance intermediaries as "producers."

Under whatever name it operates, an independent insurance producer, whether a broker or independent agent, helps consumers identify their coverage and risk management needs, matches consumers with appropriate insurers by scanning the market, and helps the consumer select from competing offers. Those independent producers who have a relationship with their customers arguably owe their customers a fiduciary duty. The custom and practice of insurance producers, along with the prior regulatory climate, however, made insurance producers unable to fully comprehend that the failure to disclose conflicts of interest was problematic.

II. INSURANCE PRODUCERS' CUSTOMS AND PRACTICES

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In the past, transparency was not the objective standard in the insurance industry. “The problem that we’ve had up till now is that there had been no disclosure. Had disclosure been in place all these years, would you see all of these knee-jerk reactions?”¹⁸

Unlike law or accounting, insurance lacks an established written set of objective laws governing business practices.¹⁹ Training of new insurance producers is typically done by more senior producers.²⁰ The training occurs without examination of the ethical considerations of the already existing business practices.²¹

Insurance regulators were also complicit in the lack of transparency. The predominate means of regulating the industry historically was through mandatory requirements and prohibitions by the state regulators, rather than voluntary disclosures.²² Prior to Spitzer’s investigation, insurance regulators reportedly did not receive many complaints from the public about broker disclosure.²³ Clearly, because consumers were kept in the dark they were unable to even recognize whether there was a problem. Since Spitzer, everything has changed and what was once acceptable is no longer acceptable.

III. THE NEED FOR DISCLOSURE

The profile of undisclosed compensation rose sharply when New York Attorney General Eliot Spitzer turned his attention to the insurance industry. Spitzer’s investigation revealed that some of the largest brokers in the insurance industry were engaged in inflating bids to steer business to preferred insurers and other activity of questionable propriety. Spitzer’s investigations involved commercial lines insurance, not personal lines. The brokers involved in the New York investigation were dealing with sophisticated purchasers, such as Washington Mutual and Costco, and significant amounts of money per client.²⁴

Following Spitzer’s example, other state attorneys general turned their attention to insurance producers. There is ongoing litigation in Connecticut against Marsh.²⁵ In Massachusetts, a \$4 million complaint and consent judgment was filed against William Gallagher Associates Insurance Brokers for double-billing customers by charging brokerage fees and receiving undisclosed standard commissions.²⁶ Florida settled with Brown & Brown over disclosure of the relationship between Brown’s retail and wholesale brokerage.²⁷

Spitzer focused the debate on contingent commissions and the widespread reexamination of the way insurance brokers do business. ²⁸ Long before Spitzer galvanized public opinion regarding the opacity in brokers fees, a movement was afoot by the insurance industry itself to introduce transparency into the broker-customer relationship. Previously, those states that required disclosure only required disclosure of compensation when the producer was paid by both the insurer and the customer.²⁹ This changed in 1999 when the Risk and Insurance Management Society (RIMS) urged disclosure of all broker compensation arrangements before insurance was purchased,³⁰ and the New York State Department of Insurance formally reminded the industry that insurance customers should be informed of all compensation arrangements between insurer and broker so that the customer could “understand the costs of coverage and the motivation of their broker.”³¹

In 2001, the NAIC began examining the effectiveness of disclosures in informing and protecting insurance consumers.³² This was done because one of the foundations and assumptions of a working market is that the consumers are informed about what is occurring in the market. In 2005, the NAIC completed its review of different forms of disclosures. The NAIC determined: (1) Consumers had limited understanding of the insurance disclosures they received; (2) Consumers look to insurance disclosures to empower themselves with information about the options available to them and to make them feel better about their insurance purchases; (3) The more specific the information in disclosures, the more positively the consumers respond to it; (4) Consumers assume that they will receive any disclosures before purchasing a policy; and (5) Consumers want the disclosures explained to them, usually by their agent/broker.³³

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Recent regulations enacted in several states expose compensation schemes and clarify the role of independent producers. For these disclosures to work and allow an efficient market response, the consumers must have a basic understanding of the underlying services they are receiving and the prices those services should cost.³⁴ Without the ability to assess the quality of various insurance options, even those customers who are aware of what is happening in the insurance markets are susceptible to being steered to insurers that are inappropriate for that customer.³⁵

State action, or inaction, post-Spitzer can be organized in four categories. The first category would be states, such as New York, that have chosen not to regulate disclosure of fixed commissions. On January 30, 2008 the New York State Insurance Department issued an opinion concerning broker disclosure of fixed commissions and other compensation, stating that as “a general matter, there is no legal requirement that a broker disclose to its clients the fixed commission that it earns on the policies that it places.”³⁶ This resulted from a New York appeals court decision that not only found that contingent commission agreements were legal but held that, without a special relationship, an insurance agent or broker had no duty to disclose the existence of the contingent commission agreement.³⁷

The second category is states, such as California, that have decided to mandate disclosures and impose civil penalties for the failure to disclose. California’s disclosure regulations³⁸ were placed in effect in November 2000 and make it an unfair trade practice to fail to provide the consumer with the Standard Broker Fee Disclosure form.³⁹ California’s position is that producers deemed to be acting as agents rather than brokers cannot charge brokers fees. In *Krumme v. Mercury Ins. Co.*, wherein the Plaintiff sought retroactive disgorgement of all brokers fees, the San Francisco Superior Court ruled that brokers for Mercury Insurance acted as de facto agents of Mercury and could not charge broker fees.⁴⁰

In this same vein, the two agencies that create model insurance laws, the NAIC and the National Council of Insurance Legislators (NCOIL), have also promulgated producer disclosure legislation. Several states, including Rhode Island⁴¹ Arkansas⁴² Connecticut⁴³ and Texas⁴⁴ have enacted the NAIC broker disclosure law in part or in whole.⁴⁵ The NAIC model rule prohibits a producer who "receives any compensation from the customer" or "represents the customer" in an insurance placement from receiving undisclosed compensation.⁴⁶ Section (1)(b) of the NAIC rule contains a generic disclosure provision, which states the producer is to disclose “...the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.”⁴⁷

The NCOIL rule is less stringent. Adopted in March 2005, the NCOIL Model law does not contain a generic disclosure provision and requires disclosure only where the producer was to be paid by both parties to the transaction. NCOIL made significant departures from the NAIC law, including limiting disclosure to only the initial placement of insurance; the means of disclosure of compensation; eliminating the definition of a customer; and, problematically, eliminating the necessity to have written acknowledgment of the disclosure.

The third category are states, such as Nevada, that have chosen to codify the existing common law requirements. In 2006, Nevada adopted Nevada Administrative Code (NAC) §683A.716, which, according to a Nevada Division of Insurance Formal Opinion, codifies the common law duties of loyalty and obedience of an agent to its principal.⁴⁸ The independent producer owes a duty to the client; therefore, the independent producer should disclose anything that might affect the fulfillment of that duty.⁴⁹ In summary, NAC §683A.716 states that the producer shall not unreasonably place his own interest above the interest of the client, and that at or before the time of the purchase of insurance, disclosure of the producer’s compensation structure with the various insurers, including sources of compensation, and written documentation of this disclosure.⁵⁰ In codifying the common law, Nevada has not substantively changed how producers should deal with their clients, but clarifies how the relationship is to operate. If the Nevada Division of Insurance enforces a violation of this regulation, then a regulatory violation occurs. As this is a codification of the common law,

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individual insureds who bring cases against their producer for violation of fiduciary duty may be awarded damages for such a violation.

The last category is states, such as Illinois, that require disclosures but eliminate penalties and civil liability, except for certain actions. Illinois codified that a producer must disclose fees, while eliminating civil liability for a breach of the producer's fiduciary duty to the consumer, except for misappropriation.⁵¹ A recent Illinois Appeals decision affirmed and clarified the statute.⁵² Before the implementation of this statute, there was clearly a fiduciary duty from the independent producer to the customer.⁵³ In 2003, Missouri rescinded a regulation ⁵⁴stating that the broker had a fiduciary duty that ran to the insured.⁵⁵

IV. THE OVERLOOKED COMMON LAW FIDUCIARY DUTY.

Overshadowed by recent regulatory developments is that independent producers have always been subject to a lawsuit in some states based upon their failure to uphold their common-law fiduciary duty to their customer. A fiduciary duty is usually defined as some variation of placing the beneficiary's (i.e. the customer's) interest ahead of, or equal to, the fiduciary's (i.e. the broker's) interest because of the right to expect trust and confidence in the fidelity and integrity of another.⁵⁶ The independent producer is the agent of the insured who has a fiduciary duty to the customer.⁵⁷ An independent producer's fiduciary duty to the customer is recognized in a number of states.⁵⁸

The independent producer has a fiduciary duty to the customer because, regardless of how well the customer understands the potential conflicts of interest that exist for the producer, customers are vulnerable to being steered to coverages that do not optimally meet their coverage needs.⁵⁹ Customers may be sold more (or less) coverage than needed to increase their producer's compensation. Insurance products are inherently complex, and such complexity makes it difficult for customers to fully understand both the coverage they need and to evaluate the service and claims paying capability of various insurers.⁶⁰ Like almost everyone else, insurance producers respond to the incentives provided to them, and the problems in the insurance industry may be traced directly to ill-conceived and hidden compensation structures.⁶¹ In an example of civil litigation resulting from the failure to disclose these hidden compensation schemes, a lawsuit alleged that the broker for an engineering firm steered it away from an admitted carrier and into a surplus lines carrier, despite the fact that the coverages provided by the admitted carrier and the surplus lines carrier were exactly the same. Further allegations stated the producer's advice was tainted by its receipt of 22.5% in commissions and fees; whereas, the producer would have only received a 7.5% commission from the admitted carrier. Another lawsuit asserted that a small trucking company was steered from a superior policy into an inferior policy for the same price because the commissions on the lower coverage policy were higher. The lawsuit was triggered by a loss not covered by the inferior policy.

In both cases, it was argued that the producer did not recommend the best coverage, but rather recommended the product that provided the most compensation to the producer in violation of the producer's fiduciary duty. Avoidance of a lawsuit against a producer for breach of fiduciary duty is a more compelling reason for full disclosure of all compensation than a regulatory fine.

V. OTHER CLAIMS AVAILABLE TO CONSUMERS AGAINST INDEPENDENT PRODUCERS

The failure to disclose compensation to a customer subjects producers to other forms of legal recovery in addition to breach of fiduciary duty. For example, Nevada has a deceptive trade practice, which is defined as a person failing to disclose a material fact in connection with the sale of goods or services and/or violating a state or federal regulation relating to the sale of goods and services.⁶² The statutes and regulations enacted post-Spitzer may support a deceptive trade practice action against the insurance producer; if the producer fails to disclose material facts in connection with the sale of his insurance services, such as the amount of compensation the producer stands to receive, the producer may be subject to a lawsuit and damages.

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Another potential claim for relief against an independent producer is negligence per se. While negligence per se varies from jurisdiction to jurisdiction, most follow a version of the statement that a violation of statute establishes the duty and breach elements of negligence if the injured party belongs to the class of persons that the statute was intended to protect and the injury is of the type against which the statute was intended to protect.⁶³ By codifying the already existing common law duties, a claim of negligence per se may be brought against a broker in addition to the common law breach of fiduciary duty claim if the broker has failed to perform disclosures as required by Nevada's statute. The law is unsettled if a violation of regulation can support a claim of negligence per se.⁶⁴ In many jurisdictions, unless there is an underlying loss, it is unlikely that a negligence claim stemming from a failure to disclose fees would be supported due to the economic loss doctrine. While the definition of economic loss varies from jurisdiction to jurisdiction, it follows the general principle that a plaintiff can not sue for purely economic loss unless there is some underlying injury.⁶⁵

For those producers who sign a contract to receive a fee paid by the insured and receive a commission on top of the fee without disclosing such a commission to the insured, a breach of the duty of good faith and fair dealing may be found. This is because in some states, the duty of good faith and fair dealing exists in every contract. ⁶⁶

VI. CONCLUSION

All insurance producers wherever they do business should follow the practice of total disclosure. As the CEO of one of the largest brokers recently stated: "Disclosure has been good for the industry. It's expensive. It's painful. But I think it's a good procedure."⁶⁷

Much like the unfair trade practices act, the disclosure statutes are a good starting point because both arguably set the minimum standards. Much like the recent fall of the credit swap defaults, the damage caused by failing to disclose compensation can rapidly spiral out of control. Insurance exists so that people may be protected from future contingencies. Between the regulatory penalties and civil damages, the producer could be substantially harmed by a lack of disclosure. The least expensive E&O insurance, and the best risk prevention technique, an independent producer can obtain is disclosure of compensation, acknowledged in writing by the customer.

Endnotes

1. This article was co-authored by Vernon E. Leverty, William R. Ginn, and Patrick R. Leverty of the law firm of Leverty & Associates Law, CHTD.
2. Some states are now requiring that all producers obtain E&O insurance as a part of their licensing. R.I.G.L. §27-2.4-23. Most insurance producers agreements contain requirements requiring E&O Insurance. Ultimately, disclosure acts as a risk prevention service by ensuring that all applicable laws and regulations are followed.
3. J. David Cummins and Neil A. Doherty, *The Economics of Insurance Intermediaries*, Journal Risk & Insurance, Vol. 73, No. 3, pp. 359 (September 2006)
4. Sean M. Fitzpatrick, *The Small Laws: Eliot Spitzer and the Way To Insurance Market Reform*, 74 Fordham L. Rev. 3041, 3054 (May 2006).
5. *Id.*

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6. *Id.*
7. Cummins, *supra*.
8. Cummins, *supra*.; *Krumme v. Mercury Ins. Co.*, 123 Cal.App.4th 924, 930 (Cal.App. 2004).
9. *Id.*
10. *Id.*
11. *Id.*
12. *Grand Hotel Gift Shop v. Granite State Ins. Co.*, 108 Nev. 811, 839 P.2d 599 (Nev. 1992); *European Bakers, Ltd. v. Holman*, 177 Ga.App. 172, 338 S.E.2d 702 (Ga.App. 1985).
13. Cummins, *supra*.
14. Fitzpatrick, *supra*, at 3048.
15. Available at http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0010-automobile/upload/Final_Web_AutoIns at pg. 3.
16. See NAIC Producer Licensing Model Act, section 1.
17. See *i.e.*, NRS 679A.117
18. Dawn Love, *Broker Disclosure Dominates Western States Surplus Lines Conference*, Insurance Journal, 8/22/2005. Available at <http://www.insurancejournal.com/magazines/west/2005/08/22/features/59613.htm>
19. Fitzpatrick, *supra*, at 3048.
20. *Id.*
21. *Id.*
22. Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, Yale Law & Policy Review, Vol. 25, p. 316 (2007).
23. Love, *supra* note 18. Sherwood Girion, deputy commissioner for consumer services and market conduct at the California Department of Insurance stated: "Since I'm deputy commissioner over consumer service and marketing conduct where all the complaints come in, I should have a big long list. I have my paper with me and it has about zero complaints on it."
24. Puget Sound Business Journal, *Marsh Settlement Offers \$14M to Washington Clients*, May 25, 2005, available at <http://www.bizjournals.com/seattle/stories/2005/05/23/daily6.html>, stating that Costco and Washington Mutual were each offered settlements in excess of \$500,000.
25. *Connecticut v. Marsh and McLennan Companies, Inc.*, 286 Conn. 454, 944 A.2d 315 (Ct. 2008)

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26. *Mass. AG files complaint against William Gallagher Assoc.*, Boston Business Journal, December 20, 2007, available at <http://www.bizjournals.com/boston/stories/2007/12/17/daily51.html>.
27. *A House Divided: While The Four Biggest Insurance Brokers – and Several Top Insurance Carriers – Shun Contingent Commissions, Many Smaller Players In The Industry Defend And Rely On Them*, Best's Review, April 1, 2007, available at http://goliath.ecnext.com/coms2/summary_0199-6518846_ITM
28. *Id.*
29. *See Wisconsin Stat. Ann.* §628.32, stating “(1) An intermediary may not accept compensation from an insured or from both an insured and another source due to the insured’s purchase of insurance or for advice regarding the insured’s insurance needs or coverage unless the intermediary, before the insured incurs an obligation to pay compensation, clearly and conspicuously and in writing discloses to the insured all of the following:
(a) The amount of compensation to be paid by the insured, excluding commissions paid by the insurer to the intermediary.
(b) If compensation will be paid by another source, the fact that the intermediary will also receive compensation from the other source.”
30. Russ Banham, *Seeing No Evil*, CFO Magazine, September 2005, available at http://www.cfo.com/article.cfm/4315564/c_4334841?f=insidecfo
31. Joseph B. Resaster, *Insurer’s Pay the Brokers, Making Customer’s Wary*, The New York Times, February 14, 1999.
32. NAIC Disclosure Guidelines and Process, August 17, 2006 draft, available at http://www.naic.org/documents/committees_ex_broker_comp_disclosure.pdf, at pg. 3.
33. *Id.*
34. Schwarcz, *supra*, at 314.
35. *Id.*, at 315.
36. New York Office of General Counsel Opinion 08-01-10, available at <http://www.ins.state.ny.us/ogco2008/rg080110.htm>
37. *The People of the State of New York by Andrew M. Cuomo, Attorney General of the State of New York v. Liberty Mutual Insurance Company, et al.* No 3972 401726/06, N.Y. App. Div., 1st Dept.
38. 10 CCR §2189.1.
39. 10 CCR §2189.5(a).
40. 2002 WL 34127822 (2002), *aff’d*, *Krumme v. Mercury Ins. Co.*, 123 Cal.App.4th 924 (2004); Mercury General Corp. form 10-Q dated 11/5/2004, available at <http://sec.edgar-online.com/2004/11/05/0001193125-04-187892/Section10.asp>.
41. R.I. Gen. Laws §27-2.4-15.1.
42. Ar. Code. Ann. §23-64-520.

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43. Ct. Gen. Stat. Ann. §38a-707a.
44. Tex. Ins. Code Ann. Ins. §4005.004
45. The NAIC broker disclosure law was promulgated first, with NCOIL then adopting a different approach.
46. NAIC Producer Licensing Model Act, §18
47. *Id.*
48. NV Formal Op. 06-005, at pg. 6.
49. *Id.*
50. NAC §683A.716.
51. 735 ILCS 5/2-2201(b).
52. *DOD Technologies v. Mesirow Ins. Services, Inc.*, 887 N.E.2d 1 (Ill.App. 2008).
53. *Black v. Illinois Fair Plan Ass'n*, 87 Ill.App.3d 1106, 1111, 409 N.E.2d 549, 553 (1980); 298 Ill.App.3d 1007, 700 N.E.2d 189 (1998).
54. <http://www.sos.mo.gov/adrules/csr/previous/20csr/20csr0608/20c700-1.pdf>.
55. 20 CSR 700-1.090, stating “*PURPOSE: This regulation explains the fiduciary duty of a broker to the insured. This regulation was adopted pursuant to the provisions of section 374.045, RSMo and implements section 375.121, RSMo.* Broker’s Duty to Insured. The fiduciary duty imposed by law upon an insurance broker shall run from the broker to the insured and not to the insurer. This duty of an insurance broker to a prospective insured shall include the primary duty of first using any funds received from the prospective insured to pay the premium for the insurance requested.” (Italics in original) Available at <http://www.sos.mo.gov/adrules/csr/previous/20csr/20csr1099/20c700-1.pdf>.
56. See Black’s Law Dictionary, (8th ed.), *Powers v. USAA*, 962 P.2d 596 (Nev. 1998); *Love v. Fire Ins. Exchange*, 271 Cal.Rptr. 246, 253 (Cal.App. 1990).
57. See *Steadman v. McConnell*, 149 Cal.App.2d 334, 338, 308 P.2d 361 (1957)(where an insurance agent was an expert in the field and the insured was a layman, a fiduciary relationship existed); *Williams v. Fab-Con, Inc.*, 990 F.2d 228 (5th Cir.1993)(an insurance broker has a fiduciary duty toward the insured); *Lake County Grading Co. of Libertyville, Inc. v. Great Lakes Agency, Inc.*, 589 N.E.2d 1128 (Ill.App. 1992); *Baldwin v. Lititz Mut. Ins. Co.*, 393 S.E.2d 306 (N.C.App 1993); *Powell v. James, Hereford & McClelland, Inc.*, 377 S.E.2d 683 (Ga.App. 1989); *AYH Holdings, Inc. v. Avreco, Inc.*, 826 N.E.2d 1111 (Ill.App.2005).
58. Nevada Formal Opinion 06-005, at pg. 6.
59. Schwarcz, *supra*, at 323.
60. Cummins, *supra*.
61. Fitzpatrick, *supra*, at 3047.

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62. NRS §598.0923.

63. *Sagebrush Ltd. v. Carson City*, 99 Nev. 204, 208, 660 P.2d 1013, 1015 (1983), *see also*, Blacks Law Dictionary 1063 (8th ed.) “**negligence per se**. Negligence established as a matter of law, so that the breach of the duty is not a jury question. •Negligence per se usu. Arises from a statutory violation. – Also termed *legal negligence*.”

64. *See Padilla v. Pomona College*, 166 Cal.App.4th 661, 82 Cal.Rptr.3d 869 (Cal.App. 2008)(no claim of negligence per se based on violation of regulation); *Joy v. Bell Helicopter Textron, Inc.*, 999 F.2d 549 (D.C.Cir.1993)(violation of regulation may lead to negligence per se); *Obendorf v. Terra Hug Spray Co., Inc.*, 145 Idaho 892, 188 P.3d 834 (Idaho 2008).

65. Douglas Laycock, *Modern American Remedies, Cases and Materials*, 116 (3d Ed., Aspen L. & Bus. 2002).

66. *See Ainsworth v. Combined Ins. Co.*, 104 Nev. 587, 592 n. 1, 763 P.2d 673, 676 (1988); *Rawlings v. Apodaca*, 151 Ariz. 149, 153, 726 P.2d 565, 569 (1986); *Freeman & Mills, Inc. v. Belcher Oil Co.*, 11 Cal.4th 85, 91, 44 Cal.Rptr.2d 420, 900 P.2d 669 (1995); *Midwest Builder Distributing, Inc. v. Lord and Essex, Inc.*, 383 Ill.App.3d 645, 891 N.E.2d 1 (Ill.App. 2007); *Dalton v. Educational Testing Services Inc.*, 46 N.Y.2d 62 (1978).

67. Jim Henderson, CEO of Brown & Brown, quoted in Best’s Daily, *supra*.

MICHIGAN'S CAPTIVE LAW

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In March 2008, Michigan joined the fast-growing group of onshore captive domiciles. With the passage of a captive law that combines provisions similar to those in traditional captive domiciles, such as the inclusion of several types of captive insurance companies, with less-common features, such as relatively low capital requirements, Michigan aimed to attract both insurance and noninsurance companies to the state and to provide financial incentives to existing businesses to domicile their captives in Michigan. The law was intended to help grow, as well as diversify, Michigan's economy: the legislative analysis suggested that "thousands" of new jobs might result from the creation of Michigan-domiciled captives.¹

In many respects, Michigan's law duplicates provisions borrowed from Vermont's seminal legislation and popular in most onshore domiciles. For instance, Michigan allows for several different types of captives,² including special purpose financial captives, a catch-all category that is specifically intended to be used for captives wishing to undertake insurance securitization transactions. In fact, Michigan's first captive was formed as a special purpose financial captive, apparently in order to securitize certain classes of risks in order to have access to alternative sources of capital.

One way in which Michigan distinguished itself from other onshore domiciles was in its capital requirements.

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Michigan chose to require relatively low capital requirements, ranging from \$150,000 for a pure captive, to \$300,000 for an industrial insured captive, to a high of \$750,000 for an association captive organized as a mutual.³ The minimum capital requirement for a special purpose captive is not set by law, but is instead determined by the Michigan Office of Financial and Insurance Regulation (OFIR).⁴ In so doing, Michigan apparently hoped to attract both first-time captive entrants and existing captives wishing to redomicile in Michigan.

Notably, Michigan's law does not impose premium taxes but instead charges captive parent companies fees linked to premium volume, ranging from \$5,000 (for captives with volume of less than \$5 million) to \$100,000 (for those with more than \$75 million in premium volume).⁵

Michigan also allows companies to form branch captives.⁶ Branch captives are generally used by companies with offshore captives that wish to fund employee benefit risks, and federal rules disallow the use of offshore captives to fund employee benefit plans covering United States employees. In addition, Michigan provides for the creation of protected cell companies,⁷ but these are not limited to captives and so may potentially be used by other Michigan-domiciled insurers.

In one respect, at least, Michigan stands out from other onshore domiciles, and this is in its disallowance of reciprocal companies. The reciprocal model is favored by tax-exempt organizations wishing to form onshore captives because it allows them to organize the company in a way that eliminates or reduces federal income tax on their profits. Without this provision, Michigan-domiciled captives may face significant federal tax liability, even if the owners of the captive are tax-exempt organizations.

The success of Michigan's captive program will have many measures, including its ability to attract entities wishing to decrease their tax liability during the economic downturn, and the readiness and availability of regulatory staff to fulfill potential and registered captives' needs.

Endnotes

1. Senate Fiscal Agency Bill Analysis, S.B. 1061 & 1062, August 14, 2008.
 2. MCL 500.4601(h).
 3. MCL 500.4611(1).
 4. MCL 500.4611(1)(f).
 5. MCL 500.4625(5).
 6. MCL 500.4611.
 7. MCL 500.4663.
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SUMMARY ORDERS IN KANSAS / THE NEW CONSUMERISM PROCEDURE

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Insurance companies spend millions of dollars responding to the various consumer inquiries sent to them by the states' insurance departments on a myriad of ongoing issues. Each state has its own quirks and procedures but in Kansas a new form of consumerism is being put out by the Kansas Insurance Department.

Typically in Kansas, a consumer will file a complaint with the Insurance Department, the Insurance Department will send a form letter to the company requesting reasons for its position and all background and support thereof, and then potentially an onslaught of letters between the Department and the insurance company, will ensure each trying to convince the other that they are correct. Historically, this is referred to as the regulatory approach, i.e., the insurance department is a regulator not a judge and jury.

However, the Kansas Insurance Department is moving towards prosecutorial mode, i.e., they are attempting to act as judge and jury on various consumer issues by utilizing a cobbled up array of state statutes to get them from A to B.

Although the Kansas Insurance Department might wish to pat itself on its back for a new age of consumerism, the road that they are going down is full of potential dangers and in this writer's opinion, in violation of the true intent of the statute.

Kansas Law, under its Administrative Procedures Act, allows state agencies to utilize summary proceedings, i.e., issuing an order prior to any formal hearing, if 1) "the use of those proceedings in the circumstances does not violate any provision of law;" and 2) "the protection of the public interest does not require the state agency to give notice and an opportunity to participate in person other than the parties."¹ In essence, this statute allows the Kansas Insurance Department to issue a Summary Order, which will outline the statutory authority for their regulatory basis, the facts as they wish to promote them, and the underlying "Order," which imposes an administrative penalty. The constitutional savings on this particular statute is that it does allow the parties, within 15 days, to request a hearing, and if said hearing is requested, the Summary Order is vacated². What the Department then claims is that since the process can withstand a constitutional attack, their use of the Summary Order is appropriate. The Department has misconstrued K.S.A. 77-537. This is not a constitutional issue - it is a question of whether the Department has exceeded its statutory authority.

Administrative agencies are creatures of statute; they may only act within the scope of authority granted by their authorizing statutes.³

Endnotes

1. K.S.A. 77-537(a)
2. K.S.A 77-537(b)

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3. *Kansas Industrial Consumers Group, Inc vs. State Corporation Commission of State of Kansas*, 36Kan. App. 2nd 83, 92, 138 P. 3d, 338 (2006).

BUT IS IT INSURANCE? INDEMNITY CLAUSES IN SELF-STORAGE RENTAL AGREEMENTS

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Across the United States, self-storage rental units have become a common sight. Generally, these units consist of free standing buildings that allow each individual access to the unit they rent; some self-storage units however, are found enclosed within a building so that the climate within the individual storage units can be controlled. Many states have some sort of statute with respect to self-service storage facilities.¹ These statutes usually define the duties of the occupant and operator. Most describe and define the duties and liability of the operator and the duties of the occupant with respect to their personal property and to the operator. Additionally, most statutory schemes describe the operator's right to a lien on the occupant's property should the occupant fail to pay their rent. These statutes also tend to describe whether the owner or occupant is responsible for the care and control of the property stored in the self storage facility. In Missouri, this statutory section is found at Mo. Rev. Stat. §415.425, which states that "except as provided in subsection 3 of Section 415.420, unless the rental agreement specifically provides otherwise and until a lien sale under Sections 415.400 to 415.430, the exclusive care, custody and control of all personal property stored in the leased self-service storage space remains vested in the occupant."

Thus, under the Missouri statutes, unless the self storage facility operator has taken control of personal property found in a rental unit, the operator is not responsible for the care, custody or control of the personal property stored in the unit. In essence, the operator is statutorily absolved of responsibility or liability for an occupant's property. The State of Missouri also requires that the lessee "be informed in writing that the lessor either does or does not have liability insurance."²

Notwithstanding statutory protections, most self-storage facility operators in the State of Missouri go to great lengths to make it clear to occupants of the facility, both in rental agreements and by signage, that all personal property owned by the occupant is stored at the occupant's risk, and the operator's agents and employees are not liable for any loss to any property in the storage space for any reason. Likewise, if the operator chooses not to carry liability insurance, this fact and also a release of the operator of all liability for bodily injuries is also found in the rental agreement. This release language is generally printed in bold face type to reduce the possibility that the occupant can claim ignorance of it or to comply with state case law that disclaimers of liability be set in type of a certain size.³

Some self-storage facility operators further require, in the rental agreement, that the occupant acquire and maintain insurance at the occupant's expense for coverage against fire, burglary, vandalism, and malicious mischief for the actual value of the stored property. Failure of the occupant to carry and maintain insurance on the occupant's stored property is a breach of the lease agreement.

Despite the fact that almost all self-storage rental agreements contain exculpatory clauses which release the operator of any liability for property damage and bodily injury, lawsuits on these issues still occur. While the fact that the exculpatory clauses appear in the rental agreements should result in a decision for the operator in

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each case, such does not always occur. Further, even if the operator wins a case of this nature, such decision may result in adverse publicity against the operator which in turn may engender ill will towards the operator and its business.

In light of these facts, some operators have elected to make available to the occupants personal property insurance coverage if the occupants do not have other coverage. Of course, providing insurance coverage to the occupants means that the owner or the owner's representative must be properly licensed and comply with all requirements for the sale of insurance. Some states have a limited license with respect to self-storage facility operators who sell insurance of this type. These programs typically require the occupant to pay the premium for the insurance coverage along with the monthly rental payment.

More recently, however, self-storage facility owners have begun to offer programs in which in exchange for a larger monthly rental payment from the occupant, the owner will accept responsibility for certain losses to the occupant's belongings in various specific circumstances; for example, if the facility roof leaks, any damage to the occupant's property will be reimbursed up to a set amount. The occupant is given the opportunity to have a lower rental rate, per the rental agreement, with the standard exculpatory clause favoring the operator, or the owner can pay a higher monthly rent for a plan which eliminates the exculpatory clause normally found in the rental agreements and provides protection for damage to the occupant's property. The question then arises as to whether or not these programs constitute insurance because they transfer risk from the occupant to the owner in exchange for additional rent (which could be construed as premium) paid by the occupant to the owner.

In Missouri, at least, these plans have not been found to constitute the business of insurance for a number of reasons. Because Missouri does not have a statutory definition of insurance, it is instructive to review how insurance has been defined by the United States Supreme Court. In *Group Life and Health Insurance Company vs. Royal Drug Company*, 440 US 205, 99 S.C. 1067 (1979), the United States Supreme Court identified three criteria to use in determining whether a particular practice constitutes the business of insurance. In determining whether a practice is part of the business of insurance, the Court directed that it be determined first, "whether the practice has the effect of transferring or spreading the policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."⁴ The Court in *Royal Drug* further noted that while none of "these criteria is necessarily determinative in itself," the arrangement between the parties must be examined.⁵

As noted above, in the State of Missouri there is no statutory definition of what constitutes the transaction of insurance. Rather, regulators examine each transaction on its facts to determine if it is indeed an insurance transaction. Likewise, there is no case law in Missouri which finds an indemnity clause constitutes an insurance transaction when the indemnity clause forms a part of a self-storage facility lease agreement.

There are cases, however, which could be considered in the State of Missouri to be instructive to those who wish to know what facts would most likely lead to a conclusion that a transaction constitutes a contract of insurance. In *Bekins Moving and Storage Company of Texas v. Williams*, the Plaintiff sued Bekins for damage to her property allegedly caused by Bekins during a move.⁶ The Plaintiff sought to recover against Bekins based on violations of the Texas Insurance Code and also for negligence.⁷ Bekins asserted, among other things, that the "Transit Insurance" provided to the Plaintiff was not insurance within the meaning of the state insurance code and was merely incidental to its "ordinary business activity," and relied on a portion of the Texas Insurance Code for its argument, Texas Insurance Code Art. 1.14-1 Section 2(a)(2) which indicates that the making of a contract of guaranty or suretyship that is simply incidental to other legitimate business does not constitute the business of insurance.⁸

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The Court, however, found otherwise. The Court noted that the "Transit Insurance" provision in Bekins' contract was not a guaranty or a suretyship.⁹ The Court found that the Transit Insurance provisions specifically provided for "insurance protection in the sum of Seventy Five Thousand Dollars," and for an "insurance protection charge of \$480.00."¹⁰ The Court further found that the provisions provided for exclusions of liability in certain instances and provided that "if the amount of the insurance does not cover the actual value of the property, the customer shall be regarded as his own 'insurer' to the extent of the difference."¹¹ The Court found that it would construe the provision as insurance as it is designated and not a guaranty or suretyship. Also, the Court found that the Bekins contract "called the coverage insurance," Bekins' representative "called it insurance," it was "paid for as being insurance," the "documents specified the amount of coverage, the parties both believed that Bekins was providing insurance, and the coverage was designed to pay Williams for damage to her property above the stated sixty cents per pound."¹² Therefore, the Court found the coverage was insurance and fell within the insurance code.¹³ While self-storage agreements differ from moving contracts, the methods used in the Bekins case to determine if a transaction is insurance can be applied to self-storage agreements to determine whether provisions in which the owner indemnifies the occupant constitute insurance.

In many business relationships, including a landlord-tenant relationship, it is not unusual for the parties to negotiate a transfer of liability within the context of the business or landlord-tenant relationship, especially in a commercial lease situation. The amount of liability or risk being transferred generally then affects the final rental price negotiated by the parties. The courts in Missouri and other jurisdictions have held that indemnity clauses between parties in standard contracts are permissible. These standard indemnity clauses traditionally have not been considered contracts of insurance.

With respect to a self-service storage facility, the subject of limited responsibility for damage to stored property obtained with an indemnity clause in a rental agreement might appear to be an insurance transaction when the transaction is in fact incidental to the agreement between the owner and operator of a self-service storage facility. Along these lines, the Missouri Court of Appeals has recognized the validity of the inclusion of an indemnity clause in a contract as a "contractual provision in which one party agrees to answer for any specified or unspecified liability or harm that the other party might incur."¹⁴ The Court has also examined exculpatory clauses and found that they are a "contractual provision" which excuse a party from liability which results from negligence or wrongful actions. ¹⁵

The Missouri Supreme Court has also found that indemnity clauses merely shift liability from one party to another and also found that indemnity clauses are acceptable when part of a larger standard agreement.¹⁶

Thus, a landlord in a self-storage facility in assuming and retaining liability in a lease agreement in return for increased rental rate does not appear to be engaging in an insurance transaction in the state of Missouri. An increase in the amount of rent paid for protection to the occupant's property appears to be merely additional consideration in exchange for taking on additional liability in the context of the rental agreement.

However, care should be taken in drafting such clauses so they do not risk being construed as insurance; for example, calling such clauses insurance should obviously never be done and the additional rent received by the operators should not be referred to as a premium payment. Also, within the body of the contract, amounts paid as indemnity for loss also should not be called "coverage," and there should be nothing described as or which acts as a deductible. In short, a clause of this nature should resemble a clause in a business contract in which one party, (i.e., a self-storage facility operator), for additional consideration, undertakes a risk for negligence which is within its ability as an entity to control. A clause of this type in a self-storage facility agreement will probably not, therefore, at least in Missouri, appear to be an insurance transaction. While each of these situations are fact specific, the situation as described above would not appear to constitute the transaction of the business of insurance in the state of Missouri.

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Endnotes

1. *See* Mo. Rev. Stat. §415, et seq.
2. Mo. Rev. Stat. §415.410.
3. *See Alack vs. Vic Tanny International of Missouri, Inc.* 923 S.W. 2d 330 (Mo. 1996)
4. *Group Life and Health Insurance Company vs. Royal Drug Company*, 440 U.S. 205,99 S.Ct. 1067 (1979).
5. *Id.*
6. *Bekins Moving and Storage Company of Texas vs. Williams*, 947 S.W. 2d 568 (Tx App. 1997).
7. *Id.*, at 572.
8. *Id.*, at 580.
9. *Id.*, at 580, 581.
10. *Id.*, at 581.
11. *Id.*, at 581.
12. *Id.*, at 581.
13. *Id.*, at 581.
14. *Caballero vs. Stafford*, 202 S.W. 3d 683 (Mo. Ct. App. 2006)
15. *Id.*
16. *Alack vs. Vic Tanny International*, 923 S.W. 2d 330, 338 (Mo. 1996).

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