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VIRGINIA INSURANCE ISSUES REGARDING PRE-NEED AND FINAL EXPENSES

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INTRODUCTION:

According to a 2007 survey by AARP, 34% of the over 50 years of age population has done some pre-planning and 23% have pre-paid a portion or all of the funeral or burial expense for themselves or someone else.[1] That translates into 20,000,000 people age 50 or older who have already paid some funeral expenses or made provisions for such payments.[2] Once your pre-planned arrangements are set you can elect to pay a portion or all of the bill before your death. This lifts the burden from family members and helps insures that the decedent's wishes are carried out. There are three main ways to fund a pre-paid funeral:

A. Final Expense Insurance ("FEI")

B. Pre-Need Insurance ("PNI")

C. Pre-Need Trust ("Trust")

FEI is basically a life insurance policy with a low face value somewhere between $5,000 and $50,000 that you buy from a fully licensed life insurance agent representing a licensed and approved life insurance carrier. You can name any beneficiary who would make a claim at the time of your death and receive the money upon your death. That beneficiary normally would be responsible for using the cash proceeds to carry out your wishes. For example, if you have a final expense insurance policy for $20,000 and your burial services end up costing $15,000.00, your beneficiary would pay the bill and keep the extra $5,000.00. Final expense insurance policies are normally low face value term or whole life policies.

PNI is different and is intended for the person who has selected specific arrangements at a funeral home and wants the assurance that those arrangements will be paid for and implemented. Unlike FEI, which you buy through a fully licensed insurance agent, PNI is sold by a funeral home director who is also licensed but is a "limited insurance licensed agent."[3] A limited insurance licensed agent normally does not have the multitude of continuing education requirements, exams, etc. that are required of a fully licensed life insurance agent.[4] Normally under a pre-need arrangement, the insured pays for this policy with a one-time premium or periodic payments and the beneficiary (normally a family member) executes an assignment of the proceeds to the funeral home. From an informal inquiry, three of the largest pre-need insurance companies, Forethought, Homesteaders and National Guardian, estimate that over 95% of their policies are offered at a guaranteed price.[5] Normally the funeral director makes the claim, receives the money and carries out the decedent's (insured's) wishes. Pre-need insurance laws vary by state and New York does not allow the sale of pre-need insurance at all.[6]

Trusts. Another option is to make prearrangements with your funeral director and fund those arrangements by putting cash into a trust which holds the money until your death and then disburses it to the funeral home. The arrangement also relieves your family of last minute decisions. Your payment for funeral arrangements is deposited into a federally or state insured bank until your death. Depending on your estate, your money may be put into individual cash trust accounts or "master trust accounts" which pools many individual trusts. The

value of the trust can rise and fall depending on the investment performance elected by the funeral director; however, if you have a guaranteed price contract from your funeral director, he takes on the market risks and must provide the services that have been selected by the decedent no matter how well or poorly the trust investments have performed.

ISSUES:

New Virginia Insurance Advertising Regulation.[7] Virginia, effective July 1, 2011, has promulgated rules governing advertisement of life insurance and annuities. This new rule was published and distributed by the Virginia Bureau of Insurance ("VABOI") a year ago with a request for comments. The new rule states "an advertisement for life insurance or an annuity in which the face amount or any part of the face amount is based on actual or estimated cost of funeral goods or services shall contain the following disclosure: "This is (life insurance or an annuity). This (life insurance or annuity) does not specifically cover financial goods or services. The beneficiary of this (life insurance or annuity) may use the proceeds of this (life insurance or annuity) for any purpose, unless otherwise directed. The face amount of this life insurance is not guaranteed to increase at the same rate as the cost of a funeral increase."[8] This new regulation became effective July 1, 2011 and has caused unrest among both pre-need insurance companies and final expense insurance companies.

First, there appears to be confusion as to whether it is applicable only to insurance for final expense and not to pre-need or applicable to all insurance policies. Second, as a practical matter, almost every life insurance policy sold in Virginia is likely to be based on some cost related to burial expenses. This probably places an unintended consequence on the VABOI by imposing a burden upon itself to review the marketing materials and advertisements of all insurance companies so as to equally apply this new regulation. Third, I believe that it is a regulation that adds unnecessary cost and burdens to all insurers doing business in Virginia, creates a new enforcement obligation upon the VABOI and may allow one portion of the marketplace (pre-need) to have a benefit over other life insurance companies who specifically market their product for final expense. Fourth, since this new regulation appears to be a result of a combination of the Code of Virginia, the old Chapter 40 of our Virginia Administrative Code and the NAIC Model Regulation (on this subject) it has become confusing to insurers. Finally, I would suggest that it is a solution looking for a problem that really does not exist in the Commonwealth of Virginia.

Hopefully our VABOI has been listening to comments from the entire industry and that either amendments to this new regulation or reconsideration and possible revocation could be in the near future.

Excess Funds for Medicaid Recipients. A funeral home director who operates his business in Virginia can legally establish an irrevocable trust for an individual for the purpose of paying for funeral and burial expenses. Under a "two-step" process, funds transferred from the individual to the funeral home are deemed a compensated transfer for value when the amount of the funds transferred does not exceed the value of the goods and services purchased. The entire amount of the trust is exempt from Medicaid eligibility when placed in an irrevocable trust by the funeral director.

The two-step process occurs when (a) the individual signs a pre-need contract with the funeral home director promising pre-payment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the funeral director; (b) then, the funeral home director in turn places the money, life insurance policy or annuity into a trust, established by a person other than the individual.

Virginia, as well as other states, are considering the situation where an individual who is a recipient of Medicaid, purchases a pre-need contract (either using all cash or funding it with insurance) and then dies and the decedent's beneficiaries elect to direct the funeral home director to provide a less expensive funeral than the one original contracted by the decedent. This "excess fund" or "Medicaid Reimbursement" topic is

becoming a paramount issue in light of the economy and in light of the cut backs by the federal government and Medicaid funding to all states. New Jersey has a specific statute dealing with excess insurance proceeds or excess cash proceeds when placed in trust for a decedent who is a recipient of Medicaid.[9] This statute is relatively specific and states that in the case of an irrevocable funeral trust (presumably a cash trust) of a decedent who is a Medicaid recipient "the entire remainder after the payment of funeral and burial goods and services shall be paid to the Division of Medical Assistance and Health Services in the Department of Human Services, as though the division were the purchaser of the trust." It further specifically applies to an irrevocably assigned "newly issued funeral insurance policy of a decedent who is a Medicaid recipient" and states that this policy will not be excluded as a resource unless the Division of Medical Assistance and Health Services is named the sole beneficiary of the policy. This statute further states that "as an alternative to being named beneficiary, (DMAS) can be named as a payee of the balance of any remaining monies subsequent to the delivery of funeral and burial goods and services, . . ."[10] California and Ohio have provisions applicable to annuity contracts or life insurance policies making the individual's estate as an alternative beneficiary and thus presumably subject to Medicaid's ability to recover from the estate any funds in excess of the cost of a pre-need contract or funeral services.[11] Although New York does not allow insurance to be used for pre-need contracts, it does allow cash trusts and it requires that the agreement have a provision that "if any money is left over after your funeral and burial expenses have been paid, it will go to the County."[12] Similar to Virginia, New York probably delegates to its Counties the responsibility of handling all Medicaid eligibility and reimbursement issues. The new (effective July 1, 2011) Indiana statute on this Medicaid Reimbursement issue is pretty unique. It allows the state to use federal or state Medicaid funds to pay life insurance premiums and expenses for a Medicaid applicant or recipient who has irrevocably named the state as the beneficiary of an in force life insurance policy or assigned a life insurance policy to the state. It also provides that life insurance proceeds that exceed the amount of Medicaid benefits be paid to the beneficiary of the recipient and that the value of a life insurance policy owned by an applicant or recipient may not be considered in determining Medicaid eligibility if the applicant or recipient has irrevocably named the state as the beneficiary or assigned the life insurance policy to the state.[13]

Endnotes

1. www.insure.com; Tips for Buying Pre-Need and Final Expense Insurance, last updated June 1, 2010

2. Id.

3. § 38.2-1800 Code of Virginia (1950, as amended); § 54.1-2800 to § 54.1- 2825 Code of Virginia (1950, as amended)

4. § 38.2-1800 et seq., Code of Virginia (1950, as amended)

5. Forethought Life Insurance; Mr. Walt Dixon, Forethought Center, Batesville, IN 47006; Homesteaders Life Insurance, Mr. Gerry Kraus and Ms. Tracy Kelly, 5700 Westown Parkway, West Des Moines, IA 50266; National Guardian Life Insurance Company, Mr. Mark Neidinger, 2 East Gilman Street, Madison, WI 53703

6. Preneed Funeral and Burial Agreements: A Summary of State Statutes, written by Sandra B. Eskin, December 1999 © 1999 AARP Public Policy Institute.

7. 14 VAC 5-41-10 et seq. (effective July 1, 2011).

8. 14 VAC 5-41-40(H).

9. New Jersey Statute Annotated: § 2A:102-22 (a) and (b).

10. Id.

11. California Chapter 22 HF No. 351(D); Ohio Administrative Code § 5101:1-39-30

12. New York General Business Law § 453

13. Indiana Code § 12-15-1-21

CONSOLIDATED ARBITRATION OF MINNESOTA NO-FAULT CLAIMS; IS ITS FUTURE BRIGHT OR IS THE END IN SIGHT?

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Developments in the arbitration of no-fault claims have prompted significant discussion among insurers writing automobile insurance in Minnesota. Several are discussing the need for reform in light of developing case law. This paper discusses several leading Minnesota cases and the resulting issues that have arisen.

Minnesota's no-fault arbitration system has as its purpose "to promote the orderly and efficient administration of justice in this State."[1] Under the statute, no-fault claims in an amount of $10,000 or less are subject to mandatory binding arbitration.[2] The mandate to arbitrate claims, and the resulting denial of the right to a jury trial, has been based both on the relatively small amounts in controversy in many cases, and the fact that the insurance industry is highly regulated, justifying administrative rather than judicial resolution of certain disputes.

Over the past decade, a line of Minnesota Supreme Court decisions permitting assignment and consolidation of windshield repair claims has resulted in an interpretation of the statute that the $10,000 jurisdictional limit relates only to *each individual claim* and not the *aggregate* of claims assigned to a no-fault assignee. Accordingly, a single no-fault arbitration in Minnesota between an insurer and one assignee may include thousands of individual claims and result in an award in the hundreds of thousands of dollars or even in excess of $1,000,000. These developments present significant issues for Minnesota insurers. And the resolution of those issues does not seem likely to come from future judicial decisions.

In Illinois Farmers Ins. Co. v. Glass Service Co.,[3] the court considered whether over 5,700 individual short pay[4] windshield claims, totaling over $1,000,000 and assigned over a 5 year period to Glass Service Co. could be combined into one proceeding. While the parties agreed that each individual claim was subject to mandatory arbitration under the no-fault statute, Glass Service advanced two distinct arguments: (1) that it (Glass Services) was a single claimant with a single claim in excess of $1,000,000[5] not subject to mandatory arbitration and alternately, (2) that if its claim(s) were all subject to mandatory arbitration then they should all be combined into a single arbitration proceeding. As to the first argument, the court agreed with Farmers that, "Glass Service may not defeat the No-Fault Act's jurisdictional mandate for arbitration by consolidating the claims of Farmers' individual policyholders" and stated that "the No-Fault Act requires that each of these

claims be arbitrated."[6]

The court then considered the issue of consolidation. The court relied upon Grover-Dimond Assocs. v. Am. Arbitration Ass'n.[7] In Grover-Dimond (a construction contract case) the court noted, "Where consolidation is not prohibited by statute or by the agreement to arbitrate, consolidation of similar disputes prevents both redundancy and conflicting awards."[8] Considering that one statutory purpose of the No-Fault Act is judicial efficiency,[9] the Court found Grover-Diamond to be a "good law" to be followed in determining whether no-fault arbitrations should be consolidated. The court acknowledged (but did not follow) federal circuit court decisions which refused to permit consolidation under the Federal Arbitration Act (FAA).[10] Accordingly, the case was remanded to district court to determine if consolidated arbitration would be efficient, avoid the risk of inconsistent results, and not result in prejudice to any party.

Upon remand, the district court did order consolidation of the 5,700 claims into three groups and, in 2007, the awards were upheld by the Minnesota Court of Appeals in an unpublished opinion.[11]

In response to the Farmers decision, automobile insurers either turned to existing anti-assignment clauses in their policies,[12] or revised the policies to include them. In Tavertine Corp. v. Lexington-Silverwood,[13] the supreme court had held that an "anti-assignment clause is a valid and enforceable term" that precluded the assignment of a right to payment under a contract.[14] Obviously, if assignment was restricted, glass vendors could not be in a position to seek consolidation. In 2009, the court addressed the validity of such clauses. But that argument was not embraced by the supreme court.

In Star Windshield Repair Inc. v. Western Nat'l Ins. Co.,[15] the court acknowledged that "an anti-assignment clause is a valid and enforceable term" under a contract[16] but did not apply this precedent to the issue of whether anti-enforcement clauses in insurance policies were enforceable. Rather, the court focused on a much more specific issue of the enforcement of such clauses where auto glass vendors sought to arbitrate disputes with insurers over assigned short-pay claims.[17] The Court looked to the No-Fault statute[18] and the Minnesota Unfair Claims Settlement Practice Act[19] to interpret the "statutory framework regarding auto glass insurance." The court interpreted these statutes as indicating a legislative intent that auto glass vendors should be able to arbitrate "their shortpay claims against insurers ... because the statutory scheme removes the policy holder from the payment process for auto glass claims and requires disputes to be arbitrated."[20] The court held that anti-assignment clauses in the insurers contracts did not defeat the insured's assignment of post-loss proceeds to a glass vendor. In a brief concurring opinion, Justice Barry Anderson argued that the validity of anti-assignment clauses in insurance contracts should be limited to pre-loss assignments.

Taken together, the decisions in Farmers and Star Windshield (and subsequent cases) make clear that (1) insureds may assign their post-loss claims to auto glass vendors and (2) such assigned claims, no matter how numerous, may be aggregated into one arbitration in the discretion of a district court. The question becomes whether auto glass vendors are a uniquely privileged class under the statute or whether any no-fault vendor can consolidate assigned post -loss claims as well.

The answer to this question now appears to be emerging in the Minnesota courts. In a recent unpublished decision, the Minnesota Court of Appeal upheld a district court order to compel arbitration of 22 No-Fault medical expense claims assigned to a medical provider.[21] The court of appeals rejected insurer arguments that (1) the assignments were invalid, (2) the No-Fault Act precludes the assignment of medical-expense claims to a medical provider and (3) the provider's arbitration of the assigned claims would constitute impermissible claim splitting. The court found that although there was no statutory framework similar to glass providers, the auto glass case law was analogous. Like the court in Farmers, it found that the medical provider had the same legal rights as the assignors had before the assignment. Significantly, in this case the insurance contract did not have an anti-assignment clause. Had a non-assignment clause been in place, the court may have enforced it.[22] Because the majority opinion in Star Windshield relies on a statutory interpretation analysis of the auto

glass laws rather than on a limiting the enforceability of anti-assignment clauses to pre-loss circumstances, contractual limitations or prohibitions against assignment to medical providers of post-loss claims appear to be enforceable. Considering the recent trend of cases, however, it is more likely that the Minnesota Supreme Court will expand its Star Windshield holding to limit the validity of anti-assignment clauses to pre-loss claims. In effect, Justice Anderson's concurrence will become the majority opinion.

Thus, it seems likely that Minnesota courts will consider post-loss assignment of no-fault claims to any vendor to be invalid and unenforceable. If this is a correct prediction, aggregation of multiple assigned claims into a single arbitration will be available to any assignee and limited only by the discretion of a district court.

Insurers have voiced significant concerns about this trend, a trend many view as judicial expansion of the no-fault statute. One overriding concern is the suitability of arbitration as a forum to resolve high value disputes. Arbitration is arguably unsuitable because under the Minnesota No-Fault Arbitration Rules:

1. Conformity to legal rules of evidence is not necessary (Rule 24).
2. A transcript, if one is made, is not considered to be an official record of the proceedings absent a determination by the arbitrator or agreement of the parties (Rule 17).
3. The fact that an arbitrator, or the arbitrator's firm represents automobile accident claimants against insurers does not create a presumption of bias (Rule 10(b)).
4. Discovery is limited (Rule 12).

In sum, no-fault arbitration is a relatively informal proceeding. Such informality is well suited to resolution of small claims which otherwise would entail significant costs to litigate. Much like conciliation court, arbitration offers access to justice at the expense of a several important rights that the parties would enjoy in a court proceeding. The issue is whether this trade off makes sense in the case of numerically complex, high value no-fault disputes.[23]

A second concern with consolidated arbitration of assigned claims is the potential for decision fatigue to influence the fact finder. In a consolidated arbitration of numerous claims, the claimant would be well advised to put his/her best foot forward from the outset by presenting the strongest claims first. As the proceeding wears on, the arbitrator may mistakenly assume that all subsequent claims are also meritorious. In a proceeding involving thousands of individual claims, they all tend to look alike after a period of time. Research indicates that judgment falters after extended periods of concentration. The New York Times has reported on a recent study of the "erratic judgment" of a panel of Israeli judges after a period of decisionmaking. The article reports, "The mental work of ruling on case after case, whatever the individual merits, wore them down."[24]

Ultimately, the issue of consolidated arbitration of assigned claims is one of public policy for the legislature. Arguing in its favor, assignment and consolidation certainly reduces the workload of Minnesota's underfunded court system. Also, there is a degree of consumer convenience in removing the insured from disputes regarding payment of claims. "Minnesota's statutory scheme for automobile insurance essentially removes the auto glass customer from the payment process."[25] However, removing insureds from the payment process may tend to inflate the cost of the vendor's services. If the health insurance system is any indication, provider costs increase when the insured has no direct financial interest at stake. Insurers point out that windshield glass claims are more costly in Minnesota than in most other states. While windshield pricing may not matter to an individual insured, the systemic impact is higher insurance prices. Logically, higher costs will also result from consolidated arbitration of assigned medical provider and body shop repair claims if the consumer has "no skin in the game." If insurers pay out more to vendors than they should, the insureds will pay a higher premium than they should. Ultimately, the issue becomes one of affordability of insurance. Hopefully, the Minnesota legislature will soon address these issues. Otherwise, the insurance consumer will become a mere afterthought in the ongoing economic disputes between insurers and no-fault vendors.

Endnotes

1. Minnesota No-Fault, Comprehensive or Collision Damage Automobile Insurance Arbitration Rules.

2. Minn. Stat. § 65B.525 (2011).

3. 683 N.W. 2d, 792 (Minn. 2004),

4. Insurer payment in an amount less than billed by the vendor.

5. The district court does not have subject matter jurisdiction over no-fault comprehensive claims of $10,000 or less. See: Olson v. Am. Family Mut. Ins Co., 636 N.W. 2d 598, 604 (Minn. App. 2001). Conversely, if the "single claim" has a value of one million dollars, the district court would have subject matter jurisdiction.

6. Id. at 804.

7. 297 Minn. 324, 211 N.W. 2d 787 (1973).

8. Grover-Dimond 211 N.W. 2d at 790.

9. Minn. Stat § 65B.42(4) states as one of the purposes: "to speed the administration of justice, to ease the burden of litigation on the courts of this state and to create a system of small claims arbitration to decrease the expense of and to simplify litigation." The question is whether small claims arbitration simplifies million dollar litigation based on over 5700 individual claims and, if so, what and whose rights are sacrificed in this pursuit?

10. Baesler v. Continental Crain Co., 900 F2nd 1193 (8th cir. 1993).

11. Glass Services Inc. v. Illinois Farmers Ins. Co., A06-1074 (Minn. Ct. App., June 26, 2007).

12. In Farmers, the supreme court did not consider the impact of anti-assignment clauses in automobile insurance contracts.

13. 683 N.W.2d 267 (Minn. 2004).

14. Id. at 269, 274.

15. 768 N.W.2d 346 (Minn. 2009).

16. Star Windshield, citing Travertine Corp v. Lexington-Silverwood, 683 N.W.2d 267 (Minn.2004) at 349. The court distinguished Travertine on the basis that it dealt with a management contract rather than an automobile insurance contract. "While we have stated that insurance policies follow general principals of contract law unless there are statutory laws to the contrary ... we conclude our analysis in Travertine is not helpful in resolving the issues presented because the statutory framework regarding auto glass insurance, as laid out above, makes the insurance policies at issue sufficiently different from management contracts." 683 N.W.2d at 269.

17. A fundamental principal of the law of contract articulated in Travertine is that the plain language of the contract. determines the intent of the parties, at 271. The court in Star Windshield did not attempt to reconcile this fundamental principal with the No-Fault Act. Rather, the court seems to have assumed that, when applied to glass vendor claims, the anti-assignment provision was in conflict with the statute.

18. Minn. Stat. §§ 65B.41-71 (2008).

19. Minn. Stat. §§ 72A.17-.32 (2008).

20. Id. at 350.

21. Medical Scanning Consultants, PA d/b/a/Center for Diagnostic Imaging v. Metropolitan Property and Casualty Ins. Co. a/k/a MetLife Auto & Home. A10-2186 (Minn. Ct. App. July, 2011).

22. See: Physicians Neck & Back Clinics, P.A., v. Allied Ins. Co., A05-1788, (Minn. Ct. App., July 25, 2006).

23. It is conceded that many complex, high value disputes are resolved in arbitration outside of the no-fault context. However, in such instances,the parties contractually agree to arbitrate.

24. John Tierney, N.Y. Times, August 17, 2011.

25. Farmers, 683 N.W.2d at 796.

FEDERAL SCRUTINY OF INSURANCE REGULATION

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The author has been practicing insurance business and regulatory law since 1974. Throughout the 37 year period there has been discussion, at varying levels of seriousness, about the prospect of regulating the insurance business on a Federal level. The underlying premise in favor of Federal regulation is always the same: 1) The existing State-based system cannot possibly be as efficient as the application of a single uniform set of laws administered at the Federal level by one or more national agencies. 2) When the existing system was created, commerce was largely conducted within the circle defined by how far a person could travel on horseback in day. Today's world requires a different approach.

It is tempting to respond to that view with a famous H. L. Mencken quote: "For every complex problem there is a simple solution ... and it is wrong." However, neither the view that a single system has to be better nor the view that there is no such thing as a simple solution to a complex problem is inherently correct. Anyone with blind faith in the one big system approach need only look at the recent meltdown events in the housing and related financial markets. The abuses that led to those problems were not only permitted under a Federal system, they were helped by it. At the same time, most of the members of our group can recite several examples of bad actors and bad practices in the insurance business where the ability to operate in one State after another has been used to the disadvantage of the public or where, in retrospect, State regulation might have performed better.

The protection of the public that is at the heart of insurance regulation deserves the kind of careful consideration which makes no assumptions and favors no particular system or solution. In this respect, the current effort by the Federal Information Office to solicit comment in twelve specific areas on ways to modernize and improve the system of insurance regulation in the United States asks good questions. While it may take some effort to look past the political context of the overall debate and the possibility that some of the questions may have been framed to favor particular solutions, the questions provide a worthwhile framework for this latest chapter of a long discussion. Given space limitations here, only a few items can be addressed and, even then, consideration of those selected is necessarily brief.

Systemic risk regulation with respect to insurance

Without question, many of the great financial risks of our times have their roots in two features of the modern financial landscape: 1) the homogenization of financial products; and 2) the concentration of the capital markets. These are facts of 21st century life. We need to deal with them.

The insurance business has features which work to its benefit in reducing risk. Among these are relatively conservative approaches to valuing investments and requirements for quality and diversification among those investments. These minimize, but do not eliminate, systemic risk. If whole asset classes (i.e., mortgages) which have been considered favorably become impaired, they threaten the financial foundation of all the interests which rely on them, including the insurance industry.

Risk based capital rules are another feature that impart stability to the insurance industry. Essentially, the amount of risk an insurer is permitted to undertake is affected by the type of risk involved, industry experience with that type of risk, and the particular insurer's own experience.

The interlocking nature of financial instruments and types of financial institutions increase systemic risk. There was a time when an annuity was a promise to pay benefits for life, not an investment vehicle. When annuities became a widely used form of investment vehicle, a broader type of risk was created. When such annuities came to be compared with other forms of investments, as opposed to insurance contracts, insurers issuing them sought to generate the rates of return necessary to compete. In an efficient market, greater return is accompanied by greater risk. Add to this attempts to achieve guarantees and outperform competitors by investing in mortgage pools and we see a classic example of systemic risk -- the herd thundering to beat each other, all headed toward the same types of investments in order to achieve comparable returns.

Financial discipline, a more careful balancing of risk and return, and true diversification are essential in reducing systemic risk -- but no industry or company within an industry can be completely insulated. The role of regulation in the process is limited but crucial. Insurers compete and it can be tempting to take risks to improve returns. Who remembers Executive Life? It offered some of the best annuity rates around -- and funded them with a class of asset which came to be known as "junk bonds" before going broke when the values of those bonds fell. The Executive Life example illustrates not only the value of conservative investments when safety is what is being sold, it also reflects the need to carefully watch and fine-tune the mechanisms in place.

More recent events demonstrate the need for responsiveness and flexibility in order to adjust to new developments.

On the State versus Federal comparison chart, State regulation is the better bet. The Federal government is in a good position to pass laws, but does not have a good track record for rapidly responding to emerging risk, especially when monied interests are pushing the other way. Recent events make the point. States do not have the same ability to make laws that apply across the land, but their ability to focus on a small geographic area may allow them to see problems sooner as well as respond more quickly. There, too, monied interests have a

role, but the accountability comes quickly and more locally. The ability of States to work together but ultimately craft their own solutions better allows for a variety of approaches before a unified solution emerges. Ultimately, only trying an approach will demonstrate whether or not it works. On a Federal level, trying something necessarily occurs on a very large scale. Flexibility on a State level lends itself to creativity and to the development of better information on which to base broader solutions.

One of the ways the rest of the financial world seeks to minimize systemic risk is to buy insurance against it. This illustrates the role our industry plays in the functioning of our society. When people and the economic system look to us as a backstop, we need to avoid being part of the problem. The collective skill of the industry and its regulators is crucial to identifying and minimizing systemic risk.

In some ways systemic risk mimics the problems that used to exist with steam boilers. They blew up all the time and boiler insurance became not so much a way to fund compensation when it occurred as the means to create and enforce standards -- if your boiler met the requirement to obtain coverage, it would not blow up. At a time when every building of any size in cold climates had a boiler, making boiler explosions a thing of the past was a huge accomplishment. By the way, it was done within the context of State regulation and at a time when cooperation and the tools for achieving it were not nearly as efficient as they are today.

Our industry needs to be more conservative than many others and to set the benchmark standards. When other types of businesses go broke, investors lose. When insurers go broke, their investors lose, but so can the insureds[1] and, where the causes reflect problems in lines of business, areas of society can come to a halt, with all the negative repercussions that entails.[2]

<u>Capital standards and the relationship between capital allocation and liabilities, including standards relating to liquidity and duration risk</u>

Of all financial areas, insurance should operate the most conservatively. While leverage is attractive to investors, the disturbing reality is that it works in both directions. State regulation has an excellent track record for requiring that capital and surplus exist in sufficient amounts, relative to type of risk, volume of business and experience on business written, and that capital, surplus and reserves are invested in vehicles which are both safe and liquid.

With recent financial events in mind, that statement might seem to be negated by the well-publicized and very serious problems suffered by AIG. However, as Forbes Magazine put it: "Most of the problems with its balance sheet were caused by AIG Financial Products Corp., a division that, like many investment banks, participated in financial risk-taking, including investments in credit default swaps written on collateralized debt obligations ... now considered to be toxic."[3] AIG, a company well known for insurance operations, got into trouble by becoming one of the largest players in what has come to be known as the "financial services industry," -- in other words, systemic risk personified, all within one group of companies.

There was a time when banks, insurance companies and mutual funds were separate businesses, not all under one roof. What came to be seen as stodgy and boring at one point can look a lot better in the midst of economic upheaval. The insurance industry has done better than many other sectors in recent years -- for one thing, it has paid its claims - and that is a direct result of the overall effectiveness of the current system.

Those sectors which performed most poorly, indeed led the charge into the depths, were Federally regulated or funded: banking, securitized instruments, mortgage lending.

The ultimate measure of quality and efficiency in a system is that it works. The existing system works.

The State-based system has provided strong protection to insureds for generations. The Federal model, for all of its potential, cannot say the same with respect to financial services. In fact, having insurance under Federal regulation, along with the rest of the financial services industry, would create a new category of systemic risk -- systemic regulatory deficiency risk. If there is only one system, and it is run by one regulator, risk is increased.

The degree of national uniformity of State insurance regulation, including the identification of, and methods for assessing, excessive, duplicative or outdated insurance regulation or regulatory licensing process

The NAIC was formed in 1871 in response to the need for coordination of multistate insurers.[4] Identifying and then promulgating uniform standards for Model Laws has been a core function of the group ever since, to the extent that its publication containing all of them consists of 6 volumes.[5]

The NAIC has made a concerted and successful effort to develop Model Laws which are appropriate for adoption across the country and in persuading States to adopt them. States feed information to the NAIC and work together through the Model Law process. This represents an effective, efficient, and proven method of developing national standards, while also permitting some variation, where appropriate, to reflect different conditions in different States.

The way the present system functions brings to mind the old adage: "If it isn't broken, don't fix it."

The regulation of insurance companies and affiliates on a consolidated basis

This area of consideration seems to assume that insurance companies belong within financial services conglomerates. My suggestion is that such ownership be permitted only in circumstances where membership in the group cannot hurt the insurer. The insurer's surplus should not rest, even in a small part, on the value of the conglomerate or any other part of it. Otherwise value tends to become circular and it is just excessive leverage with a different hat on.

The costs and benefits of potential Federal regulation of insurance across various lines of insurance (except health insurance)

If we were starting with a blank page, setting up a single, Federal, system might well be the lower cost approach. But we are not. The real question is whether setting up a largely brand-new Federal system is preferable to continuing an effective State system which is well into its second century of successful operation.

The State system offers several advantages: -

- It exists and works today;
- There are no setup costs;
- There are no issues about whether it knows what it is doing and can do it well in good times and bad -- its history speaks for itself.
- It is also consistent with the basic tenets of our national practice to leave to the States those areas which are susceptible to their regulation and for the Federal government to focus on areas clearly best addressed on a national basis.[6]

The feasibility of regulating only certain lines of insurance at the Federal level, while leaving other lines of insurance to be regulated at the State level

This is not feasible without duplication and is probably the worst solution being discussed, as it would simply leave both systems in place, with the same basic job, but subject to different sets of rules (if the rules are the same, why would there be two systems?).

The potential consequences of subjecting insurance companies to a Federal resolution authority, including the effects of any Federal resolution authority:

- ....
- On policy holder protection, including the loss of priority status of policyholder claims over other unsecured general creditor claims;
- ....

The way this comment is phrased assumes that under a Federal system policyholder claims would not receive the priority they receive under the existing State systems. If that is the case, the effect of a Federal system would be to decrease consumer protection in order to provide a benefit to business. Put simply, the claim of the paper supplier would be considered as important as the claim of the widow whose spouse's death benefits are at risk.

This would be grossly unfair:

- Insureds are often locked into an insurer -- they may not be able to change due to the passage of time (such as someone with life insurance becoming uninsurable), or the ongoing payment of benefits (such as with structured settlement annuities), or because there is a claim in process (such as a medical malpractice claim against a physician). At the time when the insured enters into the insurance contract, the insurer is authorized to do business by the applicable regulatory industry. This amounts to a seal of approval, at least as to that time, that there are requirements, those requirements are intended to protect the consumer, and the insurer is deemed sound.
- Contrast this to a business creditor. That entity is not relying on the regulator's approval -- it is relying on whatever system it uses across the board to decide on the terms it will offer its customers, likely a credit report. In addition, it typically is able to re-assess the relationship at any time. With each new order, piece of equipment leased, or other business transaction, it can decide to stop doing business with the insurer. It also has access to greater resources and typically has far greater ability to evaluate the soundness of the insurer than does an insured or prospective insured.
- If there is to be a loss, it is fairer to impose it on the general creditor, which is a general creditor by choice and undertakes the risk of that status, than to impose on the insured, who is the ultimate intended beneficiary of the entire insurance regulatory system.

Concluding Comments

If one State is paralyzed or ineffectual, that does not put the citizens of other States at risk. All 50 States can address the insurance issue involved. On the other hand, there is only one Congress and we have all seen what can happen when Congress cannot function. The country suffers. Why add to the areas already at risk, especially given the current situation, where impasse is the order of the day? Those who favor a Federal insurance regulatory system might want to wait for a better time to suggest it.

State regulation, when so much of commerce is regulated at the Federal level, emphasizes the fundamental differences between insurance and other forms of business and helps us all remember and reflect that difference. The nature of the promises made by insurers and the need for people to be able to rely on them make the business of insurance unique.

The dialogue occurring at the national level is worthwhile. It will serve to underscore areas where the existing system can be improved. The value of the State-based system must be clear and the wisdom of continuing it needs to be evaluated from time to time. Having done a good job in the past does not by itself earn the right to continue to regulate the industry in the future.

The current focus should be less on whether, in theory, regulation should occur on the Federal level, and more on whether there are examples at the Federal level that justify the suggestion that the Federal government could do a better job than is accomplished by the system already in place and proven.

Endnotes

1. Many types of policies are backed by industry guaranty funds, but such funds have limits and do not provide complete protection to all insureds. Examples of problems in particular lines have created problems.

2. Examples of areas where insurance availability and cost problems have affected large geographic areas include workers compensation, medical malpractice coverage, and liability coverage for entities such as day care centers.

3. Forbes Magazine, 9/16/2008; http://www.forbes.com/2008/09/16/aig-ny-capital-biz-wall-cz_cc_0916bizaig.html. In support, see http://www.investopedia.com/articles/economics/09/american-investment-group-aig-bailout.asp#axzz1buvHOKsf.

4. NAIC web site, "About the NAIC": http://www.naic.org/index_about.htm.

5. http://www.naic.org/legal_home.htm. The number and breadth of these Model Laws is such that they are categorized by group and can be seen at http://www.naic.org/committees_index_model_description.htm.

6. In this respect the question is less "Can there be a Federal system of insurance regulation?" than "Should there be?" Our Federal Constitution sets out various examples of activities well suited to attention at the Federal level (see Section 8, at http://archives.gov/exhibits/charters/constitution_transcript.html), such as immigration, currency, declarations of war, maintaining national armed forces, and also provides that powers not delegated to the Federal government or prohibited to the States, are reserved to the States (see the 10th Amendment to the Constitution, at http://archives.gov/exhibits/charters/bill_of_rights_transcript.html).

NRRA GROWS UP FAST

FIO May Rescue Gaps Left in the Dodd-Frank Act

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Surplus line brokers found a newborn left on their doorstep on July 21, 2011, the day when the Nonadmitted and Reinsurance Reform Act (NRRA) took effect.

Despite a 12-month gestation from the day NRRA was signed into law as part of the Dodd-Frank financial industry reforms to its effective date, the states failed to use the grace period to reach uniform agreement on any of the proposed interstate compacts to allocate surplus line tax revenues, leaving brokers with a crazy quilt of state "conforming" laws and filing forms to decipher and track.

In fairness, many states had higher priorities on their agendas, such as balancing budgets in times of slashed revenues and increased demands for services. Congress likewise had little time to spare for insurance issues, being preoccupied with raising the debt ceiling and nearly causing the first default by the U.S. government on its obligations.

The surplus lines industry is left with an infant law to feed and care for. Messrs. Dodd and Frank, the law's putative parents, clearly did not provide for the details of its upbringing. Consider:

1. *Home is where the head is?* Several states' conforming laws elaborate on NRRA's definition of a corporate insured's "home state," the threshold determination under NRRA as to which state's laws apply. NRRA adopts a headquarters test, rather than looking to the state of incorporation. That's an easy standard to apply for a company like Apple, but not all organizations have such well-defined nerve centers. California's NRRA statute provides that "if the insured's high-level officers direct, control and coordinate the business activities in more than one state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated" will be the home state. Allocating premium for multi-state property insurance is a cinch, but liability insurance isn't so simple. The test also leads to the prospect of multiple home states if, for example, a company that is directed from two states has a predominance of its D&O premium allocated to State A, but its EPLI premium is more heavily weighted toward State B.
2. *Paperwork.* NRRA does not establish a national clearinghouse or similar mechanism to allocate premium taxes among states that have joined either of the two competing, and inconsistent, multi-state compacts for tax sharing. In the absence of a national system, some states have developed their own forms and formulas for surplus line brokers to report on how premiums are allocated, even where the result under the NRRA is that only one state receives all of the premium tax revenue. California's Assembly Bill 315, for example, requires surplus line brokers to provide data on tax allocations on multi-state premiums beginning on March 1, 2012, though the California Commissioner of Insurance can decide to forego the report. Thus, a "simplified" system under NRRA becomes more burdensome and less predictable. It also outsources government data-collection functions to the brokerage community.
3. *Other loose ends.* NRRA left at least as many issues unanswered as it answered. Though it established an exception for "exempt commercial purchasers" to state-based requirements that brokers submit proposed insureds to multiple admitted carriers before resorting to the surplus lines market, NRRA did not expressly preempt existing state rules that similarly exempted "industrial insureds." The two terms are not synonymous, each having complex definitions. The result: Having determined the commercial insured's home state, the broker must next determine whether the insured meets NRRA's test for exemption, and if it does not, must apply the home state's industrial insured test. If the insured meets neither set of criteria, the home state's due diligence submission requirements must be followed.

Compacts and Conflicts

In a statement to the House Subcommittee on Insurance, Housing and Community Opportunity, the Independent Insurance Agents & Brokers of America (IIABA) cautioned that NRRA's intent could be thwarted by inconsistent rules and procedures set by states. The IIABA position paper, delivered to Congress just one week after NRRA took effect, commented, "The NRRA was intended to streamline and simplify the surplus lines regulatory system. It would be a very peculiar outcome and an unintended consequence of Congress's action if the NRRA's enactment ultimately prompted state officials to develop an even more complex and cumbersome regulatory structure for the agents, brokers, and purchasers of surplus lines insurance."

In particular, the IIABA was critical of one of the multi-state compacts, the Nonadmitted Insurance Multi-State Agreement (NIMA), because its allocation methodology "is of considerable concern to the private sector and it is one that fails to satisfy the principles that IIABA and others expect from such a system. NIMA's proposed allocation system would be more complex and cumbersome than that in place today and would require the collection of information that is not even utilized in the underwriting process."

Both NIMA and its primary competitor, the Surplus Lines Insurance Multi-State Compliance Compact (SLIMPACT-Lite, so called because it is a revised version of an earlier proposal), allow surplus lines tax revenues to be shared among states that have joined the same compact. NIMA includes an allocation method and a clearinghouse that will be available only to NIMA member states. In contrast, SLIMPACT-Lite would set up a commission to determine the methodology. As a practical matter, neither system will be up and running in 2011.

Some states, including California, Colorado, Delaware, Idaho, Illinois, Michigan, Missouri, New York, Pennsylvania, Virginia and Washington, adopted neither NIMA nor SLIMPACT-Lite during their current legislative sessions, instead enacting what might be termed "home state takes all" statutes, under which those states will assess their premium tax rates on 100 percent of surplus line premiums paid by insureds headquartered there, and have agreed to share the proceeds with no one.

California further changed the rules of the game by creating two classes of surplus lines carriers. Surplus lines brokers are allowed to place business with carriers in one class, those that have at least $45 million in capital and surplus. To place coverage with a carrier that has less than $45 million (but at least $15 million) there are added filing requirements. This appears contrary to NRRA's clear requirement that if the insured's home state approves a surplus lines carrier with $15 million in capital and surplus and that carrier is licensed in other states, the broker may place coverage on risks that are present in those states. NRRA's mandate for uniform state eligibility is the greater of the minimum capital and surplus required by the home state or $15 million (which may be further reduced upon a demonstration of compelling circumstances, but in no case to less than $4.5 million).

California's NRRA conforming legislation also replaces the List of Eligible Surplus Line Insurers (LESLI) with a List of Approved Surplus Line Insurers (LASLI). The difference is not merely semantic, though insurers that were on the LESLI list as of July 20, 2011, are grandfathered onto the LASLI list. The difference is that carriers not already approved in the California market are required to file all the documents mandated in the California Insurance Code and pay the appropriate filing fees to receive approval, even if they are already approved in the insured's home state. Alternatively, the surplus line broker may make those filings for the non-approved carrier. The California statute raises questions regarding the pre-emotive intent of NRRA to establish a level playing field.

Some other states have ignored the NRRA's statement that "an insured's home State may require … insureds who have independently procured insurance to annually file tax allocation reports with the insured's home State." Currently, about one quarter of the states do not tax independently procured insurance premiums on the same basis as premiums for coverage placed through a surplus line broker. Thus, if the home state does

not impose such a tax on the entire premium, can another state tax the portion of the premium that is allocable to risks present in that state? Here again, the level playing field is developing some hazardous bumps and divots.

For the surplus line broker, the alphabet soup of multi-state compact acronyms does not make a nourishing meal. While there are handy online guides to NRRA and the states' statutes (NAPSLO.org and CIAB.com are two worth visiting), brokers do not need a heaping helping of complexity added to their already challenging jobs.

FIO to the Rescue?

For all the campaign rhetoric about the supposedly "radical" and "socialist" tendencies of the current administration, the two hallmarks of its domestic policy thus far have been half-measures. Healthcare reform did not take the fork of the road toward a single-payer, federal solution, but an insurance-based path to be supplemented by state-based exchanges. The Dodd-Frank Act, to which NRRA was an add-on, left Wall Street still pretty much in charge of Wall Street, and left the majority of insurance regulation to the states, where it has traditionally been.

Along with NRRA, there was another insurance add-on to Dodd-Frank: the creation of a Federal Insurance Office (FIO). Michael T. McRaith, who spoke on a panel of experts for the opening general session of the Professional Liability Underwriting Society's 2006 International Conference on "the increasing impact of U.S. federal law in defining professional liability risks, and potentially in regulating the insurance industry," was appointed this year to head the FIO.

The five-speaker panel, moderated by TV journalist Forrest Sawyer, was anything but unanimous in its views. While there was undeniable federal influence in D&O liability insurance exposures in the post-Enron era, the prospect of Uncle Sam directly regulating the insurance industry received mixed reviews. For his part, McRaith, then Director of the Division of Insurance at the Illinois Department of Financial and Professional Regulation, stood strongly in favor of continued insurance regulation at the state level, while some panelists favored bringing down the barriers to a unified system of surplus line approval, either through concerted effort by the states or by federal preemption.

In the NRRA and the companion law creating the FIO, everyone on the panel may have gotten something that he wished for that day. Barriers to surplus lines carrier eligibility have come down, though not quite as dramatically or thoroughly as the Berlin Wall. Focusing on the insured's home state for both regulation and taxation will eventually simplify the broker's job, though NRRA needs some serious tweaking through improved multi-state compacts or federal action to make that happen.

For its part, the FIO can help the process simply by encouraging the organizations that developed the NIMA and SLIMPACT-Lite plans to keep working on simplifying procedures and standardizing filings.

In the longer term, the FIO is empowered to enter into agreements with other nations for "prudential measures regarding the business of insurance," and to determine, subject to judicial review, whether some types of state laws are preempted by those agreements. **It can also issue subpoenas and conduct studies regarding the "modernization of insurance regulation." Those powers appear to give the FIO a sufficiently large stick to fix NRRA, if the states do not find the carrot sufficiently motivating.**

For now, the gaps in NRRA and the inconsistencies in corresponding, conforming state laws leave brokers with a difficult path to travel. The inconsistencies in the requirements applicable to eligible surplus lines insurers and the refusal of some states to recognize the intended new rules harmonizing state recognition – and taxation – of independently procured insurance will inevitably lead to court challenges. As the orphan

statute matures, it may fulfill its original goals and make the U.S. market a more even and efficient playing field.

This article first appeared in a slightly abridged version in the September 2011 edition of Property Casualty 360°, an online publication of American Agent & Broker, www.propertycasualty360.com. Louis Castoria, the author of that article and a co-author of this article, is a partner in the San Francisco office of Wilson Elser. See also Mr. Castoria's related article, "Ready for NRRA?" in the June 2011 edition of Property Casualty 360°. This expanded article is adapted with permission of American Agent & Broker. Fred Pomerantz, a co-author of this article, is a partner in the New York City and Garden City offices of Wilson Elser as well as a member and Northeast regional Director of FORC.

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