

THE FINANCIAL SERVICES ROUNDTABLE

Financing America's Economy



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Federal Insurance Office
Department of the Treasury
1500 Pennsylvania Avenue, NW
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Dear Director McRaith:

The Financial Services Roundtable (“The Roundtable”) thanks the Federal Insurance Office (the “FIO”) for this opportunity to provide input on ways to modernize and improve insurance regulation in the United States. The Roundtable represents 100 of the largest integrated financial services companies providing banking, insurance, and investment products and services to the American consumer. Member companies participate through the Chief Executive Officer and other senior executives nominated by the CEO. Roundtable member companies provide fuel for America’s economic engine, accounting directly for \$92.7 trillion in managed assets, \$1.2 trillion in revenue, and 2.3 million jobs.

INTRODUCTION

In its paper *Financial Regulatory Reform: A New Foundation*, the Department of Treasury stated: “For over 135 years, insurance has primarily been regulated by the states, which has led to a lack of uniformity and reduced competition across state and international boundaries, resulting in inefficiency, reduced product innovation, and higher costs to consumers.”¹ The Administration’s findings reflect the concerns raised by many insurers who, increasingly, offer a multitude of products across various regulatory jurisdictions. We are pleased the study being conducted by the FIO will further review these issues, and we appreciate the opportunity to provide comments to inform this exercise.

In anticipation of the work you are now undertaking, in October, the Anthony T. Cluff Research Fund (“Cluff Fund”) of the Roundtable released a study examining the current regulation of insurance in the United States and making recommendations on how to

¹ U.S. Treasury, 2009, “Financial Regulatory Reform: A New Foundation,” U.S. Department of the Treasury White Paper. Available via the Internet: http://www.treasury.gov/initiatives/Documents/FinalReport_web.pdf

modernize the system of regulation.² The study is an important educational piece outlining a range of options for reform, both short-term changes to the state system and mid/long-term structural changes to our current regulatory system. We have attached this study for your review. We outline below specific changes that we advocate for inclusion in the study you are currently conducting.

ROLE OF THE FEDERAL INSURANCE OFFICE

We welcome the creation of FIO by Congress in the Dodd-Frank Act.³ It has been clear for some time that the business of insurance is too important to the underpinnings of our economy to be the exclusive province of the states, with no official federal representation. The creation of the FIO, for the first time, places an expert in the Department of the Treasury to increase federal understanding of the business of insurance. The creation of this office is the first of many important reforms that we hope will benefit consumers, producers and insurers.

In its early stages, perhaps the most important role of the FIO will be to understand the impact of the Dodd-Frank Act on the industry. New regulations and requirements for some insurers – particularly those with insured depositories – must be reconciled with the realities of the insurance business. Specifically, insurers that own thrifts will now be subject to dual regulation by the Federal Reserve and the states, and we are optimistic that the FIO can serve as a resource to these regulators as to how to fulfill their responsibilities without imposing conflicting or duplicative requirements. More broadly with respect to the impact of Dodd-Frank, there are legitimate concerns that the cost of new regulation could far outstrip any conceivable risk presented by the affected regulated entities. Our hope is that, from the outset, the FIO will play a significant role, in concert with insurance experts on the Financial Stability Oversight Council (FSOC), in ensuring that any new regulation imposed on insurers is commensurate with the risk posed by the regulated entity.

We look forward to working with FIO to ensure that the U.S. remains a healthy and vibrant market for insurers and their customers. This involves effective solvency regulation, which protects consumers and insurers by assuring that companies are able to pay their claims. Also, increasingly market health will be measured by efficiency and the ability of consumers to shop for insurance products in a competitive market place.

As to the role of the FIO, we strongly support increased funding, staffing, and stature for the FIO, and believe those goals should be made part of the FIO's study

² The research was conducted by L. Charles Landgraf and John S. Pruitt with the international law firm Dewey & LeBoeuf and Tom Baker, the Deputy Dean and William Maul Measey Professor of Law and Health Sciences University of Pennsylvania Law School.

³ Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, Title V, Sec. 502

recommendations. Additionally, we endorse the following additional recommendations, which are contained in the Cluff Fund study:

- **The FIO should be obligated to comment on proposed rules.** The FIO should be charged with the duty to comment on proposed rules to assure that insurers will not be subjected to regulation that is unnecessary in light of the nature of the insurance business or because other existing regulatory controls provide adequate safeguards.
- **Federal engagement in insurance should be consolidated within the FIO.** The FIO should be charged with identifying overlaps in the ways that the federal government already engages in insurance supervision activity, and it should use this information to coordinate and consolidate federal involvement in insurance.

INTERNATIONAL ISSUES

Part of FIO's important work is the mandate to represent our domestic sector internationally. We have long believed that a principle short-coming of the state-based regulatory regime is the inability to speak to international regulators with appropriate *gravitas*. There is a need for a strong federal voice on international issues to protect the domestic industry from duplicative or contradictory regulatory requirements. Equally important is the need for expertise as the U.S. negotiates trade agreements to open markets for U.S. insurers. To this end, FIO's international efforts should be focused on assuring that international accords are made in the best interests of the U.S. insurance market participants, and not simply to harmonize our laws with international standards.

We are pleased that FIO has joined the International Association of Insurance Supervisors (IAIS) and encourage its full participation to enhance the voice of U.S. market participants internationally. IAIS has developed a set of *Insurance Core Principles*⁴ designed to "provide a globally accepted framework for the supervision of the insurance sector." International discussions related to all aspects of supervision including capital and risk management will affect many Roundtable members who operate on a global basis. Indeed, implementation of Solvency II will almost certainly provide FIO with an immediate opportunity to ensure that U.S. insurers are competitive globally.

As it relates to international agreements, the FIO study should clarify the preemptive authority granted under the Dodd-Frank Act and use it, where possible, to negotiate national standards. Additionally, the study should be forward-looking to identify what

⁴ Available via the Internet:
http://www.iaisweb.org/_temp/Insurance_Core_Principles_Standards_Guidance_and_Assessment_Methodology__October_2011.pdf

regulatory changes are needed to establish a mutual recognition system that is applicable across the country.

NATIONAL STANDARDS

The majority of Roundtable members continue to support the creation of a single, national market for those insurers who operate on a national or regional basis. For too long, the cost of inefficient state regulation has added unsubstantiated costs to products offered by our members. Recent research by a former state insurance regulator, found that a national company selling personal lines of insurance in all 51 insurance jurisdictions across the country, with agents licensed and appointed to sell insurance in at least two states, spends in excess of \$14 million just to license and appoint its agents. In addition, that same company would be required to pay \$7 million a year to maintain its agents' licenses.⁵ Agent licensing is just one example of the high price our economy and consumers pay for the existing regulatory system.

The regulatory burden of duplicative and overlapping regulation has not been justified by sound reasoning and has resulted in inconsistent consumer protection. Indeed, consumers are harmed as they are denied products that may be of use based often on subjective regulatory requirements that have no bearing on solvency or consumer protection.

In a recent survey of our membership, we found that 70 percent of respondents support replacement of the existing state-based system with comprehensive federal regulation in the form of a federal charter. An equal percentage support the establishment of a federally enforced state passport system whereby a state-licensed insurer meeting specified national standards would be automatically authorized to transact insurance throughout the U.S. Under such a scenario, the FIO could develop national standards that complement existing best practices in prudential and product regulation. Conversely, fifteen percent of our member companies support retaining the existing state framework.

In the last Congress, the Roundtable supported optional federal charter legislation introduced in both the House and Senate, and encourages the FIO to review those bills.

Overall, the majority of our members still believe the federal government must play a lead role if uniformity is to be achieved. And all believe that the FIO must be a lead voice, not only in vetting options, but ensuring that a new era of insurance regulation does not come with duplicative or layered federal/state regulatory requirements.

⁵ Holly Bakke 5 Aug 2011, "Modernization: Key to Cutting Insurance Costs," National Underwriter Online News Service. (Holly Bakke served as the Commissioner of the New Jersey Department of Banking and Insurance from 2002 to 2005.)

STATE REFORMS

In the absence of a more complete overhaul of the existing system, Roundtable members have identified several updates to state regulation that are necessary to keep pace with the evolution of the insurance sector. Clearly, the current system does not promote optimal efficiency. It also raises questions of fairness for consumers when the weight of regulation stifles product innovation, limits customer choices, increases costs and inhibits the development and function of competitive markets.

The Cluff Fund study makes several recommendations and we encourage FIO to study, in particular, ways to urge states to make the following updates:

- **Expand the Interstate Insurance Compact (“the Compact”) process to cover all states and other lines of insurance; deregulate group and large commercial insurance.** While often cited as an example of its ability to improve efficiency and promote uniformity, the benefits of the Compact are incomplete and limited in terms of product scope. Seven years after its creation, nine states, including New York, Florida, and California, have yet to join the Compact. Those nine states represent nearly 30 percent of the U.S. population and one-third of the premium volume for select insurance products nationwide. The existing Interstate Compact should be made operational in all states and expanded or replicated to include additional lines of business; e.g., property and casualty insurance products. There should be complete deregulation of form approval requirements for group insurance products and insurance sold to large commercial buyers.
- **Increase harmonization and understanding of guaranty fund system.** Differences in the levels of benefits or claims payments guaranteed by the state guaranty fund system and restrictions on advertising make it impossible for insurers to have transparent communications about guaranty fund protections.
- **Remove barriers to market exit and entry.** The state licensing process and state requirements for withdrawal from lines of insurance create barriers to market entry and exit. In their most benign form, these requirements create unnecessary paperwork and delay. In their most intrusive form, they throw up barriers to market entry and exit that inhibit the development of fully competitive markets.
- **Exempt markets from rate regulation.** Rates should not be subject to regulation in properly functioning competitive markets. One approach is to exempt markets from rate regulation based on a competition analysis. Rate regulation in some states suppresses rates below actuarially sound levels, affecting availability of insurance for consumers. While systemic risk in the insurance and reinsurance industries is low, the FIO should also explore the role of so-called state residual market facilities in respect of increasing systemic risk. In their worst form, these

facilities displace private markets while leaving substantial doubt about their ability to meet their obligations and to continue to operate after a severe catastrophic loss event; many of these entities pose significant risks of default, underfunding and over-leverage.

- **Improve exam coordination and lower reliance on contract examiners.** Duplicative and overlapping financial examinations and a piecemeal approach to market conduct examinations impose time and resource burdens on the management of insurers without there being a clear regulatory benefit from the redundancy.

CONCLUSION

The financial crisis affirmed the financial health of the life and property-casualty insurance industries. This does not mean, however, the relative stability could only have been achieved through the existing state-based regulatory framework. In fact, we have found that efficiency, competitive entry, fairness, transparency and product innovation have been hampered in such a system. The U.S. is alone in this fragmented approach to the competitive detriment of its companies and disadvantage of its consumers.

Increasingly, insurance is a global business – this is certainly true as it relates to a vast majority of Roundtable members. Congress recognized this when it created FIO and gave it important responsibilities related to international negotiations. Insurance is a key component of the financial services marketplace and it is increasingly obvious that geographic boundaries mean little so long as companies properly manage risk and treat consumers and customers fairly. We hope that the FIO will not only study, but vigorously support improvements to insurance regulation which enhance consistency in regulation and support our global competitiveness.

We thank the Office for the opportunity to provide our comments. If you have any questions, please feel free to contact me or Peter Freeman at (202) 289-4322.

Respectfully submitted,



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Enclosure

Modernizing Insurance Regulation in the United States

Prepared for the Anthony T. Cluff Research Fund of the Financial Services Roundtable

October 17, 2011

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I.	Prologue	1
II.	Conclusions and Recommendations	3
	A. Purpose of the Study.....	3
	B. Framework	3
	C. Conclusions.....	4
	D. Recommendations	5
III.	First Principles – Objectives and Mechanisms of Insurance Regulation	12
	A. Objectives of Insurance Regulation	12
	B. Categories of Insurance Regulation.....	16
IV.	Where Are We and How Did We Get Here? The History, Development and Current Level of Uniformity of Regulatory Mechanisms	19
	A. The Development of Coordination Among States Within the Current State-Based System	19
	B. Solvency Regulation/Accreditation (Including Group Supervision)	21
	C. Licensing, Market Entry and Exit	24
	D. Credit for Reinsurance/Collateral Requirements	28
	E. Resolution Procedures and Guaranty Funds.....	29
	F. Residual Markets	32
	G. Rates and Insurance Product Regulation	35
	H. Financial Examinations	38
	I. Market Conduct Regulation	40
V.	Prior Federal Participation in the Supervision of Insurance.....	42
	A. Federal Insurance Programs	42
	B. Federal Agency Approval and Financial Responsibility Requirements	46

C.	Other Federal Statutes Respecting Insurance.....	48
D.	Selected Legislative Reform Initiatives	51
E.	Lessons from Federal Intervention	54
VI.	Beyond Borders – The Relevance of International Developments in Insurance Regulation to Efforts to Improve and Modernize the U.S. System of Insurance Regulation	56
A.	Global Supervision.....	57
B.	Europe.....	58
VII.	Shortcomings of the State-Based System and Federalism	62
A.	Mechanics	62
B.	Obvious Shortcomings of Current System.....	63
C.	Issues to Consider When Evaluating Alternative Regulatory Structures.....	64
VIII.	Summary of Recommendations.....	67
	Endnotes	69

Appendix A: Status of State Insurance Commissioners

Appendix B: The NAIC's Handling of the 2008 Capital and Surplus Relief Proposal for Life Companies

Appendix C: NRRRA Case Study

Appendix D: Author Profiles

I. Prologue

Unprecedented shocks tested both the life and property casualty sectors of the insurance industry during the decade beginning with the September 11, 2001 terrorist attacks. The attacks were followed by a paradigm-shifting 2004 Atlantic windstorm season and then topped by 2005's Hurricanes Katrina-Rita-Wilma, only to be followed by the greatest financial turmoil in generations during 2008-2009. As the decade closed, insured losses from natural and man-made disasters around the globe (Japan, Chile, New Zealand, Australia and higher-than-"normal" cat losses in the United States), an offshore oil spill in the Gulf of Mexico, continued regulatory uncertainty and a sustained low interest rate environment – all further challenged a now global insurance industry.

Through it all, insurer insolvencies have been negligible. Only two insurers (other than American International Group ("AIG")) accepted Troubled Asset Relief Program funds, and the financial condition of the industry as a whole has proven resilient. Solvency regulation met the test, it would seem. And, to put it in post-Dodd-Frank Act¹ terms, at no point did insurance activity appear to add systemic risk to the broader financial system or the general economy. Excluding AIG, the major multiline property-casualty insurance company failures that did occur during the past decade did not result in shocks to the insurance market, let alone the larger economy, and there were no major life insurance company insolvencies.

Still, the decade has been witness to unprecedented and sustained calls for reform of U.S. insurance regulation for good reason. The decade taught us that we do not know what the nature of the next great stress test will be. Moreover, the insurance sector is alone among financial services in being subject primarily to a fragmented and often non-uniform state-based regulatory system. It cannot be assumed that efficiency, competitive entry, fairness, transparency and product innovation have been maximized in such a system. Nor should it be assumed that the relative stability of the life and property-casualty insurance industries through the most recent crises could only have been achieved through the existing state-based regulatory framework. Moreover, the United States is alone in this fragmented approach, to possible competitive detriment of its companies and disadvantage of its consumers. All other developed countries and emerging powers have national insurance regulatory regimes and many have moved to a single consolidated regulator for all financial institutions. As the pace of international financial supervisory coordination accelerates – especially in the areas of group supervision, Solvency II transitional equivalence and systemic risk analysis – the United States lacked, until recently, even rudimentary plans for engagement on insurance. Now leadership by the United States is essential. Moreover, internally, Dodd-Frank Act reforms aimed principally elsewhere in the financial system threaten to buffet insurers, with no strong federal-level voice focused on the sector. Lack of effective group supervision has been identified as a weakness by international bodies and acknowledged by the National Association of Insurance Commissioners ("NAIC"). Even in solvency regulation, the confidence is incomplete.

Following twenty years of Congressional inquiry, Administrations of both political parties have called for a thorough examination, and reform to some degree, of the U.S. system of insurance regulation. Consistent with that, Congress, in the Dodd-Frank Act, established a Federal Insurance Office ("FIO"), invested the Secretary of Treasury and the U.S. Trade Representative with certain international coordination authority, and began the elimination of duplicative state regulation in business-to-business dealings through the Nonadmitted and Reinsurance Reform Act ("NRRRA").² Congress also charged the

FIO with evaluating and reporting to Congress on how to modernize and improve the system of insurance regulation in the U.S. It is on this last charge that the Financial Services Roundtable (“FSR” or “Roundtable”) seeks to engage with this study.

II. Conclusions and Recommendations

A. *Purpose of the Study*

This report was prepared in response to the Anthony T. Cluff Research Fund of the Financial Services Roundtable's ("Cluff Fund") request for a study to examine the current regulation of insurance in the United States and to make recommendations on how to modernize the system of regulation.

B. *Framework*

We approached our study using the following framework:

We started with an examination of core principles of insurance regulation. We sought to understand the reasons behind existing regulation to assess how those objectives are being applied and whether existing regulation meets the objectives.

Next, we examined specific areas of regulation. We covered the historical development, the current status, the extent of uniformity in regulation among the various states and shortcomings in the current approach.³ Specifically covered areas are:

- Solvency regulation (including group supervision)
- Market entry and exit (which covers licensing)
- Regulation of reinsurance, including collateral requirements for reinsurance placed with non-U.S. insurers
- Resolution procedures and state guaranty funds
- Residual markets
- Rate and product regulation
- Financial examinations
- Market conduct regulation

We then examined the current Federal involvement in insurance. This consists largely of a number of Federal programs that provide insurance for difficult-to-insure risks, but also includes Federal oversight in the form of standards used to approve insurers to provide insurance under Federal programs that mandate the purchase of insurance. We added this discussion because we believe there generally is not a widely-held appreciation of the full scope of Federal involvement in insurance.

We considered international matters, namely, the extent to which international coordination among regulators outside the U.S. has developed and the relevance of this coordination to regulation in the U.S.

We then dissected the considerations that should be weighed in considering an appropriate framework for insurance regulation within our Federal system of government.

Our study focuses on life insurance and traditional lines of property/casualty insurance. We do not address the regulation of title, financial guaranty and mortgage insurance, which due to the different nature of their businesses are regulated separately than other insurance, including the requirement that insurers writing these lines of insurance be operated as monoline insurers.

C. Conclusions

In conducting the study, we have been mindful of the Roundtable's longstanding goal of comprehensive insurance regulatory reform that promotes greater efficiency through uniformity of regulation and open, competitive markets. We work from the basic premise that to the extent there are differences in regulation among states, these differences need to be justified by sound reasons. In our study, we cover areas where greater uniformity in regulation across the 50 states has been achieved to some extent. Where uniformity does exist, it is largely the result of the efforts of the states working collectively through the NAIC. Efforts to increase uniformity implicitly acknowledge that differences can be without adequate justification. Yet the NAIC has no actual authority or governmental power to compel the states or the insurance industry to act. Its model laws and regulations have no effect unless adopted by state legislatures and enforced by individual state insurance commissioners. And while uniform laws and regulations may result in greater consistency in the written rules, they leave largely unaddressed the duplication of oversight that results from having fifty state sovereigns separately apply the uniform rules and standards.

Insurers that operate in multiple states are subjected to redundant filing and approval requirements. Inconsistent rules and interpretations prevent companies from operating in a uniform way across the nation. Different insurers incorporated in different states can be subject to different kinds solvency regulation even though they operate on a nationwide basis. Rate regulation in some states inhibits the proper functioning of competitive markets, affecting availability of insurance for consumers. Product regulation makes it difficult to launch new products nationwide and also requires different products for use in different states that aren't justified by differences in the risks or expenses.

The current system does not promote optimal efficiency. It also raises questions of fairness for consumers when it stifles product innovation, limits customer choices, increases costs and inhibits the proper functioning of fully competitive markets.

The following are ways in which these shortcomings are manifested in the specific areas of regulation we examined in this study:

- The state licensing process and state requirements for withdrawal from lines of insurance create barriers to market entry and exit. In their most benign form, these requirements create unnecessary paperwork and delay. In their most intrusive form, they throw up barriers to market entry and exit that inhibit the development of fully competitive markets.
- Reform in the regulation of reinsurance has not been attainable within the state framework. Existing requirements for non-US reinsurers to maintain collateral in the US

do not take into account the global nature of the reinsurance business. The U.S. suffers in trade negotiations as a result. Ironically, recent reform measures in New York, Florida and New Jersey have created a situation where there is an even greater lack of a uniform approach for the regulation of reinsurance.

- There are differences among states in resolution procedures for insolvent insurers that have a current operating impact on insurers. In addition, differences in the levels of benefits or claims payments guaranteed by the state guaranty fund system and restrictions on advertising make it impossible for insurers to have transparent communications about guaranty fund protections.
- There are widely varying experiences in residual market facilities, due in large part to the way in which rates in the voluntary market are regulated. In their worst form, these facilities displace private markets while leaving substantial doubt about their ability to meet their obligations and to continue to operate after a severe catastrophic loss event.
- Rate regulation in some states suppresses rates below actuarially sound levels, affecting availability of insurance for consumers.
- As noted, product regulation makes it difficult to launch new products nationwide and also requires different products for use in different states that aren't justified by differences in the risks or expenses.
- Duplicative and overlapping financial examinations and a piecemeal approach to market conduct examinations impose time and resource burdens on the management of insurers without there being a clear regulatory benefit from the redundancy.
- There is overlapping and at times inconsistent regulation by state insurance regulators and Federal bank regulators who have oversight responsibilities due to the presence of a bank or savings and loan within the insurance holding company system. The impact of this is expected to be felt more acutely as newly empowered Federal agencies begin to exercise the authority given to them under Dodd-Frank. In addition, there will be overlapping supervision for any insurance holding company designated as systemically significant.

D. Recommendations

We provide two sets of recommendations: those reforms which we categorize as medium- to long-term initiatives insofar as they relate to the basic overall framework; and those reforms which we categorize as near-term initiatives insofar as they can be implemented within the existing regulatory framework.

1. *Mid- to Long-Term Recommendations: Options for a Regulatory Framework for National Standards*

In keeping with the Cluff Fund's desire to identify a spectrum of options for insurance supervisory reform and modernization, this study sets out a spectrum of options ranging from the status quo to direct

federal regulation of insurance, as outlined below. All of the options are intended to remedy features of the insurance regulatory system that result in regulation being fragmented, inconsistent and inefficient. It is our view that these characteristics are inherent to some extent in any state-based system and can be fully addressed only by direct federal supervision over insurance. So the question in any analysis becomes whether the benefits derived from a state-based system outweigh its inherent limitations. The discussion of any option in this paper does not reflect a preference for that option on our part or any presumption by us of a preference by the FSR or any of its members for any particular option.

- **Retain the existing state-based framework and foster more uniform, national standards through state action**

This approach has worked in some areas and not in others. For example, it is widely acknowledged that the state-regulated insurance industry fared much better during the 2008-2009 financial crisis than the federal regulated banking industry. The most significant exception, of course, is AIG, whose failure pointed to the absence of any meaningful group supervision of insurance enterprises. And while the states, through the NAIC, are working hard on developing uniform standards for more streamlined regulation, an inherent weakness of the existing state-based framework is the dependence on state legislators to change laws as necessary to assure uniform national standards. To avoid dependency on state legislatures, states should voluntarily agree to be bound to national standards that are developed on a multistate basis (as is currently the case with statutory accounting and examination standards and, to a lesser extent, through the state insurance department accreditation process). Even with uniform national rules and standards, there remains a risk of divergent regulation insofar as individual states may apply the rules and standards differently.

- **Establish federally enforced state passports**

Under this approach, Congress would limit states' ability to refuse to recognize regulation by the domiciliary state, as it did in parts of the NRRRA. This approach assures that individual insurers and intermediaries will experience uniform regulation (that is, an insurer or intermediary will not be subject to inconsistent and overlapping regulatory requirements in the various states in which it operates); however, this approach does not assure that different entities will be uniformly regulated in the absence of national standards. The risk is a "race to the bottom." To address this, we have identified three approaches to establishing national standards:

Under the first approach, the states, acting collectively, develop national standards that confer passporting privileges. Licensing in a domiciliary state would be a prerequisite to recognition for "passporting" privileges only if the domiciliary state meets standards that are set by the states acting collectively. The standards would cover both substantive laws and rules that states are expected to adopt and state insurance department qualifications and processes. This approach could include authority for a state (or other authority) to determine which non-U.S. jurisdictions provide same or equivalent level/quality of supervision for purposes of cross-border passport, at least in certain lines such as reinsurance.

Under the second approach, national standards would be set by federal action. Congress, directly or through delegation of rulemaking authority to an administrative agency, would specify national standards that would go into effect if the states do not adopt and succeed in implementing an acceptable

national standard. This makes sure that the “bottom” is not too low. This approach can include authority for FIO to determine which non-U.S. jurisdictions provide same or equivalent level/quality of supervision for purposes of cross-border passport, at least in certain lines such as reinsurance.

Finally, under the third approach, FIO would have authority to declare national standards based on consensus among a plurality of states. FIO would be established as an independent office within the U.S. Treasury Department with the status and possibly the authority of OCC. FIO should be allowed or required to survey state insurance statutes and regulations and to determine where a specified percentage “uniformity” exists. FIO should follow existing FIO preemption process to “nationalize” existing insurance statutes found to be uniform. A mechanism should be developed to allow nationalized standards to be changed, if necessary, short of having to wait until the same percentage of states adopt changed standards. Simple “nationalization” of certain relevant insurance supervisory mechanisms must be tempered with an understanding (as evidenced in the relevant supervisory mechanism survey, above) of the purpose and intent of statutes and regulations that have been nationalized. Finally, FIO could be allowed to take international developments and issues of market and regulatory equivalence into consideration when “nationalizing” existing insurance statutes found to be uniform.

It may be easier to persuade lawmakers to consider passporting for pure solvency regulation than for market conduct regulation because states often perceive market conduct as a local matter that should be reserved to the local state. The risk of any transfer of regulation to a different regulator lies in divorcing market conduct and solvency regulation. Federally enforced state passporting necessarily raises the issue of the impact of one state’s rate and product controls on another state’s ability to engage in effective solvency regulation. The sole recourse for a domiciliary state that is solely responsible for the solvency of an insurer writing coverage in other jurisdictions, where rate controls prevent insurers from charging actuarially sound, risk-based premiums, would be to preclude or to limit the insurer from writing in that jurisdiction. Alternatively, if national standards are set by Congress or the FIO, they will need to address the conflict of uniform solvency regulation and local rate/form controls. Through identifying solvency as a goal paramount of insurance regulation, FIO could preempt state statutes that are inconsistent with “nationalized” solvency regulations.

Preemption of state rate/form controls that are inconsistent with “nationalized” solvency regulations does not mean the preemption of all state rate/form controls. It would, however, provide industry the opportunity to demonstrate instances in which rate controls are excessive to the extent that they prevent insurers from charging actuarially sound, risk-based premiums. Preemption of some state rate/form controls by FIO because certain rate controls are inconsistent with “nationalized” solvency regulations could provide a safe harbor for any rate controls not excessive to the extent that they prevent insurers from charging actuarially sound, risk-based premiums.

- **Direct Federal Regulation of Insurance**

Any spectrum of options for insurance regulatory reform and modernization needs to include direct federal regulation of insurance. This may culminate with direct federal oversight and regulation of all aspects of insurance business, but also includes a variety of intermediate forms of federal regulation including the availability of a federal insurance charter for insurers depending on the characteristics of a particular insurer.

The first step under this approach is to identify the characteristics of lines of insurance over which it is particularly appropriate for Congress and a federal regulatory body to exercise direct supervision. Federal licensing and attendant solvency supervision could be provided on an exclusive entity basis in the case of, say, monoline financial guaranty and life insurance and in other lines on an activity basis, such as reinsurance. In the latter case, the line of business (defined federally) could be carried on, without state interference, by an insurer otherwise licensed and supervised by a state (under passport system), or if it chose to reorganize to confine its business exclusively to the federal-authorized line (e.g., professional reinsurer with no direct business), it would *de facto* be only federally chartered and regulated.

Advocating for federal insurance regulation or chartering post Dodd-Frank requires specific attention to the role of consumer protection in insurance regulation. While Dodd-Frank created the Consumer Financial Protection Bureau (“CFPB”) in part to improve financial product clarity, transparency and uniformity, it also explicitly separated the solvency and consumer protection elements of banking regulation because of industry specific abuses unrelated to and not present in the insurance industry. Consequently, insurance products were expressly excluded from CFPB jurisdiction. They should remain excluded regardless of changes in the level of federal insurance regulation or chartering.

The discussion of the need to reform the existing regulatory framework to promote greater uniformity and efficiency has been focused on flaws inherent in the state-based system. However, any regulatory reform that places greater regulatory oversight authority in the federal government must address the possibility of redundant and inconsistent regulation by different federal agencies. The best way to address this most completely is to give a single federal regulator final say over conflicting regulations that affect insurers.

For example, as a result of the Dodd-Frank Act, many larger insurers are facing significant dual state and federal regulation. Effective July 21, 2011, many insurers that qualify as savings and loan holding companies became subject to Federal Reserve regulation. The regulatory focus of the Federal Reserve will be on the capital strength of the organization, and whether the parent company is a “source of strength” for the depository institution. This is at odds with state insurance commissioners’ views about insurance holding companies. Under another Dodd-Frank Act provision, other insurers may face systemic importance designations by FSOC. These designations could lead to increased regulation and supervision by the Federal Reserve in addition to current state-based regulation. Thus, great uncertainty exists as to how this sharing of regulatory power between the federal government and states will be conducted and whether insurers will face inconsistent regulation. Specifically, there may be issues with conflicting and inconsistent capital and reporting standards and some of the largest insurers may face unique competitive disadvantages. Simply supplanting state regulators with a newly empowered federal regulator does not resolve these problems unless the new federal regulator has the power to resolve the inconsistencies.

2. *Near-term recommendations: Specific recommendations for changes within the existing regulatory framework*

a. *FIO Coordinating Role*

For better coordination of Federal rulemaking activity, we recommend that FIO be charged with identifying overlaps in the ways federal government already engages in insurance supervision activity and that it may use this as a way to coordinate and consolidate federal involvement in insurance. We recommend FIO be empowered to monitor activities of other federal agencies that affect insurers and submit comments on proposed rules to ensure insurers will not be subjected to regulation that is unnecessary in light of the nature of the insurance business or other regulation.

b. *Improvements to State Regulation*

We also make the following recommendations for changes to existing state insurance regulation:

- ***Improve coordination of examinations among states and decrease reliance on contractors for exam responsibilities***

Insurers complain that exams are more costly than they need to be, take too long and require too much time from company personnel. A principal contributor to this is overlap among states, particularly regarding market conduct. The risk-focused exam approach is supposed to address this, but, has had too little impact to date. Contract examiners are also cited as a contributor. Incentives of contract examiners are not aligned with the regulators interest in identifying and resolving issues quickly. Better coordination of examinations by multiple states and increasing the number of qualified, well-supported insurance department staff could reduce reliance on outside contractors.

- ***Repeal seasoning requirements and state-specific license application requirements***

State seasoning requirements present a significant barrier to new market entrants and should be repealed. The existing UCAA process is inadequate to assure a simplified, efficient and prompt licensing procedure and should be changed to eliminate state-specific requirements. Doing so will transform the UCAA to a single, uniform application. The NAIC's pilot program for expedited nationwide licensing shows promise for allowing new companies to obtain nationwide licensing on a more reasonable timeframe and could be expanded to apply in all situations, not just those involving insurers that serve a regional or market need. To assure prompt action on a license application, the process should provide for automatic approval of applications if not disapproved in writing (with the reasons for disapproval set forth in writing) within a specified timeframe.

- ***Exempt markets from rate regulation***

Rates should not be subject to regulation in properly functioning competitive markets. One approach is to exempt markets from rate regulation based on a competition analysis. Standards for when a market is competitive may be promulgated by regulation; an insurer may write a line of insurance in a market free of rate regulation based on the insurer's certification that the market meets the prescribed

standards for competitiveness; the burden should be placed on the regulator to demonstrate that the market is not, in fact, competitive. Ideally, standards for competitive markets are set a federal level, with federal courts having jurisdiction to review state determinations.

An alternative approach is to exempt categories of insurance based on the line of insurance and/or characteristics of the purchasers. For example, it is widely accepted that commercial buyers and high net worth individuals need less protection than other consumers.

- **Expand the Interstate Compact process to cover all states and other lines of insurance; deregulate group and large commercial insurance**

We recommend that the existing Interstate Compact be made operational in all states and expanded or replicated to include additional lines of business; e.g., property and casualty insurance products. There should be complete deregulation of form approval requirements for group insurance products and insurance sold to large commercial buyers.

- **Remove Barriers to Exit**

We recommend increased uniformity in or abolition of the requirement for approval to withdraw from lines of insurance, specifically including any related prior notice periods (e.g., prior notice period is over a year in Florida). At a minimum, withdrawal should be permitted to take place immediately upon a showing that market competition exists.

- **Increase the harmonization, transparency and public understanding of the guaranty fund system**

Under the current system, if an insurer becomes insolvent, a policyholder in one state may receive less than a policyholder in a neighboring state who holds an identical policy with identical benefits or coverage. This is because of differences in the payment amounts guaranteed under the individual state guaranty fund laws. Furthermore, current state laws prohibit life insurers from informing life insurance purchasers about the existence of coverage under the guaranty funds, a restriction that does not apply to retirement savings and wealth accumulation products sold by other kinds of financial services institutions (banks, mutual funds and securities broker/dealers). The disparity in benefits from state to state contributes to the lack of transparency as to insurance guaranty fund protection insofar as insurers cannot describe guaranteed benefits in simple, concise terms. Consequently we recommend that benefits be harmonized to be uniform in all states and that rules prohibiting communications about the existence of the guaranty funds be reformed.

- **Consider global best regulatory standards**

State regulators should develop new rules, standards and policies with an awareness of global best regulatory standards and the impact that their rules, standards and policies have on internationally active insurers. In the absence of federal action, the need for all states to agree to the standards will be difficult. This is not meant to be a recommendation for capitulation to international standards, but is based on the need to recognize that financial services providers increasingly operate globally and that states should not impose regulation that is inconsistent with or unnecessarily duplicative of regulation that insurers face outside the U.S. (or retaliatory regulation that they could face if U.S. regulation departs from

international norms) unless a valid public policy objective is served by such inconsistency or duplication. There is, in addition, the need for a strong federal voice on international matters to protect U.S. insurers that operate internationally from being subject to duplicative and inconsistent regulation for the U.S. and non-U.S. subsidiaries. The risk, in the absence of such leadership, is that insurance subsidiaries of groups that are internationally active could be subject to multiple regulatory regimes that are at odds with each other, for example, where a non-U.S. parent company regulator requires the parents to calculate solvency capital on a different basis than is used for the U.S. subsidiaries (*i.e.*, RBC) and which does not give full credit to the capital held at the subsidiary level. The result could lead to a significant increase in capital requirements.⁴ This underscores the need for regulators to set policy with the objective of setting a level playing field that treats insurers that are part of international groups fairly in relation to purely U.S.-domestic insurance groups.

- **Enhance the status of insurance departments**

To the extent not superseded by federal regulation, the status of insurance departments may be enhanced in two distinct ways:

First, the appointment of insurance commissioners for a fixed term would enhance the authority, continuity, consistency and perceived impartiality of insurance supervision under the existing system of insurance regulation. When the International Monetary Fund assessed the U.S. regulatory system against IAIS Core Principles pursuant to the Financial Sector Assessment Program, it found that the ability of the governor in most states to dismiss commissioners at any time and the election of commissioners in other states subjected the commissioners to political pressures in conflict with the IAIS Core Principle that supervisory authority should be operationally independent and accountable in the exercise of its functions and powers. The appointment of insurance commissioners for a fixed term could further enhance the credibility of U.S. insurance supervision at both federal and international levels.

Second, it is essential that continuity in the quality of insurance department staff be assured and that they be given adequate resources to discharge their responsibilities capably and promptly. This translates into assurances that departments have adequate financial resources and training opportunities to attract, retain and develop the best possible personnel, particularly in the current period of budgetary tightening. Advocating that departmental staff receive increased resources, professional development opportunities, access to interdepartmental staff exchange programs, continuing educational opportunities or other career enhancement opportunities would likely enjoy the support of sitting and former regulators, as well as, departmental staff. Supporting career development opportunities for mid-and lower level departmental staff necessarily enhances the overall quality of insurance supervision in the U.S. and could further enhance the credibility of U.S. insurance supervision at federal and international levels.

III. First Principles – Objectives and Mechanisms of Insurance Regulation

In this Part, we seek to identify the objectives that underpin insurance regulation. While insurance regulation has developed largely in response to specific problems, we identify efficiency and fairness as separate but sometimes overlapping objectives that underlie much insurance regulation. Three obstacles that inhibit private insurance markets from achieving maximum efficiency (defined as delivering the greatest good for the greatest number) in the absence of insurance regulation are noted, to wit: the difficult-to-observe quality of insurance, the “positive externalities” of insurance and the perception that cognitive and behavioral limits of individuals may discourage people from purchasing insurance best suited to their needs. An awareness of these obstacles explains why governments do not allow consumers’ insurance needs to be served by completely unregulated private markets and therefore serves as a foundation for a fuller understanding of the proper role of traditional insurance regulatory activities – solvency regulation, consumer protection and access and availability. Fairness helps explain some aspects of insurance regulation that cannot be explained as efforts to promote the efficient delivery of insurance. We note that few argue that regulation should not promote fairness; where differences emerge is on questions about what is fair in what context, with differences in perception of what is fair reflecting different intuitions about an individual’s moral entitlements.

Insurance regulation long predates the rise of a centralized administrative state at the national level. Insurance regulation grew up at the state level out of necessity as only the states had the governmental resources at the time. At least until the late 19th century (and in many cases long after), insurers and insurance producers were largely state-specific or regional businesses. Thus, there was not the demand for strong national coordination that might have pushed the federal government to develop the necessary administrative capacity, as occurred in the transportation and banking sectors.

Moreover, it is important to recognize that insurance regulation has developed in response to specific problems, shaped by the then-prevailing political and economic understandings and opportunities, all of which evolved over more than two hundred years. There was no grand design, nor even a consistent understanding of the purposes and possibilities of insurance itself or of insurance regulation.

Nevertheless, it is possible to identify a small set of widely accepted objectives and categories of insurance regulation that can serve as a starting point for considering what can and should be done to modernize and improve the system of insurance regulation in the United States. That is the goal of this part of our report. We begin with the *objectives*, drawing from the conceptual vocabulary of social science and with the benefit of the history that gave rise to the system of regulation currently in place.

A. Objectives of Insurance Regulation

We start from the premise that there is a broad consensus that insurance regulation should rely on the private market to promote the efficient and fair delivery of insurance services, though recognizing that there is considerable disagreement about the best way to do so. These very general objectives – efficiency and fairness – provide the beginnings of a useful conceptual framework because they point toward bodies of knowledge in law and social science. The efficiency objective draws on economics and

psychology and related approaches to law and regulation. The fairness objective draws on moral philosophy and psychology and related approaches to law and regulation.⁵

1. *Promoting the efficient delivery of insurance through the market*

The concept of efficiency points toward the utilitarian objective of the greatest good for the greatest number. In the insurance context, this means spreading the most risk at the lowest cost. Social science research and insurance history have taught that there are three main obstacles that inhibit private insurance markets from achieving this objective in the absence of robust insurance regulation.

These three obstacles are: (i) the difficult-to-observe quality of insurance; (ii) the “positive externalities” of insurance; and (iii) the perceived cognitive and behavioral limits of individuals in relation to a complex product like insurance. This vocabulary and way of understanding insurance markets are relatively new, especially in the context of two hundred years of insurance regulation. Nevertheless, they provide a useful explanation for the existence of most of the core aspects of insurance regulation.

a. The difficult-to-observe quality of insurance

For markets to work, people need to have confidence in the products for sale. People also need to be able to distinguish among the quality and features of competing products, so that they can make an informed choice about how best to spend their money. Insurance poses tremendous problems in these regards. Many of the most important aspects of the quality of insurance are not easily observable by ordinary people. That makes insurance what economists call a “credence good,” meaning that people have to trust in the quality of the product even though they do not have the capacity to evaluate that quality when they buy it. Other kinds of credence goods include medicine, many kinds of food and most financial services. Governments in all advanced societies regulate credence goods to make them worthy of the trust needed to make markets in these goods possible.

The unobservable aspects of insurance product quality include the financial solidity of the insurance company, the details of the insurance contracts and the claims servicing practices of the insurance company. Some of these aspects of insurance product quality are not completely unobservable. For example, the written terms of an insurance contract appear in black and white on the insurance policy form (assuming that the insurance company is willing to provide the policy in advance, which is not always the case). But it is so time consuming and expensive to evaluate the terms of the contract or, indeed, most of the other observable aspects of quality, that no individual person or company would rationally make that effort. Other aspects of quality, such as past claims servicing practices or current financial conditions, might be observable in theory, but observation would require the disclosure of information that the insurer prefers to keep private.

Finally, some aspects of insurance product quality are completely unobservable by anyone at the time of purchase because they depend on what happens in the future. Insurance consists fundamentally of the promise to pay money in the future, sometimes very far in the future. No one can observe today the financial condition and claims paying practices of an insurance company in the future.

Much of insurance regulation can be understood as protecting the quality of insurance organizations and insurance contracts. When properly designed and implemented, solvency regulation,

market conduct regulation and the licensing of insurance companies and intermediaries all promote the consumer trust in insurance products needed to make the insurance market function.

b. The positive externalities of insurance

Sound insurance institutions are both evidence of, and preconditions for, a stable, productive society. Sound insurance institutions provide benefits to neighborhoods, communities and other social groups that exceed the aggregate value of the benefits to the individuals in the group. These “positive externalities” of insurance are an additional reason why an unregulated private insurance market will not supply as much insurance as would be optimal. Much of insurance regulation helps promote the growth in insurance markets that captures the positive externalities of insurance. Access and availability regulation is especially important in this regard. When properly designed and implemented, access and availability regulation brings insurance to individuals and entities that would not otherwise be adequately served.

The positive externalities also help explain why the costs of insurance regulation should not be imposed entirely on insurance institutions. By supporting insurance markets, insurance regulation benefits the broader society and, thus, should be supported by society at large, not just by those who purchase insurance through taxes on insurance premiums or cross subsidies within insurance pools.

c. The cognitive and behavioral limits of individuals

Psychologists and behavioral economists are only beginning to carefully study some of the limits on human decision making that may affect consumer behavior in the purchase of insurance and that explain some aspects of consumer protection regulation. Insurance is a complex product that requires people to make commitments, today, to protect themselves against things that may or may not happen, sometimes very far in the future. Cognitive and behavior limits that may discourage people from purchasing insurance appropriate to their circumstances include hyperbolic discounting (an exaggerated preference for money today rather than tomorrow), complexity aversion and procrastination. At the same time, there are other limits that encourage people to purchase some kinds of insurance that are very expensive relative to the benefit provided, such as very low deductibles, extended product warranties for relatively low cost goods and special purpose insurance against highly feared risks that could be more cheaply insured through more general purpose insurance.

A perception that individuals will not make the right decisions because of these limitations and that insurers will take advantage of this to the individuals’ detriment, rightly or wrongly, is the reason behind a significant portion of product regulation. The legislature or regulator decides whether a product or contract term is suitable or not suitable rather than leaving it to be sorted out among insurers and consumers participating in a free market. A more modern approach may be to design systems that foster allowing consumers to make appropriate choices, rather than making choices for consumers by writing rules that prevent the sale of designated products or mandate specified terms and conditions.

2. *Promoting fairness in and through insurance*

Fairness is an elusive but important concept that helps to explain some aspects of insurance regulation that cannot be explained as efforts to promote the efficient delivery of insurance through the private market. Insurance operates through “routine, mundane transactions that nevertheless define the

contours of individual and social responsibility,”⁶ with the result that “[i]nsurance, then, not only distributes risk . . . it also distributes responsibility.”⁷ So understood, it is easy to see that insurance arrangements implicate the kinds of questions about distributional and procedural justice that people think through in a commonsense way in terms of fairness.⁸

Who can be part of the risk pool? What losses are covered? How completely? Who has to pay how much for the privilege of joining the risk pool? What restrictions can the group place on the conduct of its members? What inquiries can the group make as a condition of membership or of paying a claim? What hurdles can it erect? What hoops may people be made to jump through to qualify for insurance or to make a claim?

It is not surprising that society does not leave such matters entirely to the discretion of insurance institutions or to the operation of the insurance market, no matter how much faith people have in markets. Moreover, the fact that insurance markets need some kind of regulation in order to meet the objective of promoting efficiency as just described practically guarantees that concepts of fairness will play an important role, if only because fairness provides a more effective rallying point for popular support for insurance regulation than efficiency.

In that context, the concept of “actuarial fairness” has played an important role in debates about the scope and function of insurance regulation. Among other things, actuarial fairness calls for “each insured [to] pay according to the quality of his risk,”⁹ thus justifying on the basis of fairness the approach to insurance pricing and other matters that efficiency typically would call for. While this approach to fairness has been subject to sustained attack,¹⁰ both the concept and the attack support a larger point. Whether to regulate insurance on the basis of fairness is not in question. What is in question is what is fair in what context.

As the example of actuarial fairness suggests, the efficiency-promoting aspects of insurance regulation generally can be recast in terms of fairness. For example, is it fair for someone to pay insurance premiums for years only to find that the company doesn’t have the money to pay her claim? Similarly, is it fair for insurance companies to use agents who mislead or otherwise take advantage of consumers? Few states compile and retain detailed legislative materials leading to the enactment of state laws, making it impracticable to conduct a comprehensive review of the legislative history of state insurance laws. Were we able to do so, however, we suspect that we would find many more references to fairness than efficiency and, where widely accepted notions of fairness and efficiency conflict, we would expect to see fairness prevail.

To a degree, conflicts between efficiency and fairness in relation to insurance regulation arise out of disagreements about the extent to which private insurance markets should participate in the reproduction of inequality. In part because insurance organizations have emphasized the non-commercial, altruistic and social aspects of insurance,¹¹ there is a longstanding tradition in insurance thought and regulation that regards insurance arrangements as instruments for ameliorating misfortune, with misfortune understood in much broader terms than the realization of the contingencies specified in an ordinary property casualty or life insurance contract.

In philosophical terms, this disagreement reflects different intuitions about moral entitlements and the role of insurance arrangements in relation to those entitlements. In one approach, people are morally

entitled to everything that they have, even those things over which they had no control and for which they might appear to have no responsibility for obtaining. In this view, people are entitled to the fruits of their health status even when it results from genetics and people are entitled to the fruits of the stability of their local economy whether they chose to live there or not. Taken to an extreme, this approach could lead to the rejection of insurance entirely.¹² More commonly, however, this approach regards insurance as a means to protect entitlements from loss and encourages insurance on that basis.

In another approach, people have a strong moral entitlement only to things that they deserve, and not to the outcomes of morally arbitrary events or matters, such as genetic endowment, economic conditions or childhood upbringing. In this view, people are not entitled to the fruits of their health status, except as it results from their efforts, and people are not entitled to the fruits of the stability of their local economy, except to extent that they chose on a nonarbitrary basis to live there and contributed to that stability. Taken to an extreme, this approach easily could regard most of the distribution of resources in society as morally arbitrary and, on that basis, employ insurance as an institution for very significant redistribution of resources. More commonly, however, this approach regards private insurance as a means for rounding just some of the hard corners of life and looks to progressive taxation and social insurance as the appropriate institutions for reducing inequality more broadly.

Some of the questions of insurance regulation on which these two approaches tend to diverge include limits on the discretion of insurance companies to define risk categories that are used for pricing and underwriting and limits on the discretion of insurance companies to vary premiums on the basis of those categories.

B. *Categories of Insurance Regulation*

In broad terms, traditional insurance regulatory activities can be divided into three categories: (i) solvency regulation, (ii) consumer protection, and (iii) access and availability. Solvency regulation is often treated as a subset of consumer protection (insofar as it seeks to protect consumers against the insurer failing to perform on its promises due to insolvency), but it is such a well-developed, prominent part of insurance regulation that it merits separate treatment.

1. *Solvency Regulation*

Solvency regulation has a variety of aspects that correspond to what is called safety and soundness regulation in the banking context. There are detailed financial reporting rules, capital requirements, financial monitoring and examination procedures, investment and activity limitations, reinsurance recognition rules, regulation of control persons and holding companies, resolution procedures for financially troubled insurers and guaranty funds that provide some protection in the event of insolvency. Taken together, these measures increase the security provided by the insurance market by reducing the risk of financial failure of insurance organizations, managing the winding up or reorganization of organizations that do become insolvent and providing some recovery for beneficiaries even in the event of insolvency.

Historically, solvency regulation has been the most important and active part of insurance regulators' efforts to facilitate an efficient insurance market. The goals of solvency regulation go beyond transparency, reflecting the positive externalities of insurance (because the harm resulting from the loss of insurance extends beyond policyholders) and the cognitive and behavioral limitations of individuals

(who might not understand, or act rationally in response to, accurate financial disclosure). Insurance solvency regulation reflects the view that robust insurance markets require engaged, expert regulators who do not simply trust in the market but rather actively make that market a safe place for people and organizations. This activist stance reflects the consensus view, even inside the insurance industry, that robust solvency regulation is an appropriate government function and that regulators should have the knowledge and the tools needed to carry out this function.

2. *Consumer Protection*

In general terms, insurance consumer protection regulation consists of the following activities: licensing (of insurers, agents and brokers and other intermediaries such as claims professionals and third party administrators), standards of conduct for insurers and intermediaries, insurance product approval requirements and procedures, market conduct supervision and consumer complaint handling and related information provision.

As these activities reflect, unlike the approach taken for investor protection under the securities laws, state lawmakers never adopted the view that a disclosure-based, transparency-oriented approach to regulation is sufficient to make insurance markets safe for consumers. The consumer protection aspects of insurance regulation reflect a view by state lawmakers and regulators that insurance purchasers are vulnerable to being taken advantage of at the point of sale and at the time of claim and that insurance regulation must actively prevent, and provide redress for, that exploitation, and that otherwise the insurance market will be smaller and less robust than insurance sellers or buyers would like.

Like solvency regulation, the consumer protection aspects of insurance regulation address the quality of insurance products and associated services, reflecting a view that government intervention is necessary to protect consumers because of both the credence good nature of insurance and the perceived cognitive and behavioral limitations of individuals. However, consumer protection is a more diffuse and difficult to assess goal than solvency prevention. For this and other reasons, there are greater differences of opinion within the insurance field about the degree to which regulators can effectively do more to protect consumers than monitor insurer insolvency and provide protection against obvious fraud.

3. *Access and Availability*

As the label suggests, insurance access and availability regulation is directed at making insurance available in the market and providing people with access to that market. Almost by definition, such regulation extends insurance beyond where insurance organizations would voluntarily go and, thus, there is bound to be opposition. For example, access and availability regulation can provoke claims that regulators are sacrificing efficiency in favor of misguided ideas about fairness.¹³

Access and availability regulation for property-casualty insurance consists of a variety of informal efforts by regulators to promote the growth of insurance organizations and markets, in addition to more formal measures. Among the formal measures, the creation of residual market mechanisms (insurers of last resort), competition regulation directed at expanding supply and reducing the price of insurance and mandatory insurance purchase rules are widely adopted and, although individual insurers may disagree about important details, widely accepted. Other measures that are also widely adopted, but more actively

resisted by insurance organizations on grounds that they suppress the proper functioning of competitive markets, include: (i) restrictions on insurance companies' ability to exit from all or part of an insurance market, (ii) the mandatory inclusion of particular coverage within an insurance policy, (iii) restrictions on underwriting and risk classification (rate compression), and (iv) restrictions on insurance companies' ability to charge, overall, the prices that the market would bear (rate suppression). Among these measures, rate suppression is the one that appears to be most clearly objectionable on efficiency grounds and unlikely to achieve the desired fairness objectives.¹⁴

IV. Where Are We and How Did We Get Here? The History, Development and Current Level of Uniformity of Regulatory Mechanisms

In this Part, we examine the origins and historical development of a representative set of insurance regulatory mechanisms in key areas of regulation and the level of national uniformity in each examined mechanism and gaps in the effectiveness of each. The covered mechanisms are: (i) solvency regulation; (ii) licensing of insurers and producers; (iii) credit for reinsurance/collateral requirements; (iv) resolution procedures and guarantee funds; (v) residual market regulation; (vi) rate regulation and product approval; (vii) financial examinations; and (viii) market conduct supervision. The purpose of these studies is to highlight, first, the current level of uniformity existing in these areas of state insurance regulation and, second, shortcomings in the effectiveness of such regulation. These observations serve as a basis for our recommendations.

A. *The Development of Coordination Among States Within the Current State-Based System*

Initial insurance regulation consisted solely of restrictions placed in the charters granted by state legislatures to insurance corporations.¹⁵ As insurance companies grew in size and complexity, however, independent state regulatory frameworks began to be established in the 19th century, and in 1851 New Hampshire appointed the country's first insurance commissioner.¹⁶ As it developed, sometimes insurance regulation was sought in order to avoid general unwanted consequences resulting from the business operations of insurers, such as the establishment of regulatory agencies to set reserve requirements and to collect information about company solvency after a number of early fire insurer insolvencies.¹⁷ Other times, advances in regulation were made in response to specific instances of malfeasance or scandalous events, such as the New York legislature's passage of a number of regulatory laws after the Armstrong Committee's 1905 investigation of practices by mutual life insurers under the control of various Wall Street financiers. The bundle of legislation adopted after the conclusion of this investigation included reserve requirements, limitations on premiums written and investment restrictions.¹⁸

Every state and the District of Columbia have an insurance department or insurance regulator.¹⁹ In most states, the insurance department is a stand-alone agency within the state government. In fifteen states, the insurance department is a part of a larger financial regulatory department.²⁰ The chief insurance regulatory official in every state (for ease of reference, the "insurance commissioner") is either appointed or elected. In the vast majority of the states, the insurance commissioner is appointed by the governor, subject to Senate confirmation. In eleven states, the insurance commissioner is elected. Of those appointed insurance commissioners, once approved, almost all serve at the pleasure of the governor; however, four serve at the pleasure of another state official (e.g., the Virginia Insurance Commissioner serves at the pleasure of the Virginia State Corporation Commission). Appendix A sets out the status of the insurance commissioner in each state.

Initially, only states were found to have authority to regulate insurance. An 1868 decision of the U.S. Supreme Court, *Paul v. Virginia*, held that "[i]ssuing a policy of insurance is not a transaction of commerce" under the commerce clause of the U.S. Constitution and thus not within the federal government's authority to regulate.²¹ The Supreme Court overturned the *Paul* decision in its 1944 ruling in *South-Eastern Underwriters*,²² but independent state regulation of insurance continued apace, as

Congress immediately enacted the McCarran-Ferguson Act²³ to clarify that state laws that govern the business of insurance are not invalidated, impaired or superseded by any federal law unless the federal law specifically relates to insurance.²⁴

State insurance departments are generally funded by the insurance market using fees and levies.²⁵ Fees are imposed on insurance companies for specific activities, such as licensing and examinations.²⁶ Insurance departments also collect state insurance premium taxes for the state, which goes into the general fund for the state, but can be used to further fund the insurance departments.²⁷ Some insurance departments use assessment authority to fund other government agencies and programs. In New York, for example, New York Insurance Law section 332 to assess insurance companies, but in the past the state essentially routed funds to other New York agencies and programs.²⁸

The NAIC is a private, voluntary association of chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories (American Samoa, Guam, Puerto Rico and the Virgin Islands).²⁹ The NAIC was created in 1871 as the National Insurance Convention to discuss how to harmonize regulation among the states after the Supreme Court's ruling in *Paul v. Virginia*, that insurance regulation fell squarely with the authority of the states.^{30, 31}

The NAIC is organized as a Delaware corporation and is headquartered in Kansas City, Missouri with offices in New York City and Washington, DC. The NAIC funds its activities by assessing fees for its services and publications.³² States require insurers to file their annual financial statements with the NAIC for its analysis and the NAIC charges each insurer a filing fee based on its premium volume.³³ The proposed budget in 2011 including total revenues of \$75.2 million and total expenses of \$75.4 million.³⁴

The NAIC's history reflects efforts to promote uniformity of regulation and an inconsistent commitment to preserve state regulation.³⁵ This tension is reflected in its constitution which states that the NAIC's objective is to serve the public by assisting the several state insurance supervisory officials, individually and collectively, in achieving the following fundamental insurance regulatory objectives: (i) maintenance and improvement of state regulation of insurance in a responsive and efficient manner, (ii) reliability of the insurance institution as to financial solidity and guaranty against loss and (iii) fair, just and equitable treatment of policyholders and claimants.³⁶

According to a 1999 study of the NAIC in the context of federal regulation of insurance, the primary activities of the NAIC were, at the time: (i) prescription of standard forms for insurance company annual financial statements; (ii) the coordination of regional financial examinations of insurance companies; (iii) the creation and maintenance of an extensive system of national databases to facilitate state monitoring of insurers and insurance agents; (iv) the rating of non-US insurers for the states; (v) the periodic review and accreditation of state insurance departments; (vi) the drafting of model laws and regulations, many of which have been adopted by state legislatures; (vii) the valuation of insurance company investments; (viii) training of state insurance regulators; (ix) the preparation of statistical reports for state regulators; (x) the assistance to state regulators with technical financial analysis; and (xi) the assistance to U.S. officials negotiating international trade agreements that concern insurance issues.³⁷ The NAIC's activities have expanded since then, but these remain core activities.

As a private organization, the NAIC has no actual authority or governmental power to compel the states or the insurance industry to act and the NAIC is neither accountable to voters nor subject to

government oversight.³⁸ Therefore, even though the NAIC has assumed a role of a national quasi-government agency, it cannot sanction regulators or insurers and it is not subject to various mechanisms designed to ensure a fair and open regulatory policy making and processes.³⁹

The NAIC does, however, have some authority to set standards and take action that has automatic binding effect by virtue of delegated authority under state and federal law. Every state has adopted a financial reporting law that requires insurance companies to file financial statements prepared on the reporting form prescribed by the NAIC and to calculate their risk based capital (“RBC”) in accordance with the procedures established by the NAIC. Through the standard valuation law that every state has adopted and these financial reporting requirements, the NAIC sets rules for the calculation of life insurance and annuity reserves. In addition, nearly every state has a law requiring the state insurance commissioner to conduct financial examinations of licensed insurers in accordance with the NAIC’s *Financial Condition Examination Handbook*.⁴⁰ At the federal level, the NIRA⁴¹ confers automatic nationwide eligibility to accept excess and surplus lines insurance on non-U.S. insurers that are approved by the NAIC’s International Insurance Department.

B. Solvency Regulation/Accreditation (Including Group Supervision)

The current framework for insurer solvency regulation in large part grew out of a coordinated response by the NAIC to the insurance company insolvencies that occurred in the 1980s.⁴² Representative John Dingell, then chairman of the U.S. House of Representatives Energy and Commerce Committee, led an investigation into the causes of such failures. The report of the investigation, issued by the Subcommittee on Oversight and Investigations, was titled *Failed Promises: Insurance Company Insolvencies*. In it, the Subcommittee, “found that the present system for regulating the solvency of insurance companies is seriously deficient,” lacking “regulatory controls to detect, prevent and punish” mismanagement of insurers.⁴³

In response, state insurance regulators, acting collectively through the NAIC in order to forestall federal regulation, agreed to endorse a set of financial regulation standards to be adopted and implemented by each state. The proposed financial regulation standards included model laws and regulations, staff qualifications, funding and resource requirements, as well as essential departmental practices and procedures. This initiative evolved to become the NAIC Accreditation Program.⁴⁴ Accreditation is a certification given to a state insurance department once it has demonstrated that it has met and continues to meet a set of legal, financial, functional and organizational standards. The “teeth” in the accreditation process can be found in the NAIC’s model law on examinations, which provides that a state *must* examine a foreign insurer licensed in the state unless the insurer has been examined by an accredited insurance department. All fifty states and the District of Columbia are currently accredited.⁴⁵

According to the NAIC, the emphasis of the accreditation program is on:

- (1) adequate solvency laws and regulations to protect consumers;
- (2) effective and efficient financial analysis and examination processes based on priority status of insurers;
- (3) cooperation and information sharing with other state, federal or foreign regulatory officials;

-
- (4) timely and effective action when insurance companies are identified as financially troubled or potentially troubled;
 - (5) appropriate organizational and personnel practices; and
 - (6) effective processes for company licensing and review or proposed changes in control.⁴⁶

This emphasis allows the accreditation program to ensure that state insurance departments meet minimum, baseline standards of solvency regulation, especially with respect to the regulation of multi-state insurers.

To become accredited, states must adopt model laws and regulations that incorporate insurance financial solvency and monitoring standards and submit to on site inspections by other state insurance regulators. To remain accredited, an accreditation review must be performed at least once every five years with interim annual reviews.⁴⁷ There are three major categories that the accreditation review covers: laws and regulations, regulatory practices and procedures and organizational and personnel practices. The purpose of the laws and regulations standards is to assure that an accredited state has sufficient legal authority to effectively regulate the solvency of its domestic insurers.⁴⁸ Regulatory practices and procedures are intended to supplement and support enforcement of such laws and regulations. These include procedures to adequately perform financial analysis, financial examinations and sharing information with other states. Finally, organizational and personnel practices focus on professional development, education and experience and retention.

In June 2008, the NAIC launched its most comprehensive review of the current state-based regulatory system since the *Failed Promises* report. This initiative has been pursued under the banner of the “Solvency Modernization Initiative” (“SMI”). The initiative was prompted by concerns that the regulatory system needed updating to stay in sync with evolving international standards of prudential regulation, again to ward off the threat of federal intervention. The project grew in importance in the wake of the AIG bailout and the corresponding public focus on improving oversight of financial regulation. The SMI is, in the NAIC’s own words, “a critical self-examination of the United States’ insurance solvency regulation framework and includes a review of international developments regarding insurance supervision, banking supervision, and international accounting standards and their potential use in U.S. insurance regulation. While the U.S. insurance solvency regulation is updated on a continuous basis, the SMI will focus on five key solvency areas: capital requirements, international accounting, insurance valuation, reinsurance, and group regulatory issues.”⁴⁹

As part of the SMI, the NAIC adopted a white paper that sets out the current solvency regulation framework. According to this white paper, the NAIC financial solvency approach involves seven “core principles”: Regulatory Reporting, Disclosure and Transparency; Off-site Monitoring and Analysis; On-site Risk-focused Examinations; Reserves, Capital Adequacy and Solvency; Regulatory Control of Significant, Broad-based Risk-related Transactions/Activities; Preventive and Corrective Measure (including Enforcement); and Exiting the Market and Receivership. Each core principle, as summarized by the NAIC, is an approach, a process or an action that is fundamentally and directly associated with achieving active financial solvency regulation. The core principles primarily operate through the adoption of NAIC model laws and regulations, many of which are required for accreditation.

An important component of solvency regulation is the maintenance of adequate capital and reserves. Principle 4 of the NAIC's Financial Solvency Core Principles (Reserves, Capital Adequacy and Solvency) states that "[i]nsurers are required to maintain reserves and capital and surplus to provide an adequate margin of safety for policy-holders and others." According to the NAIC, "[a]ccounting standards, risk-based capital requirements, minimum statutory reserves and state-specific minimum capital requirements form the backbone of the reserve and capital adequacy requirements."⁵⁰ Intervention by the insurance regulator is linked to the risk-based capital, or RBC, calculation. This calculation is intended to assess the capital adequacy of insurers and to identify and to assess various risks, including asset and business risks. Separate RBC formulae exist for each type of insurer (*i.e.*, life, property and casualty and health). Generally, if an insurer's Total Adjusted Capital exceeds 200% of its Authorized Control Level, no regulatory intervention is required. As an insurer's Total Adjusted Capital falls in respect of its Authorized Control Level, the following heightened regulatory intervention measures are prescribed: company submission of a corrective plan (150%-200%), the issue of corrective orders by the regulator (100%-150%), taking control of the insurer by the regulator at the regulator's discretion (70%-100%) and mandatory seizure of the company by the regulator (below 70%).

Risk-based capital standards are an example of an area of insurance regulation that exhibits a high degree of uniformity across state regulatory systems. The RBC model laws have been enacted in their standard form in virtually every state. RBC functions as a uniform tool for measuring capital adequacy because it involves other inputs where there is a high degree of uniformity: currently, every state requires insurers to prepare financial statements on the NAIC's prescribed form and in accordance with statutory accounting principles set out in the NAIC's *Accounting Practices and Procedures Manual*. The Securities Valuation Office, or SVO, operated by the NAIC, sets the valuations for investments made by insurance companies and reflected in their statutory financial statements.⁵¹ The existence of this uniform, national set of accounting principles and valuations is intended to assure that insurance company financial statements follow standardized rules, regardless of the state where the insurance company is domiciled.⁵²

There can, however, be deviations. Statutory Accounting Principles ("SAP") are the accounting principles prescribed or permitted by state law and some states may have rules that deviate from the accounting principles in the *Accounting Practices and Procedures Manual*. Further, regulators in some states may grant permitted accounting practices, by which insurers may deviate from NAIC accounting rules with the domestic's regulator's prior permission. Permitted practices offer flexibility when the rigid application of fixed rules might not make sense. However, permitted practices have also come under criticism. Consumer groups generally see the allowance of permitted practices by state insurance regulators as caving to pressure of their large domestic insurers. In his testimony before the Senate Committee on Banking, Housing, and Urban Affairs, Travis Plunkett of the Consumer Federation of America described permitted practices as a "debacle" that has "laid bare the problem with state-based financial regulation."⁵³ State regulators themselves have had concerns with permitted practices, and the NAIC has, over the years, imposed process controls and additional disclosure requirements in an effort to clamp down on the perceived abuse of the discretionary authority to allow permitted practices. Attached as Appendix B is a case study of an instance in which individual states granted permitted accounting practices during the 2008-2009 financial crisis to accommodate specific insurers' needs following the NAIC's failure to agree to the practices the insurers requested.

Partly in response to the perceived gap in regulation over financial groups that emerged following the AIG bailout, and partly in response to the International Monetary Fund's 2010 assessment of insurance regulation in the United States pursuant to the Financial Sector Assessment Program, which concluded that the approach to supervision of groups needs significant development, regulators have been working on ways to enhance oversight over groups of insurers that include both regulated insurance entities and non-regulated entities. Following a lengthy review of the current regulation of insurance holding companies, the NAIC reaffirmed its commitment to the NAIC's "windows and walls" approach to regulatory groups, by which regulators will rely on holding company disclosures and other reporting to provide clearer "windows" into group operations in order to enhance existing "walls" of solvency protection, rather than asserting direct supervision on the group and holding company.⁵⁴ The NAIC's SMI Task Force is also evaluating additional methods of capital assessments that shift the primary focus of solvency supervision away from the assessment of capital adequacy of the regulated insurance entity, including Own Risk and Solvency Assessment ("ORSA").⁵⁵ The Group Solvency Issues (EX) Working Group is currently working on a manual to provide insurers and state regulators with guidance as to what an ORSA may entail and what any possible filings should address.

C. *Licensing, Market Entry and Exit*

i. Licensing of Insurers

Consumer protection is the fundamental goal of licensing as it helps to regulate the competence, experience, integrity and financial soundness of an insurer's promise to pay someone in the future in exchange for the payment of premiums in the present.⁵⁶ Insurance companies are generally required to obtain licenses before offering insurance in a state. The license specifies the line or lines of insurance that the insurer seeks to transact in a state. Since licensing is state specific, each state's approval is required before transacting insurance within its borders.⁵⁷ Each state requires that in order to be licensed an insurer must possess a certain minimum level of capital and policyholder surplus, or net worth. The amount of initial capital depends primarily upon how much business the company intends to write, although there are minimum capital requirements in each state. The highest minimum amount is \$7.5 million; however, in reviewing the initial application for licensing, regulators are likely to require more than the minimum capitalization prescribed by statute to provide an additional solvency cushion. After formation, the insurer will need to meet RBC requirements, which are calculated based on the insurer's mix of insurance business, reinsurance and investments. The state insurance regulator also reviews the fitness and competence of the insurer's management and board of directors, as well as its business plan, product lines and market conduct practices and procedures.⁵⁸

States determine what constitutes the "transaction of insurance." As a general matter, selling, soliciting, negotiating or delivering insurance policies constitutes transacting insurance.⁵⁹ Some states also treat collection of premiums and adjustments of claims – acts that follow the sale of insurance – as a "transaction of insurance" which in turn triggers the licensing requirement.⁶⁰ A license must first be obtained where an insurer is organized or domiciled and the process must be repeated in each state in which the insurer wishes to transact insurance.⁶¹ License applications submitted to non-domiciliary states are called "expansion applications."⁶² There are exceptions to the licensing requirement.⁶³

This state specific approach has proven costly and slow. The licensing application process can take between eighteen months to two years to complete, but can take longer in states with "seasoning"

requirements. Generally, a “seasoning” provision requires that before an insurer domiciled in one state can be newly licensed in another state, it must have demonstrated successful operation for a period of time in the domiciliary states for three to five years.⁶⁴ Seasoning requirements are a significant barrier to market entry and is a primary inhibitor to launching a 50-state insurance company in a short period of time.⁶⁵ As a result, it is easier to simply purchase an insurance company that is approved for operation when trying to expand into a new market and there is an active market in “shell” insurance companies precisely for this purpose. “Seasoning” can be waived by an insurance commissioner in some states, but such waiver is rarely granted and often only in situations where there is a high level of capitalization or where the insurer deposits funds with the commissioner or offers covered in underserved lines of insurance.

The *Uniform Certificate of Authority Application* procedure (“UCAA”) was established by the NAIC to provide a frame of reference for the licensing of insurers.⁶⁶ The UCAA was developed to allow for use of a single application form for all licensing-related applications and is accepted in all states. However, the use of a uniform application form does not mean that all states require the same information, nor does the UCAA supplant individual state review of an application. The UCAA application incorporates individual state rules, regulations and requirements relative to licensing⁶⁷ and individual state applications need to be prepared as a result. This makes the form cumbersome to use. States conduct their own independent review of the application and may reach differing conclusions, even on those aspects of the application that are common to all states (such as ownership structure, business plan, financial projections and qualifications of management).

In 2007, the NAIC’s National Treatment and Coordination Working Group developed a pilot program for expedited insurance company licensing. The purpose of the program was to improve the efficiency of company licensing regulatory review processes by streamlining state-specific application requirements, including the need for hard copies of forms and supplemental information involved in the UCAA. Three newly formed monoline insurers (two financial guaranty insurers and a mortgage insurer) participated in this program. The program has now been formally established and companies must apply to the Working Group in order to participate. In evaluating a company’s application, the Working Group will consider a number of factors, most significant of which is whether the application will serve a “national or regional market need and quantification of that need.” This consideration is derived from the program’s original intent, which was to facilitate the efficient regulatory review of new entrants in insurance industry sectors deemed to be of national importance. The Working Group will also consider, among other factors: (1) the applicant’s willingness to file its licensing applications electronically, (2) the domestic regulator’s willingness to work with the Working Group, (3) the applicant’s current affiliations with insurers licensed in other states, (4) the basic financial condition of the applicant, (5) whether the company is a start up company, (6) the nature and extent of any parental guarantees, (7) experience of the management team with the lines of business being applied for, and (8) any regulatory compliance enforcement actions by the applicant’s home state for the last five years. Only two of the three participating insurers completed the program; for one, it took a year to become licensed in all states following receipt of its initial license in its state of domicile; for the other, it took approximately 10 months to become licensed in 49 states and the District of Columbia.

ii. Licensing of Producers

Licensing of sales personnel or producers is also subject to divergent state requirements. The licensing process typically requires passing an examination, background checks and, in some states, fingerprinting. In 1999, Congress passed the Gramm-Leach-Bliley Act (“GLBA”) largely in response to industry sentiment that state regulation was not effective.⁶⁸ Section 321 of GLBA required at least 29 jurisdictions to enact, not later than November 12, 2002, (1) uniform laws and regulations governing the licensure of individuals and entities authorized to sell and solicit the purchase of insurance within the state; or (2) reciprocity laws and regulations governing the licensure of non-resident individuals and entities authorized to sell and solicit insurance within those states.⁶⁹ GLBA incentivized states to improve and increase the uniformity of insurer licensing laws and regulations by threatening the establishment of a national licensing authority that would preempt state authority. In response, the NAIC created several programs to standardize licensing requirements, to make the licensing process more efficient, and to ensure high levels of consumer protection in all states.⁷⁰

State producer licensing has changed significantly over the past decade but in many respects remain substantively unchanged with respect to the licensing of resident agents.⁷¹ In 2000, NAIC created the Producer Licensing Model (“PLMA”) which created a framework for reciprocal producer licensing. It outlined reciprocal recognition of continuing education requirements for producers and the definitions of the six major types of insurance.⁷² As of March 2009, NAIC had certified 47 states and jurisdictions according to PLMA’s standards; however, three key states, New York, Florida and California, had not yet been certified.⁷³ In 2002, NAIC implemented the Uniform Resident Licensing Standards which defined standards for regulatory tasks such as license renewals and pre-licensing education requirements.⁷⁴ In 2003, NAIC also announced its Insurance Regulatory Modernization Action Plan which implemented one uniform license application and recommended the “full implementation of an electronic fingerprint system.”⁷⁵

By December 2008, all states utilized the form for non-resident applicants.⁷⁶ In 2007, the NAIC/Industry Producer Licensing Coalition was formed as a partnership of regulators and national trade organizations to focus and facilitate producer licensing uniformity initiatives.⁷⁷ Various states have worked toward streamlining and achieving uniformity as part of ALERT (Accelerated Licensing Evaluation Review Technique).⁷⁸

According to the NAIC, most states now utilize the NAIC Uniform Applications for both individuals and business entities.⁷⁹ Instead of a paper-based, forms-intensive environment, states now use electronic processing.⁸⁰ States have eliminated old barriers to an efficient non-resident licensing process, such as bond requirements, state specific applications and retaliatory licensing fees.⁸¹ States’ access to NAIC’s State Producer Licensing Database eliminates the need for producers to expend time and money obtaining and submitting proof of good standing in hard copy.⁸² Despite steps taken by states, the federal government and the NAIC to improve licensing regulation, gaps still remain. A 2008 study by the NAIC found that of 37 uniform licensing standards, there were 12 where compliance was low, which it defined as meaning less than 35 states were utilizing the standards. Even for the remaining 26 where it found compliance to be high, compliance was not necessarily complete – up to 17 jurisdictions could be applying rules other than the uniform standards and the NAIC would still consider compliance to be “high.”

iii. Market Entry and Exit

Regulators are deeply involved in entry and exit processes. As discussed above, licensing an insurer in all 50 states can be time consuming and difficult. The marketplace has been forced into a convoluted solution that allows new market participants to enter new markets quickly through the purchase of a shell company. Regulators are aware of the active commerce in “shell companies” and their acceptance of the use of shell companies reveals their belief about the lack of true need for the more burdensome review involved in formation and licensing of a new company. A more sound approach would be to eliminate seasoning requirements and simplify licensing to allow new companies to be licensed much more quickly.

Ease of exit is just as important as ease of entry in terms of fostering a properly functioning competitive market. Insurers will not enter into a market if they lack confidence that they can freely exit if expected profits do not emerge or if their business strategies change.

Regulators generally require some form of orderly exit. There are two aspects of exit: withdrawal from the active marketing of insurance and a complete exit of the insurance business with a return of the owner’s invested capital. Withdrawal is and can be done, subject to compliance with a host of regulatory notices and approvals. Complete exit generally is not possible, except by sale to another.

Twenty-one states⁸³ require property and casualty insurers to provide some form or notice or prior approval for withdrawing from the writing of new insurance business or for bulk non-renewal of insurance. Notice periods range from as little as forty-five days to as much as one year and 90 days from the proposed withdrawal date or the date when notice is sent out and some states require an explanation for the withdrawal. Waivers of the notice requirement may be granted in some states if the state commissioner finds the waiver necessary to protect the solvency of the insurer or if the insurer’s withdrawal is deemed to have a limited impact on the market.⁸⁴ Notice requirements can also be waived or alleviated if there will be a replacement carrier. Some states additionally require the exiting insurer to provide some explanation for withdrawal. Nevada, for example, requires an insurer to demonstrate the grounds for cancellation or nonrenewal by clear and convincing evidence.⁸⁵ Few states require an insurer withdrawing from the writing of new insurance business or bulk non-renewal of insurance to also surrender a license.⁸⁶

There are greater restrictions for withdrawing from a line of insurance, which typically involves surrendering a license, than for withdrawing from the writing of new insurance business or for bulk non-renewal of insurance. Insurers do not favor surrendering licenses due to the regulatory hurdles involved and the potential adverse consequences such as having to provide pre-answer security in order to enter an appearance to defend a suit. The regulatory hurdles are particularly stringent for private passenger auto and homeowners insurance lines. For example, in Massachusetts, an applicant seeking to surrender any or all of its licenses must go through a withdrawal plan approval and filing process.⁸⁷ This process involves submitting an application to surrender the license(s), an organization chart, description of lines of insurances in the states, as well as a detailed narrative of the withdrawal plan.⁸⁸ The Commissioner retains discretion to conduct a hearing to inquire into any aspect of a withdrawal plan which could extend the process of surrendering the license.⁸⁹ In Maine, an insurer wishing to terminate license authority in whole or in part must, among other things, (i) meet requirements and procedures for meeting the insurer’s existing contractual obligations and (ii) provide security in the event of a subsequent

insolvency.⁹⁰ Withdrawal from a line of insurance subject to the Automobile Insurance Cancellation Control Act additionally requires the insurer to demonstrate the availability of equivalent replacement policies for all policyholders at the same or lower rates.⁹¹

Although there have been a number of voluntary runoffs in addition to insurance department supervised runoffs of financially impaired insurers, these take many years and, in practice, there are no voluntary liquidations of insurance companies in the U.S. that can allow for a prompt exit from the insurance business and an immediate return of capital. A complete exit from the insurance business typically takes place through an ownership change (including mergers, acquisitions and name changes) or involuntary liquidation.⁹²

There are no regulatory barriers to market exit by insurance producers – a producer simply may tender its license for cancellation or allow the license to lapse without renewal.

D. Credit for Reinsurance/Collateral Requirements

Credit for reinsurance is a way of regulating reinsurance transactions with reinsurers outside the jurisdiction of an insurer's state insurance regulator. This is particularly important as reinsurance receivables are typically large assets on an insurer's balance sheet. By allowing credit against policy liabilities on an insurer's balance sheet only where the reinsurer meets certain requirements, a state can provide a strong incentive for its domestic insurers to place reinsurance only with those reinsurers that meet the state's solvency standards or otherwise secure their performance by posting acceptable collateral.

The NAIC published its first Credit for Reinsurance Model Law in 1977. The law allows insurers to receive credit for risk ceded to non-licensed reinsurers only if those reinsurers can show evidence of financial soundness or post collateral in the form of a letter of credit or funded trust. The 1984 Model Law introduced the concept of an accredited reinsurer, and allowed credit for reinsurance to be taken by an insurer when ceded to a reinsurer that was licensed or accredited in another state that had adopted the 1984 Model Law or "substantially similar" provisions. The most recent iteration of the Model Law, promulgated in 1990, enhances the regulators' financial oversight by providing for the filing of annual statements by reinsurers and granting a ceding insurer's state regulator access to its books and records. States are inconsistent in their adoption of the various versions of the Model Law, particularly with regard to the treatment of alien versus domestic reinsurers. In addition, whereas most states gave full recognition to the treatment of the reinsurance accorded by the regulator in the ceding insurer's state of domicile, until the recent enactment of the NRRRA regulators in some states applied their rules extra-territorially to insurers licensed in their state but domiciled in another. The NRRRA addressed this by prohibiting states from denying credit for reinsurance if the ceding insurer's domiciliary state has recognized the credit, provided the domiciliary state is NAIC-accredited.⁹³

The U.S. approach to regulation of reinsurance has been severely criticized – particularly as it relates to the treatment of non-U.S. reinsurers. It has the effect of allowing a ceding insurer to take full financial statement credit for reinsurance ceded to any reinsurer licensed in the various states, even if thinly capitalized and poorly rated, while not allowing credit for reinsurance placed with non-U.S. reinsurers – including the world's largest, most well capitalized and highest rated reinsurers – unless those reinsurers post collateral.

The origins of the collateral requirement for non-U.S. reinsurers dates to the establishment in 1939 of the Lloyd's American Trust Fund (the "LATF"). The original purpose of the LATF was to assure U.S. cedents that, notwithstanding the impending outbreak of World War II, payment of claims by Lloyd's would be uninterrupted by any difficulties in removing funds from the UK.⁹⁴ The 1977 Credit for Reinsurance Model Law incorporated the concept of a trust account in its collateral requirements for non-licensed reinsurers, a provision that in practice required all non-U.S. insurers to maintain reserves in the state of each ceding company until the introduction of accredited reinsurer status and trustee accounts by the 1984 Model Law.⁹⁵

This system of regulation has often been cited as a barrier to entry into the U.S. market during international trade negotiations. In recognition of the states' inability to fix a system that a broad consensus of insurance industry interests consider to be broken, in 2010 Congress gave the U.S. Treasury Secretary and the U.S. Trade Representative joint authority to enter into international agreements with foreign governments/regulatory entities that "relate[] to the recognition of prudential measures with respect to the business of insurance or reinsurance that achieves a level of protection for insurance or reinsurance consumers that is substantially equivalent of protection achieved under State insurance or reinsurance regulation."⁹⁶ In order to ensure uniform implementation of such agreements (which Congress expects will include something relating to reinsurance collateral requirements), the FIO is given the authority to preempt inconsistent state laws.⁹⁷

In addition, several states – including, namely, New York, Florida and New Jersey – have modified their credit for reinsurance rules to allow certain highly-rated non-U.S. reinsurers to apply for reduced collateral requirements. However, these reforms only affect reinsurance purchased by those insurers domiciled in those states. Also, the NAIC's Reinsurance Task Force is in the process of developing proposed amendments to the Credit for Reinsurance Model Law that would, if adopted, implement a sliding scale for collateral based on the reinsurer's financial strength. All of these reform measures require the ceding insurer's domestic regulator to make a determination that a non-U.S. insurer is domiciled in a jurisdiction that meets acceptable levels of solvency supervision and/or enter into information sharing agreements. These features would not ensure uniform application among the states, however, and the above-mentioned portions of Dodd-Frank giving authority to the U.S. Treasury Secretary and U.S. Trade Representative are likely to be needed for that reason.

E. Resolution Procedures and Guaranty Funds

Federal bankruptcy law specifically exempts insurance companies from proceedings under federal bankruptcy law.⁹⁸ Furthermore, the McCarran-Ferguson Act delegation of the "business of insurance" to the "laws of the several States" has been held to include the rehabilitation and liquidation of insurers, effectively preempting any attempt by a bankruptcy court to exert jurisdiction over the business of an insurer, even if that insurer is owned by a Bankruptcy Code debtor.⁹⁹

The Uniform Insurers Liquidation Act, now adopted in all states, was drafted in 1939 to deal with insolvent insurers that operated across state lines. The effect of this act, in practice, is for states to afford complete deference to the regulator in the insurer's state of domicile appointed as receiver. Before laws governing insolvencies were developed in state insurance codes, insolvent insurers were dealt with in equity courts. State liquidation laws were seen as being needed to constrain the power of equity courts under a statutory framework, clarifying the role of receivers.¹⁰⁰ The NAIC promulgated the first Insurers

Rehabilitation and Liquidation Model Act in 1978, which has been adopted at least partially by 32 states.¹⁰¹ In 2005, the NAIC published the Insurer Receivership Model Act after a four-year study; however, thus far it has only been enacted in two states (Texas and Utah). While the different state laws are based on the same underlying receivership and resolution concepts, there are differences on many important details. One issue that currently gets attention by insurers and their trading partners is whether a state has adopted a provision that allows swap contracts to be closed out and netted once an insurer is placed in receivership, as permitted by the federal Bankruptcy Code. The absence of a netting provision in a state's laws can affect a domestic insurer's ability to participate in swap markets and/or the collateral that it will have to provide in order to do so.

Despite the lack of uniformity of state laws, the NAIC has published a *Receivers Handbook for Insurance Company Insolvencies* (2009) as a guide to administering insurance company receiverships. According to the NAIC, such handbook “[r]epresents more than two years of work compiling information from more than 50 authorities, including actuaries, accountants and consultants who regularly work on receiverships.”¹⁰²

An important aspect of insurance company insolvencies is the operation of state guaranty funds. The primary purposes of the guaranty funds are to provide a mechanism for the timely adjustment and payment of covered claims under insurance policies issued by carriers which become insolvent, to minimize financial loss to policyholders and claimants due to the insolvency and to provide a mechanism to assess the cost of this protection among insurance companies doing business in the state.¹⁰³ States typically have separate guaranty funds for property and casualty claims and for life and health claims. Guaranty funds are created by state statutes as nonprofit legal entities whose members consist of the insurers licensed to do business in the state and that write any of the lines of insurance to which the statute applies.¹⁰⁴ They are usually governed by boards of directors elected by the member insurers and operate according to a plan of operation which establishes the procedures for the exercise of the fund's powers and duties.

The first state guaranty funds began to be established shortly before the Second World War, with New York State leading the nation in the development of guaranty fund protection.¹⁰⁵ Prior to 1969, however, still only eight states had laws providing some form of guaranty fund protection, and no state had laws providing coverage for all lines of insurance.¹⁰⁶ In 1966, in an environment affected by a growing number of insurance company insolvencies (131 property and casualty insurers went insolvent in the ten years spanning 1958 to 1968¹⁰⁷), Senator Thomas Dodd (D. Conn.) focused public attention on the problem of failing insurers by introducing a bill to establish a Federal Motor Vehicle Insurance Guaranty Corporation.¹⁰⁸ Subsequently, in 1969, Senator Warren Magnusson (D. Wash.) introduced a bill broadening the original Dodd bill, to create an FDIC-like fund of up to \$500 million to cover all lines of property and casualty insurance.¹⁰⁹ The NAIC responded by quickly passing, in 1970, the Model Insurance Guaranty Association Act. A later act was developed concerning claims against life and health insurers.¹¹⁰ Within two years of the adoption of the first Model Act, forty-five states had adopted legislation creating post-assessment property and casualty guaranty funds.¹¹¹

Currently, all fifty states, the District of Columbia and Puerto Rico have adopted legislation establishing both property & casualty and life & health guaranty funds. Additionally, each guaranty fund participates in its respective national association—the National Conference of Insurance Guaranty Funds (“NCIGF”) and the National Organization of Life & Health Insurance Guaranty Associations

(“NOLHGA”)—to coordinate payment of claims arising from the insolvencies of multi-state insurers. Since its inception, the property and casualty system has paid out more than \$26.4 billion to policyholders, beneficiaries and claimants related to over 550 insolvencies, according to the 2010 annual report of the NCIGF.¹¹² NOLHGA reports that its members have protected consumers in roughly 75 multi-state insolvency cases.¹¹³

Levels of maximum payouts for claims or benefits that can be paid out by state guaranty funds vary from state to state. For property and casualty, maximum payouts per claim are generally set by statute between \$100,000 and \$500,000, with the majority of states setting a \$300,000 cap.¹¹⁴ For example, California maintains a \$500,000 limit; New York a \$1,000,000 limit for all claims and a \$5,000,000 limit per policy for risks located outside the state; and Michigan provides \$5,000,000 in coverage per claim, adjusted annually.¹¹⁵ Even in those states that follow the majority of states in setting the maximum limit at \$300,000, certain exceptions can increase or decrease such limit. For example while Florida has a statutory maximum limit for claims of \$300,000, Florida increases this limit by \$200,000 for homeowner’s insurance and decreases it to \$100,000 per residential unit for policies covering condominium associations and homeowners associations.¹¹⁶ Furthermore, most states exclude claims by companies whose net worth exceeds a statutory limit. For life and health, according to a report by NOLHGA discussing the response by life and health guaranty funds to the financial crisis, the following amounts are deemed the “Safety Net,” with each state offering at least this much protection: \$100,000 for health claims, \$300,000 for life claims, \$100,000 in cash surrender/withdrawal values and \$100,000 for annuity claims. These amounts are subject, however, to differences among the states with some states offering more in maximum benefits, occasionally up to \$500,000 for all types of claims.¹¹⁷

Although every insurer is required to belong to and pay assessments to its state guaranty fund, state laws generally prohibit insurers from referencing the existence of guaranty funds in advertising.¹¹⁸ For life guaranty funds, explicit advertising prohibitions are contained in the guaranty fund statute itself. While no such explicit provision applicable directly to property and casualty guaranty funds exists, certain states, such as New York, have broad advertising restrictions applicable to all insurers which prohibit any statements to the effect that “the insurer’s policies are guaranteed wholly or partly by any other person, insurer or institution.”¹¹⁹

Such prohibition tends to operate to the disadvantage of small insurers, which, unlike small or local banks backed by an FDIC guaranty, cannot take advantage of their insured position in their advertising to attract clients. In fact, advertising prohibitions appear to have been lobbied by large multi-state insurers with abundant assets and surplus (which can be mentioned in advertisements) who contended that consumers should not be induced to make a purchase decision without regard to the creditworthiness of the insurer due to the existence of the guaranty fund. Despite efforts to increase awareness among consumers of the existence of the guaranty funds by NCIGF and NOLHGA, as well as by financial planners not statutorily prohibited from doing so, much of the insurance-buying public remains uninformed of the function of these entities in the protection of insurance benefits in the event of an insurer’s insolvencies.

Concern that the existence of guaranty fund coverage should not encourage consumers to ignore the financial strength of their insurer as a relevant factor in their purchase decision is valid. However, at a minimum, the insurance industry needs to have a way to be able to assure customers (who may not have the ability to replace their coverage due to health, age or other insurability issues) that their insurance

coverage is protected, and communication of this information should be allowed in a way reasonably likely to be effective.

One way to address the moral hazard issue would be to allow or require more fulsome disclosure. For example, removal of restrictions on mentioning guaranty fund coverage could be matched by removal of state law restrictions that prevent financially stronger insurers from advertising their financial strength in simple and easy-to-understand terms.¹²⁰ Limitations on references to guaranty fund coverage in advertising or at point of sale could be reformed to allow disclosure so long as it is accompanied by other relevant financial information concerning the financial strength and condition of the insurer.

F. Residual Markets

Insurers in a competitive market are free to select those drivers, property owners and commercial operations they wish to insure. Insureds also have a number of options of insurers from which to choose to provide such coverage. So called “high risk” applicants may have difficulty obtaining insurance through the regular market channels. To make some important basic coverages readily available to everyone who wants or needs insurance, special insurance plans, known as residual, shared or involuntary markets, have been set up by state insurance regulators.¹²¹

Residual markets are meant to be markets of last resort when the voluntary market fails to meet consumer needs. They exist because of a public policy determination that a greater good is served by assuring insurance covering certain risks is available to everyone, such as in situations where insurance is required by law to assure compensation to injured third parties (e.g., auto, workers’ compensation) or to promote economic development or general welfare (e.g., homeowners, fire coverage in urban areas). Difficulties with residual markets arise when a non-functioning voluntary market (most often, due to rate suppression) results in a reduced availability of coverage from the voluntary market, or when rate suppression in the residual market results in it becoming the market of first choice, rather than a market of last resort.

Where the rates charged to high-risk policyholders are too low to support the program’s operation, insurers are generally assessed to make up the difference. These additional costs are typically passed on to all insurance consumers. However, in a few states, insurers are not able to recoup their residual market losses and political pressure prevents rates from rising to the level they should be actuarially.¹²² In addition, reliance on post-event funding for some residual markets has further potential adverse consequences: first, it raises questions about the residual market’s ability to raise funds to meet obligations; second, reliance on assessments or taxes across a broad base of the population in order to assure that there is sufficient funding results in lower risk areas subsidizing higher risk areas. For example, the Chief Operating Officer of the Florida Hurricane Catastrophe Fund recently testified that the Florida fund is on “shaky ground” and expressed concern that it would not be able to raise funds to meet its obligations if major storm damage occurs. Since all Florida insurers are obligated to purchase reinsurance from the fund, this creates issues for the state’s entire property insurance market.¹²³

1. Automobile Coverage.

The first of the residual market mechanisms for automobile coverage was established in New Hampshire in 1938. As states began to pass laws requiring drivers to furnish proof of insurance, having

auto liability insurance became a prerequisite for driving a car. Today, all 50 states and the District of Columbia use one of four systems to guarantee that auto insurance is available to those who need it.

All four systems are commonly known as assigned risk plans, although the term technically applies only to the first type of plan, where each insurer is required to assume its share of residual market policyholders or “risks.” The four automobile insurance systems are: (i) assigned risk plans, (ii) Joint Underwriting Association (“JUAs”), (iii) reinsurance facilities and (iv) state funds.¹²⁴ The states with JUAs, reinsurance facilities and state funds, the plans are not able to be self-sustaining; however, the plans normally recoup losses by surcharging policyholders, deducting losses from premium taxes or assessments of insurers from the competitive market.¹²⁵

The assigned risk plan, the most common type, currently found in 42 states and the District of Columbia, generally is administered through an office created or supported by the state and governed by a board representing insurance companies licensed in the state. Assigned risk policies usually are more restricted in the coverage they can provide and have lower limits than voluntary market policies. In addition, premiums for assigned risk policies usually are significantly higher, although not always sufficiently high enough to cover the increased costs of insuring high-risk drivers.¹²⁶

A 2004 study of residual markets by the Property Casualty Insurers Association of America found that in states where competition is the primary regulator of price, the residual market tends to be small. For example, some states, like New Jersey, have seen their residual market fluctuate, depending on conditions in the voluntary market such as the regulatory environment and rate adequacy. In 1987, close to 1.8 million drivers were insured in the New Jersey shared market, compared with about 97,300 in 1993. But gradually, this number slowly increased as insurers began to withdraw from the state because of the overly harsh regulatory system. Market reforms passed in New Jersey in recent years have brought more auto insurance companies into the market, increasing competition and reducing the need for drivers to seek coverage in the residual market.¹²⁷

North Carolina is an example of a state with a proscriptive, government controlled insurance regulatory system is matched with a large residual market. In 2008, North Carolina ranked highest among states in the number of auto policies in a residual market plan, with just over 20 percent of the auto market in its residual market.¹²⁸ In contrast, participation in the South Carolina residual auto insurance market plan dropped sharply when it moved its regulatory system in the direction of a competitive markets approach. In 1998, prior to its change in regulation, the residual market in South Carolina accounted for 26 percent of all auto insurance premiums in the state, which was the highest percent in the nation in that year. In 1999, the competitive markets based approach already impacted the size of the residual market. The percent of auto insurance in South Carolina’s residual market dropped to 8.6 percent.¹²⁹ Recent statistics indicate South Carolina’s residual market accounted for nearly zero percent of the market in 2008.¹³⁰

2. *Property Insurance*

The first urban area plan went into effect in 1960 in Boston. Following a series of fires in some inner-city neighborhoods, insurers began to withdraw from these communities, making it difficult for some Boston residents to obtain fire insurance.¹³¹ In 1967, riots broke out in many cities across the nation. As property insurers continued to withdraw from inner-city neighborhoods, citing huge losses, insurance

departments and insurance industry leaders were called upon to expand existing urban plans and create new ones which eventually led to the establishment of Fair Access to Insurance Requirements (“FAIR”) Plans. As of November 2009, 32 states and the District of Columbia had property insurance FAIR Plans.¹³² Originally, most plans provided protection only for “perils” outlined in the federal statute: fire, extended coverage (which includes windstorm and hail damage) and vandalism and malicious mischief. Coverage for fire was available as a “stand-alone” policy. Almost half the Plans now offer some form of homeowners insurance policy, which always includes liability coverage. While broader coverage responds to homeowners needs in one respect, it also increases the cost of coverage.¹³³ According to the Insurance Information Institute, rates for FAIR Plan coverage are, in theory, to be set at break-even level. In practice, in most states, rates are set lower than they would be in the voluntary market, with shortfalls assessed on FAIR Plan members according to their market share, resulting in a subsidy to FAIR Plan insureds.

Beach and Windstorm Plans had a different genesis. Hurricanes in 1969 and 1970 drew attention to the insurance industry’s exposure to loss along the coastline of the Gulf and Atlantic states. This led to pooling arrangements in coastal sections of seven southern states.¹³⁴ Four of these states provide coverage for wind and hail damage only.

In an August 2011, report by the Insurance Information Institute (III) on the recent developments of property residual market insurance, over the period of 1990 and 2010, total exposure to loss in the residual property insurance market surged from \$54.7 billion to \$757.9 billion. Over the same period, the number of policies in force in the residual property insurance market went from 931,550 to 2.8 million. The largest property insurance plan (Florida Citizen), experienced growth in 2010 and 2011 due to the insolvency of several property insurers and a reduction in the number of high-risk policyholder insured by several major companies.¹³⁵ Insolvencies and the flight of capital from a market and the resulting growth in its residual market are due in many cases to regulatory policies that do not permit companies to charge appropriate and actuarially sound prices for the risk they bear.

3. *Commercial Coverage*

The mechanism used to handle the workers’ compensation residual market varies from state to state. In the four states with a monopolistic state workers’ compensation fund all businesses are insured through that fund. In most states with a competitive state fund, the fund accepts all risks rejected by the voluntary market, thus eliminating the need for assigned risk plans. In states without a competitive fund, insurers may be assigned applicants based on their market share and service those employers as they would employers that came to them through the voluntary market, through a system known as direct assignment.¹³⁶

In most states, between 80 and 90 percent of residual market plan business is assigned to the pool. In a few states the pool is the only option. In some states, the assigned risk plan is administered by the National Council on Compensation Insurance, which also administers the largest of the pooling arrangements, the National Workers Compensation Pool (“NWCP”).¹³⁷

The III August 2011, report on recent trends in residual markets reported that positive trends in the workers’ compensation residual market may be coming to an end. Premiums decreased to four (4) percent in states with such residual markets and market share was steady at five (5) percent.

Nevertheless, in 2010, insurers paid out about \$120 in residual market claims and expenses for every \$100 in premium collected. Additionally, even though the percentage of firms insured in the residual market declined 32 percent in employers with premiums of \$100,000 in the first quarter of 2011, it does not completely offset the 38% increase in employers with premiums greater than \$100,000 from the first quarter of 2010.¹³⁸

G. Rates and Insurance Product Regulation

1. Rate Regulation for Property/Casualty Insurance

Rate regulation grew out of rating bureaus. Insurance companies gathered to form bureaus in the 19th century. For better or worse, these organizations allowed them to pool data, centralize ratemaking and standardize forms.¹³⁹ Insurers feared “destructive competition” whereby premiums would fall to below actuarially sound rates, leaving companies bankrupt.¹⁴⁰ An unscrupulous businessman could profit for years by writing insurance products at low rates. When a catastrophe occurred and the bill came due, the company would be declared bankrupt allowing him to escape. Indeed, large fires and earthquakes drove many companies out of business, depriving consumers of the protection they thought they purchased.¹⁴¹

Against this backdrop, New York’s Merritt Committee concluded that reasonable rates could only be set in concert to avoid future insolvencies.¹⁴² ¹⁴³ As a check on the system, the New York statute authorized regulatory supervision.¹⁴⁴ With New York leading, the process went national, with most states following New York’s example in collaborative rate setting boards or bureaus.¹⁴⁵ By 1920 over half the states had some form of rate regulation.¹⁴⁶

The equilibrium was disrupted by the Supreme Court in 1944 when it ruled insurance was interstate commerce.¹⁴⁷ Fearing federal antitrust statutes such as the Sherman Act would interfere with collective information sharing and rate setting, the industry and the states petitioned Congress, which responded with the McCarran Ferguson Act in 1945.¹⁴⁸ It largely returned regulation to the pre 1944 status quo and gave the states the power to regulate insurance free of the dormant commerce clause.¹⁴⁹ The industry was exempt from the regulation they feared, but only if the “business of insurance” was “regulated” by the states.¹⁵⁰

Unsure of how much regulation was necessary to avoid federal involvement, states passed more stringent laws.¹⁵¹ Between 1945 and 1948 all states had passed some sort of bill regulating rates.¹⁵² These largely required prior approval of rates.¹⁵³ After a report from a Senate subcommittee a decade later said competition needed restored, states gradually loosened their grip. By the end of the 1980s, despite some individual state moves away from competition, most states had enacted some sort of competitive rating law.¹⁵⁴ Even Massachusetts, which had long required prior approval, moved towards a flex rating system.¹⁵⁵

But of course, the trend has not been smooth or constant. The periods of price increases produced regulatory changes. Some consumers blamed the industry for the increases, thinking they were working in concert. These would lead to more stringent regulation to control the perceived cartel. California passed stringent prop 103 during the 80s liability crisis.¹⁵⁶ Other consumers blamed the regulators for the high prices, saying they were disturbing competition.

The term “price controls” frequently describes state regulation of rates used by property and casualty insurers licensed or admitted in a state (the “licensed or admitted market”).¹⁵⁷ Examples of property and casualty insurance provided by the licensed or admitted market include fire, burglary, theft, workers’ compensation and commercial automobile. States generally do not formulate mandatory rates, rather insurers determine the rates they want to use in a particular state in which they are licensed, and then they must comply with the applicable rate regulation required in that state.¹⁵⁸ Insurers must justify their rates either (i) by using their own loss data and projections or (ii) by the use of rating information and loss cost factors developed by national insurance advisory organizations accepted by the state regulators. The legal standard for rates in all states is that they not be “inadequate, excessive, or unfairly discriminatory.”¹⁵⁹

The focus of state insurance regulation has shifted from looking at the adequacy of rates so as to prevent solvency problems to using price controls to hold down prices by denying proposed rate increases on the grounds that they are excessive.¹⁶⁰ States address rate regulation on most lines of commercial property and casualty insurance¹⁶¹ in a wide variety of ways:

- (i) Five states have no filing requirements and are said to have a deregulated open market for commercial lines (“No File”);
- (ii) Two states require informational rate filings only (“Information Only”);
- (iii) Two states provide for the automatic approval of rate changes within a specified band (“Flex Rating”);
- (iv) Nine states allow rates to be used without pre-filing, but they must be subsequently filed (“Use & File”);
- (v) Thirteen states and the District of Columbia require rates to be filed before they are used (“File & Use”);
- (vi) Nineteen states require rates to be filed and approved before they can be used, and generally allow rates to be “deemed” approved thirty days after they are filed if the state has not taken any action during that time (“Prior Approval with Express Deemer”) and
- (vii) Of the forty-three states with some degree of rate control, nineteen and the District of Columbia also provide for the exemption of rate approval requirements on large commercial property and casualty policies, based on policy premium “triggers” that vary in each state (from \$10,000 to \$500,000).¹⁶²

The temptation, of course, is for insurance commissioners – who are either elected or appointed by elected officials – to suppress rates below actuarially sound levels because it pleases voters. Even in the absence of such pressures, application of the standard that rates must be “not excessive” can result in limiting insurer’s profits to below what they might earn in a competitive market, and application of the standard that rates be not “unfairly discriminatory,” can result in insurers having to underwrite on the basis of risk classifications or rating factors that they would not use based on the application of actuarial practices. Evidence of a market dislocation caused by rate suppression often can be found in the size of the residual market facility in the state.¹⁶³ In states that have experienced large increases in the

population insured through the residual market, the reason is generally that private insurers have ceased or curtailed writing insurance because they cannot earn the same return on the capital necessary to support the business comparable to what they can earn by deploying their resources elsewhere. A comparison of Massachusetts and Illinois is instructive. In 2008, Massachusetts ranked second highest among states in terms of the number of auto policies written in the residual market and the residual market consisted of 2.8 percent of the state's auto insurance market share. In Illinois in 2008, the residual market only accounted for .015 percent of the auto insurance market.¹⁶⁴ The Massachusetts residual market has about 10 times as many cars in it, though the state of Massachusetts has half the cars of Illinois. Massachusetts is also an example of where distorting the rate structure can actually lead to higher costs, higher premiums, on average, than would be the case under market competition.¹⁶⁵

One well-known consumer advocate, citing the experience of California, has argued that more stringent rate regulation by states, *i.e.*, those that require prior approval by the insurance commissioner before rates may be changed, has resulted in lower rates for consumers while still permitting reasonable insurer profits and a competitive marketplace.¹⁶⁶ The experience of California is anomalous insofar as it is simply too large a market for many large, national insurers to abandon, as has happened in smaller states where rates are intensively regulated. Further, what this argument ignores, as one commentator has noted, is that the requirement of prior regulatory approval had the effect of discouraging insurers from reducing rates to match declining claims costs. In other words, if California had an open, competitive market, auto insurance would have been even lower than they actually were.¹⁶⁷

2. *Product Approval*

Product approval is the system or process by which state insurance regulators review and approve (or disapprove) new insurance policies offered by life insurers and property and casualty insurers for compliance with state laws and to protect consumers.¹⁶⁸ State regulators review policy forms and grant or deny approval based on the product's characteristics, rates and price. Most states require product approval prior to market introduction and those states justify such prior approval requirements because of the complexity and technical nature of insurance contracts, which makes them difficult for the average consumer to understand.¹⁶⁹

State regulators, through the NAIC, have taken steps to standardize the initial filing and product approval processes.

In 1998, the NAIC created the System for Electronic Rate and Form Filing ("SERFF"), which standardized the initial product filing process.¹⁷⁰ SERFF is designed to expedite the mechanics of submitting product rate and policy form filings to regulators.¹⁷¹ SERFF uses a standard electronic form for new product filings with the states and it allows regulators to receive, comment on and approve or reject insurance industry rate and form filings electronically.¹⁷² Although SERFF is becoming increasingly popular, it is not available for all types of products in each state.¹⁷³ As of March 2009, every state used SERFF.¹⁷⁴ Most importantly, SERFF is just a filing system.

Each state has its own process with varying procedures and approaches for review and follow-up on filings.¹⁷⁵ State insurance departments also vary in the level of expertise and resources devoted to the review process. The variances among states delay product approval and increase costs for consumers.

The NAIC has attempted to address this for life insurance, annuities, disability and long-term care insurance by establishing the Interstate Insurance Product Regulation Commission (“IIPRC” or “Compact”). The Compact is intended to promote speed-to-market and uniform national standards by providing for a single filing for a new product, which will be reviewed and approved by a single reviewing entity (the IIPRC), which will apply a single set of standards. A product approved by the IIPRC will be automatically approved for use in all compacting states. Uniform product standards are developed through a deliberative process that allows participation by regulators in both compacting and non-compacting states, the insurance industry and consumer representatives. The product standards set out detailed specifications for the product filing itself and requirements for mandatory and prohibited terms and conditions that serve consumer protection objectives. The uniform standards supersede individual state requirements, although some standards incorporate individual state rules.¹⁷⁶ The Compact became operational in 2006 and now has 41 member states, representing two thirds of the premium volume nationwide.¹⁷⁷ However, several major states, such as California, Florida and New York, have not yet joined the Compact and certain product approval decisions are still left to the states’ discretion.¹⁷⁸ Life insurers are generally satisfied with the functioning of the Compact and cite as its principal failing that it is not operational in all states, including three of the largest states.

Other efforts to streamline product review and approval processes focus on reducing differences among the states’ product filing requirements and identifying best practices.¹⁷⁹ Efforts under the NAIC’s *Improvements to State-Based Systems* focus on reviewing and eliminating “unnecessary” product filing requirements that have accumulated over time.¹⁸⁰

The NAIC has also developed a model law aimed at strengthening the product approval process for commercial property and casualty insurance. The *Property and Casualty Commercial Rate and Policy Form Model Law*, adopted by the NAIC in March 2002, would ease some of the current state rate and form submission requirements if adopted by the states.¹⁸¹ No state, however, has adopted this NAIC model law.

H. Financial Examinations

Financial examinations started as a means to identify fraud and errors in the financial statements filed with state insurance departments.¹⁸² The NAIC established a Committee on Examinations in 1936. The NAIC bylaws set forth duties of the Committee, thus setting forth the initial ground rules of financial examination.¹⁸³ After the insurance insolvencies of the 1980s, Congress criticized state insurance regulatory practices, including lack of mandatory and consistent field examination and independent verification of financial statements.¹⁸⁴ In response to the criticism, the NAIC initiated its Financial Regulation Standards and Accreditation Program, adopting a set of financial regulation standards for insurance departments. When the NAIC instituted its accreditation program, its stated purpose was to improve solvency regulation and financial examinations by state regulators.¹⁸⁵

Today, in all 50 states and the District of Columbia, insurers are subject to a full-scope financial examination at least once every 5 years.¹⁸⁶ The states have adopted uniform standards on how often an insurer is examined and the process used to examine the insurer.¹⁸⁷ Specifically, every state has adopted the substantive requirements of the NAIC Model Law on Examinations that requires that the insurance commissioner consider the standards of the *Financial Condition Examiners Handbook* (“Examiners Handbook”) relating to when an examination should be called; nearly every state has

adopted the Model Law's requirement that the commissioner observe the Examiners Handbook's guidelines and procedures in the conduct of an the examination.

The NAIC moved to a risk-focused approach surveillance of insurance companies and the revised NAIC Examiners Handbook in 2007.¹⁸⁸ The revised Examiners Handbook was mandated as an accreditation standard for all examinations commencing after January 1, 2010.¹⁸⁹ According to the Examiners Handbook, many solvency problems have been caused by inadequate management oversight. Inadequate management oversight typically results from inaccurate financial reporting, which can prevent the regulator from taking timely remedial action.¹⁹⁰

The Examiners Handbook sets forth the risk-focused surveillance process, which includes identifying significant risks, assessing and analyzing those risks, documenting the results of the analysis and developing recommendations for how the analysis can be applied to the ongoing monitoring of the insurer.¹⁹¹

Insurers operating in multiple states and insurance groups with multiple insurers domiciled in different states will be subject to examinations by the various individual states. Through protocols set out in the Examiners Handbook and established regulatory practices that have developed over time, the various states seek to coordinate their examinations to eliminate duplication and maximize the efficient use of the examiner's resources. This does not mean that an insurer or an insurance group operated on a fully integrated basis will be subjected to only a single examination, but rather that the various individual examinations of different examining states will be coordinated to some extent. For example, the Examiners Handbook sets forth the concept of the Coordinating State, as the state that assumes the leadership role in coordinating group examinations.¹⁹²

To determine which state should be the Coordinating State, the Financial Condition Handbook sets forth certain factors that the may be considered.¹⁹³ Such factors include: (i) input from the company, (ii) the domiciliary state of the parent company, (iii) if no insurance parent, the state where the largest insurance subsidiary is domiciled based on direct written premium as shown on the last filed Annual Statement, (iv) the state with the largest number of domestic insurance companies in the group, (v) the state with large premium volume or exposure, (vi) the domiciliary state of the top-tiered insurance company in an insurance holding company system, (vii) the domiciliary state of the lead company in an intercompany pooling arrangement, (viii) the physical location of the main corporate offices or largest operational offices of the group, (ix) the expertise and resources of the domestic states within the group as well as areas of concern and experience of staff in these areas and (x) the state whose regulatory requirements have driven the design of the organization's infrastructure. The NAIC Financial Examiners Coordination Working Group will determine the Coordinating State for each holding company group.¹⁹⁴

The responsibilities of the Coordinating Examiner are set out in the Examiners Handbook. These include, among other things, notifying other regulators of an upcoming examination, seeking input from other regulators in the planning of the examination, developing an examination team, obtaining a thorough understanding of the organization as a whole and interviewing management and board members at the holding company level (participating states conduct interviews at the entity level, delegating responsibilities among the examination team, reviewing the work of the participating states and resolving disputes or disagreements regarding the examination. The Coordinating Examiner has no

power to compel a participating state to take or not take any action; rather the system turns on a system of voluntary deference by participating states to the Coordinating State in the interests of comity.

I. *Market Conduct Regulation*

“Market conduct” refers to the manner in which an insurer behaves in the society in which it operates. An insurer’s conduct in the market is often expressed by the manner in which the insurer prices its products, makes its products available, fulfills the various obligations ascribed to the insurer under an insurance policy, and other behavioral patterns which affect current and potential policyholders.¹⁹⁵ Various states, and, to a lesser extent, federal, regulatory schemes have evolved over the years to define, determine, deter and punish improper conduct in the insurance marketplace. These schemes seek to deter unfair, deceptive and anti-competitive conduct.¹⁹⁶ In recognition of the evolving and technical nature of the products which insurers may introduce into the marketplace, legislatures have granted state departments of insurance, federal agencies such as the Department of Labor or the Securities and Exchange Commission and other administrative bodies the authority to promulgate rules and issue orders within a specified delegation of regulatory authority.¹⁹⁷

State insurance laws and regulations regulate trade practices in the business of insurance by defining, or providing for the determination of, all practices in the state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting such trade practices.¹⁹⁸ The states have also adopted standards for the settlement of claims arising under insurance policies issued to residents of the state. States require insurers to settle insurance claims in a fair and equitable manner.¹⁹⁹ Market conduct examinations focus on the business practices of insurers, agents and brokers.²⁰⁰ The purpose is to monitor compliance with licensing requirements, use of approved rates and forms, underwriting and claims practices, advertising and policyholder services. Through market conduct examinations, regulators seek to identify market conduct problems that have a substantial adverse impact on consumers, policyholders and claimants to prompt insurers, agents and brokers to remedy those problems.²⁰¹

The NAIC has adopted a Market Conduct Surveillance Model Law (Model #693) that addresses market conduct examination. The model law establishes a framework for insurance department market conduct oversight, which includes procedures for identifying, assessing and prioritizing market conduct problems and communicating and coordinating market conduct actions among states. The model law is not widely adopted, and most states rely on their general powers to examine the affairs of insurers and other licensed persons and entities and to bring enforcement actions for violations of the insurance laws. The NAIC has also adopted a Market Regulation Handbook that sets out guidance for market analysis and guidelines for market investigations and examinations of specific entities. The Handbook includes specific examination standards for each kind of regulated insurance entity. These standards are generally applied by insurance commissioners in market conduct examinations, although not always, and few states have adopted laws that actually require the insurance commissioner to use it. Targeted examinations may focus on a specific practice or legal requirement.²⁰²

Market conduct examinations and enforcement actions typically focus on the general business practices and compliance activities of insurers rather than identifying infrequent or unintentional random errors that do not cause significant consumer harm. However, individual instances of a violation of the insurance laws and regulations may precipitate a market conduct investigation and/or enforcement action.

The NAIC's Market Regulation Handbook sets out areas of focus for market conduct examinations, which include the examination standards applicable to each kind of regulated entity.²⁰³

In the absence of a statute specifically addressing market conduct examinations, the processes for the issuance and adoption of a report will be the same as for a financial examination. Generally, examiners will share their findings with the targeted entity before rendering a final report. The targeted entity will then respond with comments and typically will work with the Insurance Department to resolve issues and finalize the report. The final adopted report is a public document in most states. If the examination results in a finding of a violation, the examination report may be accompanied by an order imposing penalties and enjoining further violations. The order also may require corrective action with respect to consumers harmed by any violations noted in the report. The regulated entity often resolves the violation through a settlement, which may take the form of a stipulation or order by consent.²⁰⁴

In 2003, the Government Accountability Office ("GAO") found, in general, that states do not depend upon other states' regulation of in companies' market behavior and therefore most states feel a responsibility for overseeing all of the companies selling insurance in their states, and that states vary in the emphasis they give to market conduct examinations, resulting in variations from state to state in the number and the comprehensiveness of examinations. It also concluded that interstate coordination and communication is inconsistent and infrequent and that industry participants interviewed by the GAO expressed concerns with excessively frequent and duplicative examinations. Since the time of the GAO report, there may be greater sharing of information through NAIC databases and committees.²⁰⁵ However, insurers continue to complain about the lack of coordination by states on market conduct examinations.²⁰⁶

State insurance department oversight of market conduct often overlaps with enforcement powers of state attorneys general, who may have general enforcement powers over all violations of state laws or under separate unfair trade practices laws that overlap with the unfair trade practices laws within the state insurance code. Because state attorney generals may be separately elected from the insurance commissioner or governor who appointed the commissioner, this can lead to inconsistent and competing enforcement and regulation of market conduct.

V. Prior Federal Participation in the Supervision of Insurance

While McCarran-Ferguson is frequently viewed as a Congressional blessing of the supremacy of state insurance regulation, in truth it is grounded in the notion that Congress has the power to enact laws regarding insurance regulation, and will do so provided it makes that intention clear. State regulation continues as a Congressional forbearance, if you will, which can be (and often is) modified or overridden by Congress in specific ways.

This Part examines such federal activity, organizing the review into three broad categories: (i) federal programs that replace, supplement, or channel private-market insurance or reinsurance, (ii) elements of other federal programs or agencies which conduct solvency review or issue qualifications or approvals to insurers to write insurance or other forms of financial responsibility, the procurement of which is required under diverse and numerous other federal programs and (iii) other federal statutes directly impacting insurance regulation.

The last category includes elements of regulation under the Dodd-Frank Act that are not specifically focused on insurance, but which have the potential for greater involvement by various federal agencies in regulatory supervision over insurers, namely bank and savings and loan holding companies, the designation of an insurance holding company as presenting systemic risk, resolution authority of the Federal Deposit Insurance Corporation (“FDIC”), the so-called “Volker Rule” and Commodities Futures Trading Commission (“CFTC”) rules that affect insurers involved in derivatives trading.

This Part also examines other attempts at federal-level insurance reform and provides our conclusions on the lessons that can be learned from existing federal intervention

A. *Federal Insurance Programs*

There are a number of federal programs where the government acts either as an insurer or a reinsurer. There are “one off” solutions that largely deal with the risks that the private sector often does not insure. Here, federal regulation displaces private insurance and removes the states’ role as regulator.

i. Terrorism Risk Insurance Act

The Terrorism Risk Insurance Act (“TRIA”) was enacted in November 2002 in response to market conditions resulting from the September 11th terrorist attacks. Prior to the attacks, acts of terrorism were not regularly excluded under commercial property & casualty policies, and following the attacks insurers largely did not try to use the “acts of war” exclusion to deny claims. Thereafter, insurers began largely excluding acts of terrorism in commercial property & casualty (“P&C”) policies due to concerns over an inability to model the frequency and severity of such losses. At the same time, lenders began requiring terrorism insurance for commercial properties and many construction projects were halted because such coverage was difficult if not impossible to obtain in the private market.

Congress thus enacted TRIA to create a federal “backstop” for the private terrorism insurance market.²⁰⁷ Under the TRIA program, the federal government provides partial indemnification for commercial P&C losses resulting from certified acts of terrorism. TRIA requires insurers to make terrorism coverage available to policyholders in certain commercial lines, and in the event of a certified

act of terrorism, the federal government will cover 85% of terrorism losses above a statutorily-defined “deductible” based upon the insurer’s direct earned premium for the prior year. Federal indemnification is also conditioned upon a “program trigger” – through which the federal government will only cover its share of losses if the terrorist event results in at least \$100 million in aggregate insured losses.

Originally enacted as a three-year program, TRIA was extended for two years under the Terrorism Risk Insurance Extension Act of 2005 (P.L. 109-144), which also made modifications to the program including the elimination of certain lines of the program and the institution of the “program trigger” described above. TRIA was subsequently reauthorized through 2014 under the Terrorism Risk Insurance Program Reauthorization Act of 2007 (P.L. 110-160), which largely kept the program unchanged, with the principal change being the removal of a distinction between foreign and domestic terrorism (prior to 2007 domestic terrorism was not included in the program). While there have been some concerns expressed about the program’s potential to expose U.S. taxpayers to substantial losses in the event of a catastrophic terrorist event, TRIA has enjoyed broad support since its enactment, and state insurance regulators have generally supported the program and its continuation.

ii. National Flood Insurance Program

The National Flood Insurance Program (“NFIP”) was first authorized under section 1304 of the National Flood Insurance Act of 1968, P.L. 90-448, 42 U.S.C. §4011. At the time, assistance for flood victims was generally limited to post-event disaster assistance, as private insurers generally did not provide coverage at affordable prices due to an inability to develop an actuarial rate structure to reflect flood risk.²⁰⁸ The NFIP is a program whereby the federal government sells flood insurance policies through either participating private insurers (known as the “Write Your Own” program) or directly through state-licensed agents and brokers.

The NFIP is available only in communities that participate in the broader program (which includes floodplain mapping and management requirements), and eligible properties are subject to coverage limits for both the building and for personal property.

The rates charged for flood insurance are required to be actuarially-based; however, properties constructed prior to the adoption of a Flood Insurance Rate Map (known as “pre-FIRM” properties) have subsidized rates where policyholders pay less than the full-risk premium.

The NFIP incurred substantial losses from the severe hurricane season of 2005 and remains in debt. Enacting reform legislation has proven an elusive goal in recent years.

iii. Federal Crop Insurance Corporation

The original crop insurance program began as a pilot program in 1938 when the Federal Crop Insurance Corporation (“FCIC”) was created as a reaction to the “Dust Bowl” conditions of the 1930s in the Great Plains and Midwestern United States brought on by severe drought and poor farming techniques. The program was generally limited to major tilled crops in main producing areas. Prior to 1980, farmers could receive ad hoc disaster assistance free of charge (*i.e.*, unlike crop insurance, for which a premium was charged), and without condition of participation in the FCIC program which – for forty years – was treated as a pilot program.

In 1980, the Congress enacted the Federal Crop Insurance Act, P.L. 96-365, which codified the program and expanded it to include more regions of the country and more crops. Also in order to encourage more farmers to participate in the program, the 1980 Act authorized a premium subsidy to be paid by the federal government.

As currently structured, the program is a partnership between the government and the private sector, with both the government and private sector sharing in the losses through a reinsurance mechanism. Although the federal crop insurance program is carried out by the FCIC, it is administered by the Risk Management Agency within the U.S. Department of Agriculture, the Administrator of which serves *ex officio* on the FCIC's Board of Directors. The government generally plays two distinct roles in crop insurance: (i) it subsidizes premiums paid by farmers and (ii) it acts as a reinsurer to the private sector crop insurers who sell and service crop policies. The premium subsidies are by far the largest share of the government's total cost in the program. The amount of the subsidy depends upon the crop and the level of coverage sought.

In its role as a reinsurer, the government negotiates a Standard Reinsurance Agreement ("SRA") that it enters into with the private sector insurers. Under the SRA, the government has two distinct responsibilities. First, the government reimburses the private companies for their administrative and overhead ("A&O") costs according to a formula established under the SRA. The formula is based on a percentage of total premiums. Second, the government will absorb a portion of the program losses pursuant to its function as a reinsurer under the SRA (the proportion varies by crop and region).

Crop insurance policies, while reinsured by the federal government, are sold and serviced by private sector insurers approved for this purpose by the RMA. Currently, there are 16 approved crop insurers participating in the program. Private insurers are required to file an annual Plan of Operation with the RMA and certain other information throughout the year, including documentation to support requests for A&O reimbursements.

iv. Department of Transportation War Risk Insurance

The U.S. Government has provided marine and aviation war risk insurance for decades. The marine war risk program was originally enacted in 1950, and was a standby program reactivated following the September 11th terrorist attacks in order to ensure the flow of U.S. foreign commerce when commercial insurance cannot be obtained on reasonable terms. The program is overseen by the Maritime Administration ("MARAD"), and is authorized through 2015.

The aviation war risk insurance program was first authorized in 1951. Prior to the September 11th terrorist attacks, the Federal Aviation Administration ("FAA") was initially authorized to provide insurance and reinsurance for losses "arising out of any risk" of the operation of aircraft, but only if the President determined that continued operation of such aircraft "is necessary to carry out the foreign policy of the United States Government." During this time, the insurance was only provided to U.S. air carriers for flights outside the United States, and only during times of international crisis.

Following 9/11, the program was amended so that insurance could be provided if necessary "in the interest of air commerce or national security." President Bush issued Presidential Determination 01-29, which authorized the FAA to provide insurance to U.S.-flag air carriers "whenever [the Secretary of

Transportation] determines that such insurance cannot be obtained on reasonable terms and conditions” from the private market. The Secretary made such a determination, and the determination has been extended consistently through to the present. The program was extended through 2013 in the FY2008 National Defense Authorization measure, P.L. 110-181.

v. Price-Anderson Act

In 1954 Congress enacted the Atomic Energy Act Amendments of 1954 (P.L. 83-703) which for the first time authorized the licensing of private entities to develop commercial nuclear power. Utilities, however, were reluctant to enter the nuclear power industry without adequate liability insurance and had difficulty obtaining the amounts of coverage desired in the private insurance market. To address this concern, Congress enacted the Price-Anderson Nuclear Industries Indemnification Act of 1957 (P.L. 85-256), which requires nuclear power licensees to enter into what amounts to a sort of no-fault liability system for nuclear accident damages, whereby most legal defenses are waived. Licensees are required to obtain the maximum amount of liability insurance available from the private market, and damages exceeding that amount will be covered by the industry as a whole through a retrospective assessment up to a statutory liability limit.

The Price-Anderson Act was reauthorized through 2025 as part of the Energy Policy Act of 2005, P.L. 109-58.

vi. Overseas Private Investment Corporation

The Overseas Private Investment Corporation (“OPIC”) is an independent government corporation that provides political risk insurance and project finance to U.S. businesses in over 150 emerging markets and developing countries. OPIC was established in 1969 to assume investment promotion and guarantee functions that had been conducted at the time by the Agency for International Development. OPIC began operations in 1971, and operates largely on a self-sustaining basis but has its credit program level and budget for administrative expenses set out by Congress in the annual appropriations process. OPIC’s statutory authorization expired in 2007 but has been extended annually through the appropriations process.

OPIC provides to U.S. individuals and companies several types of political risk insurance, including currency inconvertibility, expropriation, political violence, standalone terrorism and small business coverage. It utilizes brokers, who may receive a 15% commission, and may also utilize co-insurance and reinsurance in order to increase capacity for large projects. OPIC insurance is backed by the full faith and credit of the U.S.

vii. Riot/Crime Insurance

Due to extensive rioting that took place in many inner-cities in the mid-to-late 1960s, insurers began to withdraw from such areas and the lack of available insurance for inner-city properties began to compound problems in such areas. In response, Congress enacted the Urban Property Protection and Reinsurance Act of 1968 (P.L. 90-448), which established a federal reinsurance program covering losses from riots or civil disorders and available in states that had enacted plans to ensure fair access to insurance requirements (known as “FAIR plans”). Under the program, insurers paid reinsurance premiums to the Secretary of Housing & Urban Development, and the reinsurance was only available if

the insurer agreed to participate in the state-level FAIR plan. Authority for the program terminated on November 30, 1983, under P.L. 98-181.

B. *Federal Agency Approval and Financial Responsibility Requirements*

In addition to the various federal insurance programs described above, a number of federal agencies impose what are, in a sense, mandatory insurance requirements. Most commonly, agencies that regulate a particular activity frequently require commercial entities that engage in that activity to demonstrate financial responsibility – a requirement that is typically satisfied by filing evidence of insurance. Agencies and regulations differ in what insurance (and with whom) may qualify, and some agencies even go so far as to examine and specifically approve insurers for a particular purpose. The existence of these programs demonstrates that the Congress clause can be used by Congress to create national insurance regulation. The following are examples of such agency requirements.

1. *Department of the Treasury Surety Bond Branch*

Under 31 C.F.R. Part 223, the Treasury Department must specifically approve insurers to write surety bonds running to the benefit of the United States (federal bonds). The Treasury Department's Surety Bond Branch examines substantial material from applicants to determine their financial strength and to establish an underwriting limit for each "Approved Surety." Additionally, only "Certified Reinsurer Companies" may reinsure federal bonds, and thus reinsurers must apply and submit to similar examination by Treasury for such certification.

In Treasury's examinations, credit for reinsurance showing on a surety's balance sheet will only be given if the reinsurer is on Treasury's list of "Admitted Reinsurers." As is the case with both sureties and certified reinsurer companies, in order to become an "admitted reinsurer" the Surety Bond Branch requires the filing of substantial material including financial statements.

Approval by the Surety Bond Branch is also required for other federal activities by virtue of cross-references to the Treasury list; for example, insurers must be on the list in order to provide ERISA fidelity bonds for plan fiduciaries²⁰⁹ and to provide customs bonds.²¹⁰

2. *Maritime Administration*

MARAD approves underwriters for marine hull insurance, in accordance with 46 C.F.R. Part 249, for U.S.-flag vessels in which the U.S. Government has a security interest (arising from a construction loan guarantee or an operating subsidy). Specific approval by MARAD is not needed if the insurer is (1) licensed in one or more states, (2) an Underwriter at Lloyd's or (3) a member company of the Institute of London Underwriters. Otherwise, MARAD must specifically approve the insurer, requiring such insurers to maintain a high rating (A or comparable) from an accepted international rating service, and submit substantial financial data to MARAD. On approval, such applicants are required to establish a U.S. trust fund (for the benefit of its U.S. policyholders) of at least \$1.5 million. Insurers then file annual financial statements, as well as annual affidavits reaffirming the continued access to U.S. insurers of the insurer's home market for hull insurance.

3. *DOT Aircraft Accident Liability*

The Office of the Secretary of Transportation, under 14 C.F.R. Part 205, requires that all U.S. and foreign air carriers engaging in air transportation in the U.S. carry certain levels of aircraft accident liability coverage. Air carriers must have a Certificate of Insurance on file with the Department of Transportation with coverage obtained from an insurer that is (1) licensed in any state, (2) listed on a current list of surplus lines insurers approved by any state or (3) licensed or approved by a foreign government for the purpose of writing aviation insurance. While the regulations do require that air carriers have certain minimum levels of coverage, no eligibility requirements are applied to their insurers other than that they fall under one of the three categories listed above.

4. *Bureau of Ocean Energy Management, Regulation and Enforcement*

In accordance with the Oil Pollution Act of 1990, and detailed in regulations under 30 C.F.R. Part 253, covered offshore facilities (such as drilling platforms) are required to demonstrate oil spill financial responsibility (“OSFR”) to the Bureau of Ocean Energy Management, Regulation and Enforcement (“BOEMRE”). Insurance may be used to satisfy all or part of the owner/operator’s required OSFR, with coverage limits dependent upon the type of facility/vessel. BOEMRE only requires that the insurer has “achieved a ‘Secure’ rating by A.M. Best’s Insurance Reports, Standard & Poor’s Insurance Rating Services, or other equivalent rating made by a rating service acceptable to [BOEMRE].” Policyholders are required to submit information about the insurer to BOEMRE, which will be part of the OSFR demonstration.

5. *U.S. Coast Guard*

In order to comply with the financial responsibility requirements of the Oil Pollution Act of 1990 and the Comprehensive Environmental Response, Compensation, and Liability Act, most vessel owners entering U.S. waters must demonstrate financial responsibility to cover any potential liabilities arising under those statutes. Under 33 C.F.R. Part 138, a vessel owner may establish evidence of financial responsibility is by filing an insurance guarantee form, executed by up to four insurers, with the Director of the Coast Guard’s National Pollution Funds Center (“NPFC”). The regulations define an insurer as “one or more insurance companies, associations of underwriters, shipowners’ protection and indemnity associations, or other persons, each of which must be acceptable to the Coast Guard.” The NPFC Director is given a broad amount of discretion as to how an insurer may be found “acceptable” to the Coast Guard.

6. *Federal Motor Carrier Safety Administration*

The Federal Motor Carrier Safety Administration (“FMCSA”) requires many for-hire motor carriers to maintain cargo insurance in prescribed amounts and file evidence of this insurance with the agency. 46 C.F.R. Parts 365 and 387. The requirement, which applies to interstate common carriers of property and freight forwarders, was significantly cut back by a rule change which went into effect on March 21, 2011, which left the requirement in place only for household goods carriers and freight forwarders.²¹¹

7. *Federal Maritime Commission*

The Federal Maritime Commission requires ocean transportation intermediaries to show evidence of financial responsibility under 46 C.F.R. Part 515, and a showing of passenger vessel financial responsibility under 46 C.F.R. Part 540. While the passenger vessel financial responsibility regulations do not specify the type of insurance that will be accepted, ocean transportation intermediaries using insurance for financial responsibility must place the insurer with an insurer that (1) has a “financial rating of Class V or higher under the Financial Size Categories of A.M. Best & Company, or equivalent from an acceptable international rating organization;” (2) is an Underwriter at Lloyd’s; or (3) is a surplus lines insurer listed on the NAIC’s IID list.

8. *Other Agencies*

Among the several other agencies that have similar insurance/financial responsibility requirements are:

- **Department of Labor:** Longshoremen’s and Harbor Workers’ Compensation Act. 33 U.S.C. §901 et seq., 20 C.F.R. Part 703. Program is also extended to civilian employees at U.S. military bases and defense contractors under the Defense Base Act, 42 U.S.C. §§1651-1655.
- **Department of Defense:** Military Surface Deployment and Distribution Command, requiring cargo insurance filings similar to FMCSA described above. Defense Transportation Regulation 4500.9-R, Part II.
- **Federal Aviation Administration:** Requires evidence of financial responsibility/insurance for licensees engaging in commercial space launch activities. 14 C.F.R. Part 440.

C. *Other Federal Statutes Respecting Insurance*

1. *Liability Risk Retention Act*

In response to a hardening market where liability insurance was difficult to find or afford, Congress enacted the Liability Risk Retention Act of 1986 (P.L. 99-563), which permits commercial and governmental entities to form “risk retention groups” to provide members of the group with liability insurance. The statute is limited to liability (*i.e.*, not property) insurance, and members of the group must all be engaged in a similar business or exposed to similar risks. The statute also permits the formation of “risk purchasing groups” whereby similar groups can exercise collective purchasing power without regard to state insurance agent licensing laws, or state “fictitious group” prohibitions.

Under federal law, risk retention groups must be licensed as an insurer in one state, but are largely exempted from most insurance regulation in any other state in which they operate. Accordingly, due to the federal preemption of contrary state law under the Act, risk retention groups essentially have a single regulator even if they operate in several different states.

2. *Gramm-Leach-Bliley Act*

The 1999 Congress enacted a large financial regulatory reform measure commonly known as the Gramm-Leach-Bliley Act, P.L. 106-102. Though dealing with the entire financial services sector, several provisions of the statute dealt directly with insurance, including preemption of state laws preventing the redomestication of mutual insurers, and federal oversight of financial holding companies which include insurance subsidiaries.

Most notably, the Act included the creation of a National Association of Registered Agents and Brokers (“NARAB”), which would have been a non-governmental nonprofit corporation with the authority to establish uniform licensing requirements for insurance producers and preempt contrary state law. The NARAB would have been supervised by the NAIC. Interestingly, the Act provided that NARAB would only be created if, after three years following the date of enactment, a majority of states had not enacted uniform producer licensing laws, or reciprocity laws. Ultimately, because a majority of states did act, NARAB was not created.

3. *Federal Securities Laws*

Annuity contracts issued by insurers are largely exempt from regulation by the Securities and Exchange Commission (“SEC”) under Section (3)(a)(8) of the Securities Act of 1933, provided the issuer is supervised by a state regulatory authority. Variable life insurance and annuities; however, are subject to SEC regulation. (A long standing dispute as to whether indexed life insurance and annuities were subject to SEC regulation was largely resolved by the Dodd-Frank Act, which provides that the SEC does not have jurisdiction over indexed products that meet certain conditions.) Life insurance company separate accounts used for variable life and annuity products are treated as investment companies subject to registration and other regulatory requirements under the 1940 Investment Companies Act. SEC jurisdiction over variable products has been upheld by the U.S. Supreme Court.²¹²

4. *Dodd-Frank Act*

In addition to the Dodd-Frank Act’s creation of the FIO and its streamlining of surplus lines and reinsurance regulation (see NRRA discussion in Appendix C), several other reforms in the Dodd-Frank Act could impact insurers and potentially, depending upon the insurer’s activities and structure, subject them to some level of federal supervision. Such areas include:

a. Systemic Risk

Insurers could potentially be determined by the Financial Stability Oversight Council (“FSOC”) to present systemic risk to the financial system and thus be supervised by the Federal Reserve. Such supervision would subject these insurers to certain prudential standards, if the FSOC determines that financial distress at the company would pose a threat to the U.S. financial system. A presidentially-appointed insurance expert serves on the FSOC to remedy the fact that none of the federal regulators who sit on the FSOC deal with insurance. Additionally, the FIO Director and an NAIC appointee have nonvoting seats on the FSOC. The FIO Director is specifically tasked with recommending to the FSOC that an insurer be considered for designation.

b. Orderly Liquidation

The legislation provides an “Orderly Liquidation Authority” mechanism whereby the FDIC would have enhanced powers to resolve distress at financial institutions. Insurance holding companies and any non-insurance subsidiaries of insurers may be subject to this authority. Insurance companies are generally exempt from the liquidation authority, but the FDIC would have “backup authority” to place an insurance company into orderly liquidation under state law if the state regulator has not done so within 60 days of a systemic risk determination.

c. Liquidation Fund Assessments

The bill creates an Orderly Liquidation Fund to help fund the cost of resolving a failing financial firm, which would be funded by assessments on large financial companies – including, potentially, insurers. The size of an entity appears to be the key determination as to the amount of any assessment, but other non-size risk factors are supposed to be taken into consideration. For insurers, contributions to state guaranty funds must be considered.

d. Thrift Supervision

The Dodd-Frank Act eliminated the Office of Thrift Supervision (“OTS”) and transferred its supervisory responsibilities to various other agencies. In particular, oversight of savings and loan holding companies (“SLHCs”) was transferred to the Federal Reserve Board (“FRB”) as of July 21, 2011, pursuant to section 312 of Dodd-Frank.

Insurers who are structured as SLHCs or who were otherwise supervised by the OTS prior to the enactment of Dodd-Frank therefore have a new federal agency supervising them. As such, rulemakings, reporting requirements and other transitional measures may impact insurers differently than previous federal supervision, and in some cases additional burdens may be imposed. In particular, such rulemakings by the FRB aimed at SLHCs may focus more upon banks and banking activities.

One such FRB proposal concerned financial reporting, and would have required SLHCs to submit the same reports that the FRB currently requires of bank holding companies. Insurers commenting on the proposal noted that many insurers, particularly those with a mutual, reciprocal or fraternal structure, file statutory accounting rather than GAAP financial statements. Such requirements could be overly burdensome and costly, and the FRB agreed to exempt temporarily certain SLHCs from the requirement.²¹³

Unlike systemic risk designations by the FSOC, the FIO does not have any concrete role in determining the impact of federal regulations on the insurance industry. In the case noted above, industry comment on the rulemaking was needed to provide such insight.

e. Proprietary Trading (“Volcker Rule”)

Section 619 of the Dodd-Frank Act (commonly known as the “Volcker Rule”) prohibits banking entities, including companies that control an insured depository institution, from engaging in proprietary trading or acquiring or retaining any equity, partnership or other ownership interest in or sponsoring a hedge fund or private equity fund. There is a presumption that proprietary trading conducted on the

general account of a State-regulated insurer is permissible if conducted accordance with the relevant insurance company investment laws – unless, however, “appropriate Federal banking agencies,” after consultation with the FSOC and relevant State insurance commissioners, jointly determine, that a particular State law is insufficient to protect the safety and soundness of a banking entity “or of the financial stability of the United States.” Moreover, insured depository institutions controlled by an insurer’s holding company are potentially subject to the Volcker Rule even without such determination.

f. Derivatives Regulation

The Dodd-Frank Act requires most standardized derivatives to be routed through clearinghouses and traded on exchanges. Two new classes of regulated entities are created – swap dealers and “major swap participants” – which would be required to register with the SEC and/or the CFTC and would be subject to margin, capital, record-keeping and business conduct requirements. The SEC and CFTC jointly published a proposed rule regarding the definitions of several key terms, including “Swap Dealer” and “Major Swap Participant.”²¹⁴ While there are no specific exclusions for insurers in the proposed definitions, the agencies have specifically requested comment on whether certain types of entities, including “State-regulated insurers,” should be excluded.

g. Consumer Financial Protection Bureau

One of the more high-profile provisions of the Dodd-Frank Act is that which creates the Consumer Financial Protection Bureau, a new federal-level entity within the Federal Reserve with authority to regulate the types of financial products offered to consumers. There is a specific carve-out for the “business of insurance” from the Bureau’s jurisdiction; however, the exemption does not apply to activities by insurers that do not fall within the definition of the “business of insurance.” The extent to which the Bureau may oversee certain insurers’ activities remains to be seen.

D. Selected Legislative Reform Initiatives

1. *Optional Federal Charter*

Modeled after many national insurance regulatory regimes, as well as the U.S.’s dual-charter banking system, the optional federal charter (“OFC”) proposal would (depending on its scope) allow certain, some or perhaps all insurers to elect to obtain a federal insurance charter that would permit them to operate in all U.S. jurisdictions without having to obtain a license in each jurisdiction or file rates and forms with state regulators.

OFC bills have been considered at several hearings in both chambers of Congress over the past several years. Additionally, an OFC regime for insurance was recommended in the Bush Administration’s Treasury Department’s Blueprint for a Modernized Regulatory Structure, albeit only as a medium term transition toward an FSA-style unified financial institutions chartering system, including insurers.

The most recent OFC bill, entitled the “National Insurance Consumer Protection Act,” was introduced in the 111th Congress by Rep. Ed Royce (R-CA). The bill would have created an Office of National Insurance (“ONI”) within the Department of Treasury and headed by a Commissioner of National Insurance. Though established within the Treasury Department, the ONI’s independence and authority would be comparable to that of the banking regulators within Treasury – the Office of the Comptroller of

the Currency and the Office of Thrift Supervision. The ONI would be financed through assessments, examination fees, other fees and penalties paid by insurers.

The ONI would have a Division of Insurance Fraud and a Division of Consumer Affairs, and the Commissioner could also register and supervise insurance self-regulatory organizations, which would have the authority to enforce compliance to federal insurance law among its members. The OFC bill provided for the chartering of “National Insurers” and “National Insurance Agencies.” National Insurers may be licensed to write life insurance, property-casualty insurance, or the reinsurance of life and property-casualty insurance – health insurance has typically not been a permitted line of business for national insurers under OFC bills. National Insurers would receive a federal license from the ONI and would be permitted to write business nationally. National Insurance Agencies would receive a federal producer license authorizing the agency to sell insurance nationally for any federally licensed or state licensed insurer. Finally, the bill would have established a National Insurance Guaranty Corporation that would be authorized to make assessments on national insurers in order to pay the claims of a national insurer that has been placed into receivership.

The OFC proposal should leave the state regulatory system intact, as states would retain their regulatory authority over state-chartered insurers, subject to the scope of the federal regulatory authority would set limits on state regulatory power. Furthermore, OFC proposals often preserve the rights of states to tax National Insurers in the same manner as they would tax state insurers, and National Insurers would still be required to contribute to state guaranty funds. National Insurers and National Insurance Agencies would also be subject to state escheat laws, laws pertaining to assigned risk plans, compulsory coverage requirements for workers’ compensation or motor vehicle insurance, and any other mandatory residual market mechanisms designed to make insurance available to those unable to obtain insurance in the voluntary market.

2. *NARAB II*

The original authorization to potentially establish the National Association of Registered Agents and Brokers (“NARAB”) was enacted as part of the Gramm-Leach-Bliley Act in 1999. Aimed at promoting uniformity in producer licensing, the original NARAB would have created a producer licensing passport system unless a majority of states enacted certain reciprocity measures within three years. Since a majority of states met the reciprocity requirements, creation of NARAB was forestalled. Certain parties assert, however, that in the intervening years the reciprocity called for in NARAB did not go far enough to eliminate inefficient and duplicative producer licensing requirements.

As a result of these cited remaining inefficiencies, new legislation has been proposed, popularly termed “NARAB II.” The proposed legislation would establish NARAB as a nonprofit corporation in the District of Columbia (not an agency of the federal government). The creation of NARAB would go into effect immediately; it would not be conditioned upon any state-level action or inaction. NARAB would offer voluntary membership for producers who maintain a license in their home state and who meet other NARAB-established eligibility criteria. NARAB members would be permitted to do business in any state provided the member has paid the requisite licensing fee in that state, and provided the business the producer conducts is in a line of insurance specified on the member’s home state license. The legislation prohibits states from imposing any additional licensing requirements upon non-resident producers that are NARAB members. The effect of this legislation would be to permit producers licensed in one state to

obtain – by virtue of NARAB membership – a “passport” to do business in any other states (in the same lines of business as permitted by the producer’s home state).

States would, however, retain the ability to apply their consumer protection and market conduct regulations to non-resident producers. The legislation also requires NARAB to establish an Office of Consumer Complaints to receive and investigate complaints by consumers and state regulators related to NARAB members.

In all, the NARAB II proposal would provide no federal regulatory authority, as NARAB would be an independent nonprofit corporation and not an entity of the federal government. Arguably, NARAB would be unnecessary if there were a federal regulator with authority over producer licensing. As proposed, NARAB II’s impact on the state regulatory system would be limited but significant: it would eliminate states’ authority to issue non-resident producer licenses. It would not, however, restrict the authority of states to regulate the market conduct of non-resident producers. The latest version of NARAB II was introduced on March 16, 2011 in the House of Representatives by Rep. Randy Neugebauer (R-TX).

3. *SMART Act*

Although it never made it past the “discussion draft” phase, a 2005 proposal circulated by then-Rep. Richard Baker (R-LA) to attempt to achieve some national uniformity in insurance regulation garnered substantial attention from the insurance industry and regulators. The proposal, entitled the State Modernization And Regulatory Transparency (“SMART”) Act was designed to first encourage, and then force the States to adopt uniform laws and policies and to ensure uniform application and interpretation of such rules. It sought to do this while avoiding the creation of a new federal bureaucracy even to enforce the requirements on the States, similar to the NARAB mechanism in the Gramm-Leach-Bliley Act. The SMART Act would have created a State National Insurance Partnership, a seven-member panel with both federal agency (Treasury, Federal Reserve and SEC) and State regulator representation, which reported directly to the President on matters within its responsibility, including both State progress/compliance with uniformity mandates as well providing the federal government for the first time with policy input on insurance aspects of tax and fiscal policy and international affairs. It had a mediation role and authority to seek judicial enforcement of its advisory opinions.

Though some suggested that the bill’s uniformity standards enshrined NAIC Model Acts, in most of the subject areas, the bill did not mandate adoption of NAIC Model Acts but gave the State legislatures the option to develop and enact an alternative standard on the same subject. So long as a certain number of States adopted such standard with three years (in most cases) that standard then would become the federal mandate to which all States would have to conform, either voluntarily or by federal preemption. NAIC Model Acts were, in most cases, merely default standards to which the States would have to conform if they fail collectively to develop a common alternative in the permitted time period.

The areas in which this mandate of uniformity applied included most sectors of the insurance industry; both P/C and life insurers, as well as intermediaries would have been profoundly affected by one or more of the uniformity titles.

For P/C insurers, the most noteworthy changes would be the move to Illinois-style competitive pricing with 2-3 years, preemption or streamlining of form approval (essentially file-and-use with max. 60 day objection period) and mandated deference to the domiciliary or primary market regulator for financial/solvency supervision of all insurers. For life insurers, the major change would be the title designed to streamline product approval with an interstate compact to eliminate the speed-to-market disadvantage which life insurance products now suffer vis-à-vis investment products of banking and securities firms.

Producer licensing would be moved from the reciprocity required by NARAB to true uniformity. Surplus lines business would also be given some simplification including multi-state tax allocation rules and one-stop surplus lines eligibility. U.S.-based reinsurers would get essentially deference to home-state supervision, and the Uniform Receivership Model Act would be mandated nationwide as would coordination of and deference to home-state on market conduct examination.

4. *Dingell Reports*

In the wake of collapses of Transit Casualty and Mission Insurance, two of the largest insurer insolvencies in the late 1980s, Rep. John Dingell (D-MI), who then chaired the House Energy & Commerce Committee, held a series of hearings and issued a scathing report – *Failed Promises: Insurance Company Insolvencies* (1990) – that were critical of state insurance regulation – particularly in the area of solvency regulation. Legislation was drafted to provide for federal chartering of commercial lines insurers and reinsurers, but no mark-up occurred. The House Banking Committee held their own hearings on the issue and at least two Senate committees held enquiries during the same time.

These Congressional actions, especially the high-profile efforts by John Dingell, spurred substantial action by state regulators, resulting most notably in the establishment of the NAIC's accreditation process for state insurance departments. With continued insolvencies; however, in the early 1990s, Chairman Dingell released a new report – *Wishful Thinking: A World View of Insurance Solvency Regulation* (1993) - continuing the criticisms of solvency regulation and advocating a federal role to ensure minimum solvency standards, enforcement and some form of control over non-U.S. insurers and reinsurers. A minority report concurred with some of these recommendations but objected to a federal insurance regulator.²¹⁵

E. *Lessons from Federal Intervention*

Some things only the national government is equipped to do. The War Damages Corporation in World War II and the post-9/11 TRIA program are important examples of federal intervention *in extremis* circumstances that helped to calm markets and provide the general economy security against an extreme form of perceived human threat. The large scale of both the threat and the response necessitated federal action. Both these programs responded to the catastrophic “single data point” problem for the industry. Along similar lines were the 1960s Riot Reinsurance and Crime Insurance programs, where there were plenty of data points but general perception of widespread urban social unrest potentially yielding extreme concentration of risk. All of these programs expired as the threats receded, except TRIA which is scheduled to expire in 2014.

More controversially, in the past half-century the NFIP and Federal Crop Insurance programs are examples of federal programs enacted to respond to market imperfections, but which arguably for political

reasons have grown ever larger and have assumed onto the taxpayers more of the risk of loss from natural hazards and, in some cases, persistent inadequate pricing, all resulting in displacement of private insurance markets. Other federal programs such as the aviation and maritime war risk programs were originally fashioned as stand-by mechanisms to be activated only when the private international war risk market actually or effectively ceased writing in the face of actual or imminent hostilities. Post-9/11 the aviation program in particular experienced mission-creep, being transformed in some respects into continuous alternative to a functioning, if occasionally expensive, private war-risk market.

Still other programs, such as the Price-Anderson nuclear liability insurance program demonstrate a successful long-term use of federal authority to facilitate formation of private insurance and reinsurance for a massive complex exposure by channeling public liabilities and mandating purchase of commercially available financial responsibility products. Several other programs described above follow this pattern.

In many of these programs which admit participation of private insurers, the responsible federal agency is charged with determining insurer qualification. Most of these rely derivatively on a combination of State licenses, surplus lines eligibility and financial strength rating from nationally recognized agencies. There are some examples, notably the Treasury Department's Surety Bond Branch, where the federal agency performs its own review and adjustment of insurers' financial statements to independently determine financial strength and underwriting capacity. These agencies have thus developed substantial expertise in industry-specific financial review and solvency evaluation, and familiarity with large segments of the industry. Other, disparate portions of the federal government – e.g., offices within Treasury, Commerce and the Office of the U.S. Trade Representative, have developed deep knowledge of the insurance industry's international challenges and development objectives, but before FIO there has been no overall consolidation of this expertise or responsibility for understanding and analyzing the industry as a whole.

VI. Beyond Borders – The Relevance of International Developments in Insurance Regulation to Efforts to Improve and Modernize the U.S. System of Insurance Regulation

This Part describes existing and developing coordination in insurance supervisory matters among regulators throughout the world. Regardless of one's views about the desirability of regulatory systems that are emerging outside the United States, including Solvency II, external realities make it necessary to consider international regulatory activities when evaluating options for the improvement and modernization of the U.S. system of insurance regulation. Those realities are the commitment of the G20 countries to coordinate on matters affecting financial stability, evolving international standards as to what constitutes adequate supervision, greater efforts at coordination among regulators in different countries and a greater presence within the United States of insurers that are part of internationally active insurance groups. Moreover, the recent large catastrophic events should remind us all that extreme events are most efficiently financed on a global basis. For this and other reasons policymakers should promote the free flow of capital and risk management on an integrated global basis and encourage capital accumulation for severe risk events in the private sector (rather than relying on the public purse). This should apply not only to insurance supervisory statutes and regulation but to other sectors, such as disaster response law, tax and monetary policy, infrastructure policy, etc., although in doing so, regulators must keep in mind that insurance is not banking – and merits a differentiated supervisory approach.²¹⁶

A substantial portion of all capital in the U.S. insurance market is provided by companies with ultimate domiciles outside the U.S. The preponderance of unaffiliated reinsurance capacity supporting the U.S. industry, especially catastrophic risk exposure, is provided by non-U.S. groups. This is true for both the life and non-life sectors. By the same token, many, perhaps most, of the major U.S.-based insurers and reinsurers have local operations in or assume business from Europe, Asia and other major markets around the globe. It is no longer prudent, or even possible, for insurance regulation to be conducted in the United States, whether state-based or nationally, without taking into account the standards and systems of prudential regulations that exist and, more importantly, that are emerging in the international context.

At a minimum, U.S. supervisors and negotiators need to be engaged internationally to defend their stake in any system which will impact capacity and soundness of players and products reaching the American market. Ideally, the international engagement also will lead to harmonization and efficiency of supervision – including identification of global currents – and both U.S. and international regulators will identify best practices and develop more efficient methods from the cross-pollination. To give one example, the determination of third-country regulatory “equivalence” under Europe's Solvency II has begun for certain other non-European Union (“EU”) jurisdictions who will be ahead of a U.S. system that, in some cases, has not even provided a clear voice for engaging European counterparts.

This section is not to be an exhaustive survey of international developments, but rather seeks to identify those most relevant to improvement and modernization in the U.S. system.

A. *Global Supervision*

1. *The International Association of Insurance Supervisors*

Established in 1994, the International Association of Insurance Supervisors (“IAIS”) represents insurance regulators and supervisors of some 190 jurisdictions. Originally established simply as a forum in which regulators from member countries could meet to discuss core principles, the IAIS has emerged as an increasingly powerful voice in insurer regulation and now, for example, is part of the Joint Forum which was established in 1996 under the aegis of the Basel Committee on Banking Supervision (“BCBS”), the International Organization of Securities Commissions and the IAIS to deal with issues common to the banking, securities and insurance sectors, including the regulation of financial conglomerates.

U.S. state regulators are currently engaged in IAIS matters. The NAIC is an active member of the IAIS, attending and giving presentations at IAIS conferences and meetings, and drafting and commenting on papers that deal with international insurance supervisory issues.²¹⁷ The NAIC is helping to revise the Insurance Core Principles (“ICPs”), which are due to be finalized by the IAIS in October 2011. The ICPs are utilized within the Financial Sector Assessment Program (“FSAP”) by the World Bank and the International Monetary Fund. The NAIC conducted a self-assessment using these ICPs in August 2009 as well as participated in the FSAP process which reviewed the United States and was completed in July 2010.²¹⁸

The IAIS has initiated and is pursuing a number of initiatives aiming at: (i) promoting effective and globally consistent supervision of the insurance industry in order to develop and maintain fair, safe and stable insurance markets for the benefit and protection of policyholders and (ii) contributing to global financial stability. It is not within the scope of this paper to provide an exhaustive list of the numerous IAIS initiative relevant to the supervision of international groups, which include the following:

- a. The principles on Group-wide Supervision (2008)²¹⁹;
- b. The Guidance paper on the use of supervisory colleges in group-wide supervision, the role and responsibilities of a group-wide supervisor (2009)²²⁰;
- c. The Guidance paper on the role and responsibilities of a group-wide supervisor (2008)²²¹;
- d. The Guidance paper on the treatment of non-regulated entities in group-wide supervision (2010)²²².

2. *ComFrame*

One initiative which is considered as having a potentially significant impact on the supervision of insurance at international level is the “Common Framework for the Supervision of internationally active insurers” (referred to as “ComFrame”²²³). ComFrame was initiated in 2010 and aims at creating an integrated package that will provide supervisors with the means to assess and compare internationally active insurance groups around the world through better aligned and more consistent supervision undertaken by home and host supervisors on a multilateral basis. Substantively, ComFrame will: (a) set out parameters for assessing the group structure and the group business from a risk management

perspective as well as quantitative and qualitative requirements that are specific and focused but not rules-based; b) cover the area of necessary cooperation among supervisors.

3. *Financial Stability Board*

A number of initiatives aim at identifying and potentially addressing the systemic risk of insurance and reinsurance, based in part on the declarations of the G20 on financial stability which led to the establishment of the Financial Stability Board (“FSB”). FSB is in the process of developing a list of systemically important financial institutions (“SIFIs”). The conclusions of the 2010 IAIS 17th annual conference panel sessions²²⁴ indicate that higher capital requirements and stronger resolution frameworks will be required for all SIFIs. In addition, according to these conclusions, supervision of SIFIs needs to be more intense and effective. In addition, it is argued that while core insurance activities do not pose systemic risk, non-regulated entities and conglomerates could pose systemic risk and the potential for regulatory arbitrage needs to be monitored. Recent developments on the structure of supervisory cooperation in the EU signal a significant evolution towards convergence of internationally active insurance groups.

The U.S. participates in the FSB through the memberships of the Board of Governors of the Federal Reserve, the SEC and the Treasury.²²⁵ According to the FSB Charter, “the number of seats in the Plenary assigned to Member jurisdictions reflects the size of the national economy, financial market activity and national financial stability arrangements of the corresponding member jurisdiction.”²²⁶ Accordingly, the G7 (France, Germany, Italy, Japan, the United Kingdom, the United States and Canada) and BRIC countries (Brazil, Russia, India and China) were each given three seats, while others received two or one.²²⁷ International financial institutions and international standard setting, regulatory and supervisory bodies are also eligible to become members.²²⁸ U.S. officials advocated strongly for the creation of the FSB. At the G20 Pittsburg summit, Treasury Secretary Timothy Geithner described the importance of U.S. participation in the international creation of and accountability to a level playing field.²²⁹

B. *Europe*

1. *The current “Solvency I” regime*

The current EU framework for the prudential supervision of insurers and reinsurers is based on a series of EU directives concerning respectively life assurance, non-life insurance and reinsurance (the “Directives”). This framework is often referred to as “Solvency I”, which distinguishes it from Solvency II which will enter into force on January 1st, 2013. It is not within the scope of this study to describe in detail the features of Solvency I, but rather to focus on the aspects which are relevant in the context of this paper, *i.e.*:

- a. **A Minimum Harmonization Framework** – Solvency I is based on the principle of minimum harmonization. This means that the directives set minimum criteria (*e.g.*, level of the required solvency margin) but Member States have the ability to impose stricter requirements. The result is that while EU Member States share a set of minimum requirements, the actual regulatory framework and supervisory practice varies greatly from one to another.

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- b. **Single Passport Mechanism** – Single license or “passport” delivered by the “home” Member State, allowing (re)insurers to do business across all other States which are part of the European Economic Area; the (re)insurer is therefore only subject to the prudential supervision of its home Member States and does not need to obtain a separate license in each Member State in which it offers its products.
 - c. **Minimum capital requirements based on solo requirements** – While the European Union has put in place mechanisms for the supervision of insurance groups, the regulatory requirements and prudential supervision are primarily conducted at subsidiary (or “solo”) level. As such, each subsidiary of a group is required to satisfy capital requirements in the Member State in which it is established.
2. *Solvency II*

The Solvency II directive is expected to come into force on 1 January 2013 and apply across the EU. It introduces a new risk-based system of regulation whereby the risk profile of an insurer or reinsurer (or group thereof) will drive its capital requirements. An insurer will be required to control its risk and maintain strict standards of governance, but it is hoped that it will be incentivized to do so given the lower capital requirements that will result from this. These requirements will be largely self-assessed but will be subject to supervisory review and the possibility of a “capital add-on”. Solvency II is largely “maximum harmonizing” meaning that an EU member may not impose greater (or lesser) requirements, hence creating a more even playing field across the EU. In the sections that follow, we briefly describe the legislative and supervisory structures that will accompany Solvency II. We also briefly set out some of the key substantive aspects of Solvency II, with particular attention to the aspects of greatest impact for non-EU insurers (whether doing business in the EU or not):

- a. **Solo** – Under Solvency II, each insurer will continue to be supervised on an individual level by its national supervisor (subject however to the powers of the group supervisor and college of supervisors - see below).
- b. **Group** – Solvency II provides also for a supervisor in relation to a group. As a general rule, the group supervisor must consult with the college of supervisors before taking any decision in relation to the group, failing agreement on which, it may refer the issue to EIOPA for mediation. However, in some instances, the decision of the group supervisor will prevail, for instance in decisions relating to the group internal model, group solvency and the co-ordination arrangements of the college of supervisors itself. In a national group, the identity of the group supervisor will be clear. In a group spanning more than one EU member state and with a holding company and an insurer in the same jurisdiction the group supervisor will be of that jurisdiction. Otherwise, the group supervisor will generally be that of the insurer in the group with the largest balance sheet.
- c. **College of Supervisors** – Solvency II provides for a college of supervisors in relation to a group. The task of the college is to ensure that co-operation,

exchange of information and consultation processes among the members are effectively applied with a view to promoting the convergence of their respective decisions and activities. A college of supervisors will comprise the group supervisor and the supervisors for each individual insurer in the group. To stay abreast, U.S. regulators are being encouraged to hold, or join, supervisory colleges for internationally active insurer groups domiciled in their states. Such colleges, transcending Europe, will be important for insurer groups, if any, determined to be “globally significant financial institutions.”

- d. **Solvency Margin** – Solvency II allows insurers to calculate their solvency requirements using either (i) a standard model or (ii) a full/ partial internal model. The formula for the standard model is set out in the Level 1 directive. It prescribes the treatment that a firm must apply and as such will typically be suitable for relatively small/ unsophisticated firms. An internal model is a bespoke instrument, designed by the firm itself, but subject to regulatory approval. It should reflect the material risks to which the firm is exposed. As such an internal model will typically be suitable for relatively large/ sophisticated firms only.
- e. **Capital/Own Funds** – Under Solvency II, a company’s capital is eligible if it falls into one of two categories: Basic own funds. These include share capital and certain forms of long-term and subordinated debt. Ancillary own funds. These are other items that can be called up to absorb losses. They require regulatory approval and may include the following (i) unpaid share capital or initial own funds that have not been called up (ii) letters of credit and guarantees and (iii) any other legally binding commitments received. Capital/own fund items must be classified into one of three “Tiers”, depending upon the loss absorbency of the item in question. Accordingly, for example, Tier 1 own funds must constitute at least 50% of the solvency capital requirement and Tier 3 eligible own funds may not exceed 15% of the solvency capital requirement.
- f. **Equivalence** – Solvency II does not limit itself to the EU and EU insurers. It also seeks to engage with other regulatory regimes. A key plank to this approach is found in the concept of equivalence. Equivalence assessments have begun for Bermuda, Switzerland, and Japan (reinsurance only for Japan). Because of the EU’s uncertainty as to application to the U.S. state-based system, determination has not begun for the “United States,” but some transitional rules are being discussed which would defer any penalty for non-equivalence for a time pending agreement on a way forward. This question of equivalence issue arises in three contexts:
 - i. The treatment of reinsurance with a reinsurer in a non-EU jurisdiction.
 - ii. The calculation of group solvency where a stake is held by an EU insurer in a non-EU insurer.

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- iii. Group supervision where the holding company is located outside the EU.

The first round of equivalence assessments is currently underway for Switzerland, Bermuda and Japan (reinsurance only). The Committee of European Insurance and Occupational Pensions Supervisors (“CEIOPS”) originally noted certain difficulties in rendering an assessment of equivalence for the U.S., namely, the lack of a single, central regulator; the absence of a group supervisory framework; and professional secrecy issues involved in the exchange of information with the NAIC, as the NAIC does not act as a “supervisory authority.”²³⁰ After a response by the NAIC and the passing of the Dodd-Frank Act, CEIOPS made its final recommendation that despite the noted difficulties, it stood ready to undertake an assessment if asked.²³¹ In its final decision, however, the European Commission indicated only that the U.S. “would be a primary candidate for which a transitional regime would be relevant.”²³²

g. **Branches** – Solvency II does not amend the passporting system that was introduced by Solvency I (see above). Hence, an EU insurer may “passport” to other EU jurisdictions by establishing branches there. This approach will continue to be an important structural option both for EU and non-EU insurance groups. The increased requirements that are expected to result from Solvency II are likely to increase the advantages of this approach. There are a number of benefits of adopting a branch structure, including as follows:

- i. reduced regulatory burden
- ii. capital efficiency
- iii. reduced operating costs

VII. Shortcomings of the State-Based System and Federalism

In this Part, we return to a broad discussion of inherent flaws in the current state-based system, working from the basic premise that to the extent there continues to be differences in regulation among states, these differences need to be justified by sound reasons. From this vantage point, we discuss the fundamental tensions in insurance regulation between uniformity and experimentation, on the one hand, and administrability and redundancy, on the other, and how each principle is advanced or thwarted, as the case may be, under a state-based or Federal regulatory framework.

In short, we conclude that the current system subjects insurers to redundant filing and approval requirements. This redundancy creates significant barriers to entry into new markets and makes it difficult to launch new and innovative products. States apply different prudential standards. Some state insurance regulatory standards not only vary widely from state to state but they are sometimes even conflicting. These differences hurt the consumer by adding costs and unnecessary complexity to the insurance products they purchase. These flaws create inefficiencies and raise important questions about fairness – efficiency and fairness being the two primary objectives of regulation.

We then discuss how there are costs and benefits to any structural reform. A purely federal approach to insurance regulation would increase uniformity, reduce the room for regulatory experimentation, eliminate regulatory competition within the U.S., and, most likely, reduce redundancy. A “passport” approach, in which an insurance company is regulated largely or exclusively by a single state, regardless where it sells its products, would, over time, increase uniformity and reduce redundancy. An optional federal charter for insurance companies, paired with the existing fifty state approach, would increase uniformity for those companies that selected the federal charter and, as with the passport approach, would reduce redundancy for those aspects of regulation that the federal charter would pre-empt.

A. *Mechanics*

Our federal system of government confers on the U.S. Congress the power to regulate matters affecting interstate commerce. Most insurance in the U.S. is provided by insurers that operate in multiple states and many that operate globally, but Congress has left primary responsibility for regulation of the business of insurance to the various states, even though it has used its power to regulate other major financial services that have direct contact with consumers, such as banking and securities. The federal government has involved itself in insurance business only on an episodic basis to address narrow problems (e.g., flood, crop and terrorism), but regulates other areas of commerce that have an incidental impact on insurers that may be significant to the affected insurers (e.g., ERISA, bank and savings and loan holding companies, SIFIs). In addition, federal tax policy has a huge impact on insurers: life insurers must design products to qualify as insurance for tax purposes; both life and property-casualty insurers are affected by the tax code’s treatment of reserves. Federal regulation of securities also has a significant impact on variable life insurance and annuities and the broker-dealers who sell them.

The result is that insurers that operate nationwide are subject to regulation by all fifty states, as well as a hodge podge of federal agencies under different regulatory regimes. In addition, the market conduct practices of insurers remain subject to the scrutiny of state attorneys' general, who engage in *de facto* regulation through enforcement actions brought under state unfair trade practices laws.

B. Obvious Shortcomings of Current System

The obvious shortcomings of this approach is that insurers are subjected to redundant filing and approval requirements that create significant barriers to entry into new markets and make it difficult to launch new and innovative products. Inconsistent rules and interpretations prevent companies from operating in a uniform way across the nation. New York consumers cannot buy life insurance and annuity products available to other consumers because the New York Insurance Department will not approve them. An Arkansas domestic insurance company may only invest up to 5% of its admitted assets in foreign securities (see Ark. Code Ann. § 23-63-824), whereas a Nebraska domestic insurance company may experience higher yields on its investment portfolio because it can invest in foreign securities up to 20% of its admitted assets (see Neb. Rev. Stat. § 44-5137). Insurers and agents can rebate a portion of their insurance premiums to California consumers, while rebating in other states is prohibited.

Some state insurance regulatory standards not only vary widely from state to state but they are sometimes even conflicting. There are numerous examples of conflicting state mandates/requirements which permeate all aspects of insurer operations. Review of a few areas of these conflicts is illustrative, but far from comprehensive. States vary greatly in the amount of prior notice required to non-renew or amend policy provisions ranging from 30 days to 90 days. In New York, although the notice of nonrenewal of a homeowners policy must be given between 45 and 60 days, a policy that has been in force for more than 60 days cannot be non-renewed for 3 years, except under very narrow circumstances. Many states also have conflicting requirements for the reasons a policy can be non-renewed. In addition, states have widely divergent rules regarding the ability to specify the use of non-original equipment (non-OEM) in the repair of automobiles following an accident. The amount of time within which a response must be made to a claim varies greatly as well—requirements that make properly prioritizing the most serious claims in multistate catastrophes very difficult.

These differences hurt the consumer by adding costs to the insurance products they purchase and make it unnecessarily difficult to understand insurance. Consumers can be frustrated by the myriad differences between states, as a mobile population relocates. Many state regulations are not substantively different, but create procedural variations that simply add cost and complexity, with no identifiable added benefit to consumers. Insurance prices and products typically have to reflect these differences from one state to the next even though the underlying risk may be essentially the same. Technology systems have to accommodate differences, mailing times may vary, mandatory font type sizes may vary, all making it more expensive and complicated to serve customers than is necessary or appropriate.

These shortcomings create inefficiencies and raise important questions about fairness. The question that policymakers have to answer is whether the benefits of maintaining the status quo outweigh these shortcomings – efficiency and fairness being the two primary objectives of regulation.

C. *Issues to Consider When Evaluating Alternative Regulatory Structures*

The shortcomings of the state-based system raise a set of structural issues that should be considered when evaluating ways to modernize and improve the current system of regulation in the U.S. To the extent there continue to be differences among the states, the regulators need to provide sound justification for the differences. The NAIC efforts to increase uniformity implicitly acknowledge that many of the differences today are without adequate justification. Moreover, to the extent the states have developed or are moving towards uniformity, the question becomes one of justifying the continuation of having 51 separate state sovereigns enforce the same sets of laws and regulation.

In this context, we consider four structural issues: uniformity, redundancy, regulatory competition and regionalism.

Uniformity refers to the degree to which insurance organizations operating within the United States are subject to the same standards within each state. A fifty state system will tend to reduce uniformity, compared to a national system, though there are ways to increase uniformity within the state-based system, as will be addressed in the section on potential reforms. The benefits of uniformity include greater predictability for companies that expand into new regions, reduced regulatory compliance costs, and, to the extent that there are scale economies in insurance products, reduction in other costs attributable to variations in regulation across state boundaries. There are also costs to increasing uniformity. Variation allows for experimentation and reduces the likelihood of a systematic failure attributable to a particular approach to regulation. The experience of the NAIC's handling of the capital and surplus relief sought by life companies during 2002 (described in Appendix B) illustrates one case where segments of the life industry benefited from variation.

Redundancy refers to the degree to which there are multiple oversight mechanisms. A fifty state system will tend to increase redundancy, though there are ways to reduce redundancy within a state-based system (for example, through the passport approach). The theoretical benefits of redundancy that status quo proponents cite include the idea of there being a community of regulators able to work in a collaborative rather than hierarchical manner, potentially creating a robust system of accountability that is less subject to the consequences of incompetence or capture of any individual department at any particular time, and a potential reduction in the likelihood that a failing or non-compliant company will evade detection. The costs of redundancy include the obvious – duplication, delay, red tape – as well as less obvious risks. Redundancy also can lead to a free rider problem, in which one or more states decide not to invest in high quality insurance regulation, and it may also make it easier for fraudulent actors to evade regulation.²³³

Regulatory competition refers to competition among jurisdictions for the “business” of regulation.²³⁴ Whether regulatory competition increases the quality of regulation depends on the nature of the regulated industry. In situations in which firms have an incentive to seek out high quality regulation, competition will tend to increase the quality of regulation. For example, many corporate law scholars explain the high quality of Delaware corporate law and associated legal institutions as a result of a “race to the top” in corporate law.²³⁵ In situations in which firms have an incentive to seek out the least costly regulation, without regard to quality, competition will degrade the quality of regulation, in a “race to the bottom.” Many banking law scholars conclude that this is the situation with regard to consumer protection in the credit card market.²³⁶

The impact of regulatory competition on the quality of regulation depends, at least in part, on whether the beneficiaries of the regulation take the quality of regulation into account when choosing what products to buy or assets to invest in. Corporate law arguably benefits from a “race to the top” because the efficiency of the securities markets means that firms chartered in high quality corporate law jurisdictions are able to sell their securities at a premium.²³⁷ As explained in Part I of this report, much of consumer insurance regulation is predicated on the conclusion that insurance consumers are not able to make these kinds of judgments.

Regionalism refers to the degree to which states or groups of states pursue policies that benefit residents in those states or regions at the expense of residents in other states or regions. Regionalism is hard-wired into the U.S. system of government. State-based insurance regulation arguably encourages regionalism, but so, too, do geographic-based U.S. Congressional districts and the two Senator per state composition of the U.S. Senate. Arguably, regionalism is part of the intended checks and balances nature of U.S. government. But regionalism can make it more difficult to address national problems. For example, in the insurance context regionalism has impeded the development of a sound approach to insurance for natural catastrophes. Further, regionalism as a reason for local regulation does not account for the fact that significant economic activity and human movement is across regions. Accidents frequently involve out of state insurers, cross-state citizens and settlements through out of state offices.

As this discussion illustrates, there are costs and benefits to any structural reform. Promoting uniformity is widely regarded as desirable, but uniformity reduces the room for experimentation and the benefits of diversification in regulatory approaches. Similarly, eliminating redundancy saves costs, at least in the short term, but it places greater responsibility in the hands of the sole or primary regulator, and it eliminates the benefits of the more cooperative, collaborative approach that is possible when there are multiple regulators with substantial authority and autonomy in their jurisdictions.

A purely federal approach to insurance regulation would increase uniformity, reduce the room for regulatory experimentation, eliminate regulatory competition within the U.S., and, most likely, reduce redundancy. Although some would argue that a federal approach would reduce regulatory experimentation, there is no reason a federal regulator cannot experiment with different approaches on a pilot basis. In theory federal regulation could build in redundancies and back-up procedures, but unless there were multiple independent regulatory agencies with jurisdiction over insurance companies, there would be a natural tendency to rationalize procedures within the federal insurance regulator that would reduce redundancy over time.

A “passport” approach, in which an insurance company is regulated largely or exclusively by a single state, regardless where it sells its products, would, over time, increase uniformity, though potentially following a period of experimentation (as states compete to serve as insurance regulators of choice). For those aspects of regulation that are subject to the passport, there would be little or no redundancy, reducing compliance and other costs, with the corresponding increased risk of regulatory failure. A risk to be addressed is a race to the bottom in the “market” for consumer insurance regulation.²³⁸

An optional federal charter for insurance companies, paired with the existing fifty state approach, would increase uniformity for those companies that selected the federal charter and, as with the passport approach, would reduce redundancy for those aspects of regulation that the federal charter would pre-

empt. The optional federal charter grants only one regulator – the federal insurance regulator – the power to issue a national passport. As a result, there is less regulatory competition and, hence, less risk of race to the bottom.²³⁹

VIII. Summary of Recommendations

Our recommendations as to initiatives the FSR might consider advocating as it continues to pursue the goal of comprehensive insurance regulatory reform and modernization are set out in full in Part I.

To recapitulate:

Our recommendations are divided into near-term recommendations and mid- to long-term recommendations that include a discussion of direct federal regulation of insurance. For mid- to long-term recommendations, we list a range of options for dealing with the features of the current regulatory system that result in regulation being fragmented, inconsistent and inefficient. The first option is to retain existing state-based framework and leave it to the states to foster more uniform national standards (but while doing a much better job at achieving uniformity). The second option is to establish federally enforced state passports whereby a state-licensed insurer meeting specified national standards would be automatically authorized to transact insurance through the U.S. The third option is to replace the existing state-based system with comprehensive federal regulation of insurance. We have set out a framework for evaluating each of the various options based on considerations of uniformity, redundancy, regulatory competition and regionalism.

For immediate to near-term recommendations, we propose that the FIO be charged with identifying overlaps in the ways that the federal government already engages in insurance supervision activity and that it use this information to coordinate and consolidate federal involvement in insurance. We further recommend that the FIO be empowered and charged with the duty to monitor the activities of other federal agencies that affect insurers and to submit comments on proposed rules to assure that insurers will not be subjected to regulation that is unnecessary in light of the nature of the insurance business or because other existing regulatory controls provide adequate safeguards. Rulemaking activities under the Dodd-Frank Act that have the potential to unnecessarily burden insurers make this a more pressing need. Finally, we recommend specific improvements to existing state regulation:

- Improve coordination of examinations among states and decrease reliance on contract examiners
- Repeal “seasoning” requirements and state-specific license application requirements
- Exempt competitive insurance markets from rate regulation using objective criteria for competitiveness
- Expand the Interstate Compact product review process to cover all states and other lines of insurance; exempt group and large commercial business from product approval procedures
- Remove barriers to market exit for insurers that wish to discontinue writing insurance in a line of insurance or market

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- Harmonize the benefits guaranteed by state guaranty funds; remove impediments that prevent insurers from informing consumers about guaranteed benefits in a transparent way
 - Consider global best supervisory standards and the impact that U.S. rules, standards and policies have on insurers that are part of internationally active insurance groups or are themselves internationally active
 - Enhance the independence of state insurance departments by appointing insurance commissioners for a fixed term (in lieu of direct election or serving at the pleasure of the governor) and provide insurance department staff with adequate resources.

¹ Dodd–Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376 (2010) (“Dodd-Frank Act”).

² See *id.* at Title V, Subtitle B.

³ We began our study with a literature review that identified economic, public policy and administrative law literature on the need for and objectives of insurance regulation reflecting varying perspectives and policy agendas. We then conducted legal research of applicable laws, regulations, law review articles, trade press and relevant case law to identify how insurance regulation has evolved into the current structure. Finally, we conducted informal surveys of practitioners for their views of gaps and failures of existing regulation. We canvassed our Dewey & LeBoeuf law partners who work exclusively in insurance, management at various insurers and FSR members.

⁴ Ernst & Young, *Solvency II equivalence, Implications for the US insurance market* (October 2010).

⁵ There are other objectives of some parts of the current regulatory system that are less widely accepted as legitimate, but which must be taken into account in any reasonably complete discussion of insurance regulation. These objectives include the protection of existing insurance organizations from competition, the promotion of employment or economic development within a particular city, state or region, and the channeling of capital to preferred purposes through the regulation of insurance investments. These objectives conflict with the broader goals of efficiency and fairness, at least as those goals would be pursued on a national basis.

⁶ Tom Baker, *On the Genealogy of Moral Hazard*, 75 Tex. L. Rev. 237, 291 (1996).

⁷ Tom Baker, *Risk, Insurance, and (the Social Construction of) Responsibility*, U. of Conn. Sch. of L. Articles & Working Papers at 1 (Jan. 1, 2002), available at http://lsr.nellco.org/cgi/viewcontent.cgi?article=1007&context=uconn_wps&sei-redir=1#search=%22Tom%20Baker%20Risk%2C%20Insurance%2C%20Social%20COnstruction%20Responsibility%22.

⁸ Kenneth Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 Va. L. Rev. 403 (1985).

⁹ See Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. Health Care L. & Pol’y 287, 293 (1993).

¹⁰ *Id.*; see also Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification, Risk and Morality* (Richard Ericson & Aaron Doyle, eds. U. Toronto Press 2003), 9 Conn. Ins. L.J. 371 (2003) (describing actuarial fairness as “a watered down form of liberalism that privileges individual interests over the common good”).

¹¹ See, Viviana Zelizer, *Morals and Markets: The Development of Life Insurance in the United States* (New York, Columbia University Press); Baker, *On the Genealogy of Moral Hazard*.

¹² Zelizer, *Morals and Markets*; Ibsen, *Henrick Ghosts* (1881).

¹³ See, e.g., B. Glenn Blackmon & Richard Zeckhauser *Mispriced Equity: Regulated Rates for Auto Insurance in Massachusetts*, Am. Econ. Rev. 65, Vol. 81 No. 2 (May (1991); see also Baker, *supra* note 10 at 396 (quoting the objections of the president of the American Academy of Actuaries to restrictions on risk classification).

¹⁴ There is a technical counter-argument in the auto insurance context in which rate suppression reduces the number of uninsured motorists and, thus, captures some of the positive externalities of auto insurance. See Dwight M. Jaffee & Thomas Russell, *The Causes and Consequences of Rate Regulation in the Auto Insurance Industry*, *The Economics of Property-Casualty Insurance* (David Bradford, ed., U.

Chicago Press, 1998) (addressing the California auto insurance market). *Cf.*, B. Glenn Blackmon & Richard Zeckhauser, *supra* note 13 (finding a different result in Massachusetts).

¹⁵ Baird Webel & Carolyn Cobb, Cong. Research Serv ("CRS")., RL 31982, Insurance Regulation: History, Background, and Recent Congressional Oversight 5 (February 11, 2005), *available at* http://assets.opencrs.com/rpts/RL31982_20050211.pdf.

¹⁶ National Association of Insurance Commissioners ("NAIC"), State Insurance Regulation: History, Purpose and Structure, *available at* http://www.naic.org/documents/consumer_state_reg_brief.pdf.

¹⁷ Webel & Cobb CRS at 7 (2005), *supra* note 15.

¹⁸ Jerry W. Markham, *A Financial History of the United States*, vol. 3, pp. 18-20 (Dec. 2001).

¹⁹ National Conference of Insurance Legislators ("NCOIL"), *The Insurance and Legislative Fact Book & Almanac* (2010). Effective October 3, 2011, the New York Insurance and Banking Departments will be combined into a Unitary Department of Financial Services. For ease of reference, in this paper we will include the District of Columbia in our discussion of state regulation and treat it as equivalent to a state.

²⁰ *Id.*

²¹ *Paul v. Virginia*, 75 U.S. 168, 169 (1869). See also discussion in Susan Randall, Insurance Regulation in the United States: *Regulatory Federalism and the National Association of Insurance Commissioners*, 26 Fla. St. U.L. Rev. 625, 630-32 (1999).

²² *United States v. South-Eastern Underwriters Assoc.*, 322 U.S. 533 (1944).

²³ 15 U.S.C. §§ 1011-1015.

²⁴ *Id.* at § 1012.

²⁵ International Monetary Fund, "Financial Sector Assessment Program United States of America — IAIS Insurance Core Principles Detailed Assessment of Observance (May 2010) ("2010 FSAP"), p. 10.

²⁶ *Id.*

²⁷ *Id.*

²⁸ <http://ifawebnews.com/2010/01/13/group-sues-new-york-over-deceitful-insurance-fund-diversions/>

²⁹ Webel & Cobb, CRS at 4, *supra* note 15; see also National Association of Insurance Commissioners ("NAIC"), *The NAIC's History and Background*, *available at* http://www.naic.org/index_about.htm ("History of the NAIC").

³⁰ *Paul v. Virginia*, 75 U.S. 168.

³¹ Webel & Cobb, CRS at 7 (2005), *supra* note 15.

³² See Webel & Cobb, CRS at 5 (2005), *supra* note 15.

³³ See *id.*

³⁴ NAIC, 2011 NAIC Proposed Budget at 4, *available at* http://www.naic.org/documents/about_budget_11budget_proposed_budget.pdf (Fall National Meeting Oct. 2010).

³⁵ See Randall, *supra* note 21 at 686-89.

³⁶ *Id.* at 634-35.

³⁷ *Id.* at 636-38.

³⁸ *Id.* at 638-39.

³⁹ *Id.* at 639.

⁴⁰ Only Georgia, Michigan and New York do not have statutes or regulations that explicitly require the use of the NAIC Examiner's Handbook to conduct examinations.

⁴¹ *Supra* note 2.

⁴² A.M. Best Co., *Best's Insolvency Study, Property/Casualty U.S. Insurers, 1969-2002* (2004).

⁴³ U.S. Congress, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Failed Promises: Insurance Company Insolvencies*, 101st Cong., 2nd Sess. 1990 (Comm. Print 101-P), at iii.

⁴⁴ U.S. Government Accountability Office, *Insurance Regulation: The NAIC Accreditation Program Can Be Improved*, Report to the Honorable John D. Dingell, Ranking Minority Member, Committee on Energy and Commerce, House of Representatives (Aug. 2001), available at <http://www.gao.gov/new.items/d01948.pdf>, at 3.

⁴⁵ The United States Insurance Financial Solvency Framework (2010) ("Solvency Framework"), at 3, available at http://www.naic.org/documents/committees_e_us_solvency_framework.pdf.

⁴⁶ *Id.* at 9.

⁴⁷ *Id.* at 10.

⁴⁸ The NAIC divides the laws and regulations standards as follows: examination authority, capital and surplus requirements, accounting practices and procedures, corrective action, valuation of investments, holding company systems, risk limitation, investment regulations, liabilities and reserves, reinsurance, CPA audits, actuarial opinions, receivership, guaranty funds, NAIC filings, producer controlled insurers, managing general agents, and reinsurance intermediaries.

⁴⁹ NAIC, "Solvency Modernization Initiative: An NAIC Issues Brief (Sept. 3, 2009), available at http://www.naic.org/documents/committees_ex_isftf_smi_overview.pdf.

⁵⁰ Solvency Framework at 17, *supra* note 45.

⁵¹ Jane Boisseau, *et al.*, *PLI: Insurance Regulation Answer Book 2011* (Dewey & LeBoeuf LLP 2011), at 24.

⁵² *Id.* at 173.

⁵³ Testimony of Travis B. Plunkett regarding Regulatory Modernization before the United States Senate Committee on Banking, Housing, and Urban Affairs (July 28, 2009), at 6, available at http://banking.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=05fda10c-4785-425f-89b5-e772755ef95f.

⁵⁴ NAIC, Group Solvency Issues (EX) Working Group, Memorandum to Director Christina Urias (Feb. 26, 2010), available at http://www.naic.org/documents/index_smi_group_solvency_windows_and_walls.pdf.

⁵⁵ NAIC, *Solvency Modernization Initiative ROADMAP* (May 20, 2011), at 2, available at http://www.naic.org/documents/committees_ex_isftf_smi_roadmap_110520.pdf; NAIC, *Issues for Consideration in the Solvency Modernization Initiative* (June 14, 2009), available at http://www.naic.org/documents/committees_ex_isftf_smi_issues_consideration.pdf. See also Ray Spudeck, *U.S. Solvency Modernization Initiative* (presentation), Études et Dossiers No. 360-08 (Geneva Assoc. 2010), available at <http://www.genevaassociation.org/View.aspx?id=2495&cat=Working%20Paper%20Series>.

⁵⁶ Boisseau at 46, *supra* note 51.

⁵⁷ *Id.* at 48.

⁵⁸ U.S. Dept. of the Treasury, *Blueprint for a Modernized Financial Regulatory Structure* (Mar. 2008), at 68, available at <http://www.treasury.gov/press-center/press-releases/Documents/Blueprint.pdf>.

⁵⁹ Boisseau at 47, *supra* note 51.

⁶⁰ *Id.* at 47 – 48.

⁶¹ *Id.* at 48.

⁶² *Id.*

⁶³ The most prominent, recognized by all states, is for surplus lines. Boisseau, *supra* note 51 at 56. Surplus lines market allows the insurance buyer access to unlicensed or non-admitted insurers in a state, generally through a specially licensed insurance broker, when the insurance buyer is unable to find the desired coverage in the licensed and admitted market or when the insurance buyer is a large commercial policyholder. See Blueprint, *supra* note 58 at 70. This allows risks that could not be placed after a “diligent search” to obtain insurance from one or more licensed companies or admitted carriers and instead to be placed with certain non-approved carriers. Boisseau, *supra* note 51 at 57, 60. Some states allow further exceptions when no diligent search has been performed. A common one covers lines of business with a known shortage of coverage. *Id.* at 60. For such risks a diligent search wastes effort. States additionally still exempt some lines of business where most purchasers are likely sophisticated, for example marine and aviation insurance. *Id.* at 62.

⁶⁴ Boisseau at 49, *supra* note 51.

⁶⁵ *Id.*

⁶⁶ NAIC, *Company Licensing Best Practices Handbook* (2005), at 59, available at http://www.naic.org/documents/members_tech_ucaa_company_licensing_best_practices.pdf.

⁶⁷ Boisseau at 48, *supra* note 51.

⁶⁸ NAIC, *NAIC Producer Licensing Assessment, Aggregate Report of Findings* (Feb. 19, 2008), at 2, available at http://www.naic.org/Releases/2008_docs/producer_licensing_assessment_report.pdf.

⁶⁹ *Id.*

⁷⁰ U.S. Gov’t Accountability Office, GAO-09-372, *Insurance Reciprocity and Uniformity: NAIC and State Regulators Have Made Progress in Producer Licensing, Product Approval, and Market Conduct Regulation, but Challenges Remain* (2009). Print. 2.

⁷¹ *Supra* note 68 at 5.

⁷² GAO-09-372 at Print. 13.

⁷³ *Id.* at Print. 15.

⁷⁴ *Id.* at Print. 14.

⁷⁵ *Id.* at Print. 3.

⁷⁶ *Id.* at Print. 4, 16.

⁷⁷ *Supra* note 68 at 6.

⁷⁸ *Supra* note 58 at 59.

⁷⁹ *Supra* note 58 at 5.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Illinois, Kansas, Maryland, Mississippi, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and West Virginia.

⁸⁴ See, e.g., N.J. Stat. § 17:17-10(e) (2011).

⁸⁵ NV Ins. Code § 687B.410(2) (2010).

⁸⁶ See NM Ins. Code § 59A-6-3; FL Ins. Code § 624.430(4).

⁸⁷ Mass. Regs. Code tit. 211, § 54.01.

⁸⁸ *Id.* at § 54.05.

⁸⁹ *Id.*

⁹⁰ Me. Rev. Stat. Ann. tit. 24-A, § 415-A.

⁹¹ *Id.* at § 2916-C.

⁹² W. Jean Kwon, *et al.* *Can Insurance Firms Easily Exit from the Market? A Global Comparative Analysis of Regulatory Structures*, The Geneva Papers (2005), *available at* [http://www.genevaassociation.org/PDF/Geneva_papers_on_Risk_and_Insurance/GA2005_GP30\(2\)_Kwon,%20Kim%20&%20Lee.pdf](http://www.genevaassociation.org/PDF/Geneva_papers_on_Risk_and_Insurance/GA2005_GP30(2)_Kwon,%20Kim%20&%20Lee.pdf).

⁹³ 15 U.S.C. § 8221(a).

⁹⁴ NAIC, “Lloyd’s: A Review by U.S. State Insurance Regulators,” Report of the Examination Team to the Surplus Lines (E) Task Force (Sept. 14, 1998).

⁹⁵ Chawaga, Stephen and Tanker, Marcy, Uniformity in credit for reinsurance regulation, 15 J. Ins. Reg. 1, 2-3 (1996). The 1984 Model Law also included a provision known as the “Lloyd’s Provision” which applies to groups of individual unincorporated underwriters and requires a substantially higher base amount to be held in a trustee account.

⁹⁶ 31 U.S.C. § 313(r)(2).

⁹⁷ *Id.* at § 313(f).

⁹⁸ 11 U.S.C. § 109(b).

⁹⁹ Boisseau, *supra* note 51 at 182.

¹⁰⁰ Karl L. Rubinstein, “The Legal Standing of an Insurance Insolvency Receiver: When the Shoe Doesn’t Fit”, 10 Conn. Ins. L.J. 309, 326 (2004).

¹⁰¹ Francine L. Semaya, and William K. Broudy, , “A Primer on Insurance Receiverships,” 40 The Brief 22 (2010), at 22.

¹⁰² NAIC, Financial Regulation, *available at* http://www.naic.org/store_pub_fin_receivership.htm.

¹⁰³ National Conference of Insurance Guaranty Funds, “Capacity of the National Network of State Guaranty Associations to Protect Consumers of Nationally Chartered Insurance Companies (2002),” at 5-6, *available at* http://www.ncigf.org/media/files/media_ofc.pdf.

¹⁰⁴ *Id.* at 6.

¹⁰⁵ The Honorable John R. Dunne, “Insurer Insolvency and State Guaranty Funds,” 416PLI/Comm. 83, 85 (1987) (PLI Order No. A4-4185). In New York, the Workmen’s Compensation Security Fund was established in 1935, followed by the Public Motor Vehicle Liability Security Fund in 1939 and the New York Life Insurance Guaranty Fund in 1941. *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 86.

¹⁰⁸ Linda M. Lasley, *et al.*, “Insurance Guaranty Funds: The New ‘Money Pit’?” 416 PLI/Comm. 113, 115 (1987) (PLI Order No. A4-4185).

¹⁰⁹ *Id.* at 117.

¹¹⁰ Forney, Kent M., “Insurer Insolvencies and Guaranty Associations,” 4 Kent L. Rev. 813, 823 (1995).

¹¹¹ *Supra* note 105 at 86.

¹¹² National Conference of Insurance Guaranty Funds, *The Property and Casualty Guaranty Fund System: Built to Work* (2010 Annual Report), at 3, *available at* http://www.ncigf.org/media/files/NCIGF_2010AnnualReport.pdf.

¹¹³ Peter G. Gallanis, “NOLHGA, the Life and Health Insurance Guaranty System, and the Financial Crisis of 2008-2009”, (June 5, 2009), *available at* <http://www.nolhga.com/resource/file/NOLHGAandFinancialCrisis.pdf>.

¹¹⁴ See NAIC, 2010 Summary of Property and Casualty Insurance Guaranty Association Acts, Summary by Provision, *available at* http://www.ncigf.org/media/files/CLAIMS_PARAMETERS_2010.doc.

¹¹⁵ Cal. Ins. Code § 1063.1(c)(7) (“Covered claims” does not include that portion of a claim, other than a claim for workers’ compensation benefits, that is in excess of five hundred thousand dollars (\$500,000).”); N.Y. Ins. Law § 7603(a)(2) (“No payment from the property/casualty insurance security fund shall be made to any person who owns or controls ten percent or more of the voting securities of the insolvent insurer and no payment on any one claim shall exceed one million dollars, provided that the amount of payment on a claim and the aggregate for all claims shall be further limited by the provisions of paragraph two of subsection (g) of section seven thousand six hundred two of this article.”); N.Y. Ins. Law § 7602(g)(2)(B) (“the aggregate limit for all claims arising out of any one policy, excluding claims with respect to property or risks located or resident in this state, shall not exceed the lesser of the aggregate limit of the policy or five million dollars”); Mich. Comp. Laws Ann. § 500.7925(6) (“Covered claims shall not include that portion of a claim, other than a worker’s compensation claim or a claim for personal protection insurance benefits under section 3107, that is in excess of \$5,000,000.00. The \$5,000,000.00 claim cap shall be adjusted annually to reflect the aggregate annual percentage change in the consumer price index since the previous adjustment, rounded to the nearest \$10,000.00. The effective date of the adjustment shall be January 1 of each year and shall apply to claims made on or after that date. The claim cap in effect at the time of payment of a claim shall apply.”).

¹¹⁶ Fla. Stat. Ann. § 631.57(1)(a)2 (“The obligation under subparagraph 1. includes only the amount of each covered claim which is in excess of \$100 and is less than \$300,000, except that policies providing coverage for homeowner’s insurance shall provide for an additional \$200,000 for the portion of a covered claim which relates only to the damage to the structure and contents.”); Fla. Stat. Ann. § 631.57(1)(a)3 (“Notwithstanding subparagraph 2., the obligation under subparagraph 1. for policies covering condominium associations, or homeowners’ associations, which associations have a responsibility to provide insurance coverage on residential units within the association, shall include that amount of each covered property insurance claim which is less than \$100,000 multiplied by the number of condominium units or other residential units; however, as to homeowners’ associations, this sub-subparagraph applies only to claims for damage or loss to residential units and structures attached to residential units.”).

¹¹⁷ See Ex. 2 to Gallanis, *supra* note 113.

¹¹⁸ See, e.g., summary of advertising prohibitions in life and health guaranty association laws available at <http://www.nolhga.com/factsandfigures/main.cfm/location/lawdetail/docid/18>.

¹¹⁹ NY Ins. L. § 1313(d).

¹²⁰ For example, under New York law, any advertisement purporting to make known the insurer’s separate financial condition shall either show the amount of its admitted assets, liabilities and reserves required or permitted by law, surplus and paid up capital stock as last reported on its annual statement, or shall show only the insurer’s capital paid up or its surplus and capital. N.Y. Ins. Law §1313(a). Advertisements also may not create the impression that the insurer’s financial condition or status is superior to that of another insurer “unless such can be proven.” 11 NYCRR §219.4(o). Rules for advertisements for accident and health insurance prohibit “unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.” 11 NYCRR §211. In applying these rules, regulators have been somewhat hostile to comparisons based on financial strength. See e.g. N.Y. OGC Op. 08-04-19 (April 11, 2008).

¹²¹ Insurance Information Institute, *Topic: Residual Markets*, July 2011.

¹²² *Id.*

¹²³ "Florida Hurricane Chief Warns State in Danger, *Florida Sun Sentinel* (September 31, 2011). See also "A.M. Best Continues with Current Assessment of Insurers' Potential Exposure to the Florida Hurricane Catastrophe Fund, Á.M. Best Release (June 1, 2011); Towers Perrin, "Study of Recent Legislative Changes to Florida Property Insurance Mechanisms, prepared for the Associated Industries of Florida" (March 19, 2007).

¹²⁴ *Supra* note 122.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ AIPSO Facts Report, 2010/2011 edition; calculated by dividing the total residual market for a state by the sum of the voluntary business and residual market business in 2008. (Note: 2008 is the last year for which this data is available).

¹²⁹ Robert E. Litan and Phil O'Connor, "The Consumer Benefits of an Optional Federal Charter: The Case of Auto Insurance," July, 9, 2008, at 15 available at http://bipac.net/fsrac/litan_and_oconnor.pdf. Another argument in this vein is that personal lines P&C is local (*i.e.*, local accidents, homes, etc.).

¹³⁰ *Supra* note 129.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ Insurance Information Institute, "Residual Markets," August 2011.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ See NAIC, Product Filing Review Handbook 9 (Draft 2008).

¹⁴⁰ Webel & Cobb, CRS at 6, *supra* note 15.

¹⁴¹ *Id.* at 6-7.

¹⁴² Meier, Kenneth J., THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE, Albany State Univ. of New York Press, 1988, p. 59. See also, WEBEL & COBB, CRS at 7 (2005) *supra* note 15; NAIC, PRODUCT FILING REVIEW HANDBOOK 7 (Draft 2008).

¹⁴³ WEBEL & COBB, CRS at 7 (2005) *supra* note 15; see also *supra* note 143.

¹⁴⁴ NAIC, *supra* note 140.

¹⁴⁵ See WEBEL & COBB, CRS at 7 (2005), *supra* note 15. See also *supra* note 143.

¹⁴⁶ See also *supra* note 143.

¹⁴⁷ WEBEL & COBB, CRS at 7 (2005), *supra* note 15. *Supra* note 143 at 10.

¹⁴⁸ *Id.* at 10.

¹⁴⁹ *Id.* at 8-9.

¹⁵⁰ *Id.* at 10-11.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*; NAIC, PRODUCT FILING REVIEW HANDBOOK 10-11 (Draft 2008).

¹⁵⁴ WEBEL & COBB, CRS at 12 (2005), *supra* note 15. [Citation: "By 1987 some type of competitive rating laws were in effect in most states. However, there was some movement away from open competition. In a number of states insurance companies were required to roll back rates. Perhaps the prime example of

this was the 1988 passage of Proposition 103 in California. Among the Proposition 103 requirements placed on insurance companies was the reduction of most insurance rates 20% below the level that existed Nov. 8, 1987.]

¹⁵⁵ Kelly Cruz-Brown et al., *Recent Developments in Insurance Regulation*, 44 TORT TRIAL & INS. PRAC. L.J. 591, 614 (2009).

¹⁵⁶ NAIC, Product Filing Review Handbook 12 (Draft 2008).

¹⁵⁷ <http://www.treasury.gov/press-center/press-releases/Documents/Blueprint.pdf> at 69.

¹⁵⁸ *Id.* at 70.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ See Section 2 for discussion of life insurance product approvals by the Interstate Insurance Product Regulation Commission.

¹⁶² Blueprint at 70, *supra* note 159.

¹⁶³ See, e.g., Robert E. Litan, “Regulating Insurance After the Crisis,” Initiative on Business and Public Policy at Brookings (Mar. 4, 2009), at 10, *available at* http://www.brookings.edu/~media/Files/rc/papers/2009/0304_insurance_litan/0304_insurance_litan.pdf. (“by artificially restraining [auto insurance] premiums, state premium controls have caused many more higher-risk drivers in states where these controls are present to obtain their insurance from so-called “residual risk” markets or plans because insurers cannot profitably sell insurance to these drivers at the controlled premiums.”).

¹⁶⁴ AIPSO Facts Report, *supra* note 131.

¹⁶⁵ Litan and O’Connor, at 4, *supra* note 130 (This is also flawed because accidents frequently involve out of state insurers, cross state citizens, etc. Location of a home does not mean that local adjusters can’t evaluate the costs of the claims, etc., any more than the mortgage company needs to be state regulated.)

¹⁶⁶ J. Robert Hunter, “State Automobile Insurance Regulation: A National Quality Assessment and In-Depth Review of California’s Uniquely Effective Regulatory System.” (Apr. 2008), at 20, *available at* http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/state_auto_insurance_report.pdf.

¹⁶⁷ *Id.*

¹⁶⁸ *Supra* note 58 at 68.

¹⁶⁹ *Id.*

¹⁷⁰ GAO-09-372 at Print. 5, *supra* note 70.

¹⁷¹ U.S. Government Accountability Office, *State Insurance Regulation: Efforts to Streamline Key Licensing and Approval Processes Face Challenges*, Statement for the Record by Richard J. Hillman, Director Financial Markets and Community Investment (2001), at 9, *available at* <http://www.gao.gov/new.items/d02842t.pdf> 9.

¹⁷² *Id.* at 13.

¹⁷³ *Id.*

¹⁷⁴ GAO-09-372 at Print. 22, *supra* note 70.

¹⁷⁵ *Id.* at Print. 5.

¹⁷⁶ See http://www.insurancecompact.org/documents/compact_statute.pdf (last visited Sept. 7, 2011).

¹⁷⁷ See <http://www.insurancecompact.org/about.htm> (last visited Sept. 7, 2011).

¹⁷⁸ GAO-09-372 at Print. 5, *supra* note 70.

¹⁷⁹ *Supra* note 172.

¹⁸⁰ *Id.* at 13.

¹⁸¹ *Id.*

¹⁸² See Randall, *supra* note 21 at 642-43.

¹⁸³ Nordman, Eric, Journal of Insurance Regulation, “The Early History of the NAIC” (Winter 2000).

¹⁸⁴ See Randall, *supra* note 21 at 642.

¹⁸⁵ *Id.* at 645.

¹⁸⁶ *Supra* note 43 at 16. Some states require an exam once every three years.

¹⁸⁷ *Id.* at 17 (“to prevent duplicative examination efforts by regulators for insurers writing in multiple states, regulators may rely on the exam work of the NAIC accredited domiciliary state. Additionally, for large insurance holding company groups, regulators are encouraged to coordinate their examinations of individual entities by following a lead state concept, thereby allowing the pooling of resources to complete one coordinated exam for the insurer group.”).

¹⁸⁸ NAIC, Financial Condition Examiners Handbook (2011), at 3, available at http://www.naic.org/committees_e_examover_fehtg.htm.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 9.

¹⁹¹ *Id.*, at 3.

¹⁹² *Id.*

¹⁹³ *Id.* at 28.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Supra* note 53.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ U.S. Government Accountability Office, Testimony Before the Subcommittee on Oversight and Investigations, Statement of Richard J. Hillman, Director, Financial Markets and Community Investment (2003), available at <http://www.gao.gov/new.items/d03738t.pdf>.

²⁰⁶ Boisseau at Chapter 17, *supra* note 51.

²⁰⁷ There was precedent both for sudden industry recoil from similar peril and for the federal response to such market dislocation. Within days of the 1941 Japanese attack on Pearl Harbor (and the Philippines), Congress authorized the War Damages Corporation (WDC), a federally-capitalized (via New Deal-era Reconstruction Finance Corporation) insurer that provided cover against the peril of “enemy attack.” Similar to the NFIP Write-Your-Own program (see, *infra*), private insurers were authorized to attach the WDC rider to personal lines and commercial property fire or multi-peril policies. WDC was also statutorily authorized to retroactively assume the losses to civilian property from the initial December 1941 attacks in Hawaii and the Philippines (then a US protectorate). Initially, there was no co-share and insurers received a ceding commission very much like NFIP W-Y-O; mid-war this was changed to have the participating private insurers follow the fortunes of the program on a pooled basis by sharing collectively 10% of any profit or loss from the WDC program, which of course proved to be very profitable as the enemy did not

again reach US territory. In the last year of WW II, policies were renewed without additional premium, and no new policies were written after surrender. The Corporation was wound up in the 1950s after run-off or settlement of all claims. The largest set of losses from a covered incident other than the retroactive losses, arose from an accidental explosion of a U.S. destroyer moored in Brooklyn harbor.

²⁰⁸ Fed. Ins. & Mitigation Admin., National Flood Insurance Program: Program Description 1 (Aug. 1, 2002).

²⁰⁹ 29 C.F.R. § 2580.412-21.

²¹⁰ 19 C.F.R. § 113.37(a).

²¹¹ 75 Fed. Reg. 35318 (June 22, 2010).

²¹² See *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959); *SEC v. United Benefit Life Ins. Co.*, 387 U.S. 202 (1967).

²¹³ Proposed Transition to BHC Reporting Forms, 76 Fed. Reg. 53129, 53133 (Aug. 25, 2011).

²¹⁴ 75 Fed. Reg. 80174 (Dec. 21, 2010).

²¹⁵ Webel & Cobb, CRS 18-19 (2005), *supra* note 15.

²¹⁶ Institute of International Finance, THE IMPLICATIONS OF FINANCIAL REGULATORY REFORM FOR THE INSURANCE INDUSTRY (AUGUST 2011), p.3.

²¹⁷ NAIC, "International Association of Insurance Supervisors (IAIS)," *available at* http://www.naic.org/topics/topic_iais.htm.

²¹⁸ *Id.*

²¹⁹ International Association of Insurance Supervisors ("IAIS"), *Principles on Group-Wide Supervision* (Oct. 2008), *available at* http://www.iaisweb.org/__temp/7__Principles_No__3_4_on_Group-Wide_Supervision.pdf.

²²⁰ IAIS, *Guidance Paper on the Use of Supervisory Colleges on Group-Wide Supervision* (Oct. 2009), *available at*

http://www.iaisweb.org/__temp/Guidance_paper_No__3_8_on_the_use_of_supervisory_colleges_in_group-wide_supervision.pdf.

²²¹ IAIS, *Guidance Paper on the Role and Responsibilities of a Group-Wide Supervisor* (Oct. 2008), *available at*

http://www.iaisweb.org/__temp/18__Guidance_Paper_No__3_7_on_the_role_and_responsibilities_of_a_group-wide_supervisor.pdf.

²²² IAIS, *Guidance Paper on the Treatment of Non-Regulated Entities in Group-Wide Supervision* (Apr. 12, 2010), *Available at* http://www.iaisweb.org/__temp/21__Guidance_paper_on_the_treatment_of_non-regulated_entities_in_group-wide_supervision.pdf.

²²³ See the IAIS ComFrame page at <http://www.iaisweb.org/Common-Framework-for-the-Supervision-of-internationally-active-insurers-765>.

²²⁴ See IAIS, Press Release: *Insurance Supervisors Confirm Commitment to Regulatory Reforms* (Nov. 2, 2010), *available at*

http://www.iaisweb.org/__temp/2_November_2010_Final_Annual_Conference_Closing_Press_Release.pdf.

²²⁵ Financial Stability Board, "Links to FSB members," *available at*

<http://www.financialstabilityboard.org/members/links.htm>. See also Financial Stability Board, Annex A (List of FSB Members), Financial Stability Board Charter, *available at* http://www.financialstabilityboard.org/publications/r_090925d.pdf.

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- ²²⁶ Financial Stability Board Charter, Art. 10(1), *available at* http://www.financialstabilityboard.org/publications/r_090925d.pdf.
- ²²⁷ Eric Helleiner, “What Role for the New Financial Stability Board?”, 1:3 GLOBAL POLICY 282, 284 (2010).
- ²²⁸ *Supra* note 227.
- ²²⁹ *Supra* note 228 at 285.
- ²³⁰ Kush Kotecha and David Payne, “Solvency II equivalence: Implications for the US insurance market,” *Financial Services* (Ernst & Young, Oct. 2010), at 2, *available at* <http://www.soa.org/library/newsletters/financial-reporter/2010/december/frn-2010-iss83-kotecha.pdf>.
- ²³¹ CEIOPS Advice to the European Commission, “Equivalence assessments to be undertaken in relation to Articles 172, 227 and 260 of the Solvency II Directive,” CEIOPS-DOC-92-10 (Aug. 31, 2010), at 6.1.5.
- ²³² Letter of Director-General Jonathan Faull to CEIOPS, Ref. Ares (2010)759124 – 29/10/2010.
- ²³³ Report to the Honorable John D. Dingell,, *supra* note 44.
- ²³⁴ See Daniel Schwarcz, *Regulating Insurance Sales or Selling Insurance Regulation?: Against Regulatory Competition in Insurance*, 94 Minn. L. Rev. 1707 (2010).
- ²³⁵ See, e.g., Ralph K. Winter, Jr., *State Law, Shareholder Protection, and the Theory of the Corporation*, 6 J. Legal Stud. 251 (1977).
- ²³⁶ See, e.g., Adam R. Levitan, *Hydraulic Regulation: Regulating Credit Markets Upstream*, 26 Yale J. Reg. 143 (2009); Elizabeth R. Schiltz, *The Amazing, Elastic, Ever-Expanding Exportation Doctrine and Its Effect on Predatory Lending Legislation*, 88 Minn. L. Rev. 518 (2004). *But see* Todd J. Zwyci, *Economics of Credit Cards* 3 Chap. L. Rev. 79, 147 (2000) (arguing that regulatory competition reduced the impact of inefficient usury restrictions).
- ²³⁷ See Robert M. Daines, *Does Delaware Law Improve Shareholder Value?*, 62 J. Fin. Econ. 525 (2001) (presenting empirical evidence supporting a race to the top).
- ²³⁸ *Id.*
- ²³⁹ *Id.*

Appendix A

Appendix A

STATUS OF STATE INSURANCE COMMISSIONERS

	Insurance Commissioner			
	Elected	Appointed	Term	Ins Dep't is not Stand-alone Agency
Alabama		X		
Alaska		X		
Arizona		X	6	
Arkansas		X	4	
California	X		4	
Colorado		X		
Connecticut		X		
Delaware	X		4	
District of Columbia		X ¹		X
Florida		X	4	X
Georgia	X		4	
Guam		X		
Hawaii		X		X
Idaho		X		
Illinois		X		
Indiana		X		
Iowa		X	4	
Kansas	X		4	
Kentucky		X		
Louisiana	X		4	
Maine		X	1	X
Maryland		X	4	
Massachusetts		X		
Michigan		X		X
Minnesota		X		X
Mississippi	X		4	
Missouri		X		
Montana	X		4	X
Nebraska		X		
Nevada		X ²		X
New Hampshire		X		
New Jersey		X		X
New Mexico		X ³		X

	Insurance Commissioner			
	Elected	Appointed	Term	Ins Dep't is not Stand-alone Agency
New York		X		X
North Carolina	X		4	
North Dakota	X		4	
N. Mariana Islands		X		
Ohio		X		
Oklahoma	X		4	
Oregon		X		
Pennsylvania		X		
Rhode Island		X		
South Carolina		X		
South Dakota		X ⁴		X ⁵
Tennessee		X		X
Texas		X		
US Virgin Islands	X ⁶			
Utah		X		
Vermont		X		X
Virginia		X ⁷		X ⁸
Washington	X		4	
West Virginia		X		
Wisconsin		X		
Wyoming		X		

¹ Appointed by the Mayor of the District of Columbia.

² Appointed by the Director of Business and Industry.

³ Appointed by the Public Regulation Commission.

⁴ Appointed by the Governor and the Secretary of Revenue and Regulation.

⁵ Serves at the pleasure of the Secretary of Revenue and Regulation.

⁶ The Lieutenant Governor is the Commissioner of Insurance.

⁷ Appointed by the State Corporation Commission.

⁸ Serves at the pleasure of the State Corporation Commission.

Appendix B

Appendix B

THE NAIC'S HANDLING OF THE 2008 CAPITAL AND SURPLUS RELIEF PROPOSAL FOR LIFE COMPANIES

On November 11, 2008, in the midst of the 2008 financial crisis, American Council of Life Insurers (“ACLI”) President Frank Keating sent a letter to Sandy Praeger, Kansas Insurance Commissioner and President of the NAIC, asking the NAIC to consider certain proposals to “provide important near term relief from conservative reserve and risk-based capital standards” (the “ACLI Proposal”). The ACLI told the NAIC it believed that the NAIC could adopt the ACLI Proposal by year-end 2008.

The ACLI Proposal

The ACLI Proposal consisted of nine “Ideas and Concepts”, broken into four broad subject areas: life insurance, variable annuities, investments and accounting. These “Ideas and Concepts” may be summarized as follows:

Life Insurance

- a. Allow the 2001 Preferred Mortality Tables to be used for any 2001 CSO product.
- b. Make Section 8C of Actuarial Guideline 38 (“AG 38”) retroactive to 7/1/05.
- c. Clarify that 2001 Non-preferred Mortality Tables can always be used for determining segments within Actuarial Guideline 38.
- d. Eliminate artificial constraints in Regulation XXX for the calculation of X factors with consent of the domestic regulator.
- e. Facilitate a commissioner’s use of current discretionary authority to exercise judgment to determine U.S. collateral for reinsurance.

Variable Annuities

- a. Eliminate redundant use of the stand-alone asset adequacy analysis required by Actuarial Guideline 39 (“AG 39”), which covers only Variable Annuity living benefit guarantees and associated revenue under the contract.
- b. Waive the Standard Scenario as the floor in the C-3 Phase 2 calculation of risk-based capital for year ends 2008 and 2009.

Investments

- a. Temporarily fix the calculation of the Mortgage Experience Adjustment Factor (“MEAF”) in the risk-based capital calculation.

Accounting

- a. Change Statutory Accounting requirements to follow GAAP rules regarding recognition of the Deferred Tax Asset (“DTA”).

The NAIC's Consideration of the ACLI Proposal

Actions taken prior to the NAIC's 2008 Winter National Meeting

Shortly after receipt of the ACLI Proposal, the NAIC's Executive Committee organized a new "Capital and Surplus Relief Working Group" to oversee the NAIC's consideration of the ACLI Proposal. The Working Group was charged as follows: 1) Consider the need and appropriateness for changes to existing NAIC solvency framework components that impact statutory capital and surplus requirements; and 2) Provide any recommended changes, including whether or not the changes should be temporary, to the Executive Committee.

The nine elements of the proposal were then assigned to four of the NAIC's technical committees. Each of these technical committees held at least one confidential conference call or meeting to discuss the matters assigned to it prior to the NAIC's Winter Meeting that was held from December 4 to December 8, 2008.

Actions taken during the NAIC's Winter National Meeting

Many interested parties arrived at the NAIC's Winter Meeting hopeful that the NAIC would begin to discuss in public its views regarding the ACLI Proposal. That did not occur.

The Capital and Surplus Relief Working Group did hold a meeting. However, there was no discussion of the substance of the ACLI Proposal and none of the technical committees provided the Working Group with any reports.

Behind closed doors, however, in regulator-only sessions, a relatively great deal of action was happening. Each of the Life and Health Actuarial Task Force, the Life Risk Based Capital Working Group, and the Reinsurance Task Force held closed sessions to discuss the ACLI Proposal. The NAIC's Executive Committee also met behind closed doors for considerable time prior to opening its meeting, presumably to discuss the ACLI Proposal.

In an unprecedented commitment to maintaining confidentiality, regulators were remarkably tight lipped about what they had discussed in their closed meetings.

Some small pieces of information regarding the reaction of the NAIC to the ACLI Proposal did become available over the course of the NAIC's Winter Meeting.

The Life and Health Actuarial Task Force publicly adopted a resolution following its closed session concluding that allowing 2001 Preferred Mortality tables to be used for any 2001 CSO product, clarifying that 2001 non-preferred mortality tables can always be used for determining segments within AG 38, and eliminating artificial constraints in Reg XXX for calculation of X factors with consent of domestic commissioner do not "compromise regulatory objectives," but that the ACLI's proposal to make Section 8C of AG 38 retroactive to 7/1/05 "may compromise regulatory objectives" and the proposal to "eliminate use of stand-alone asset adequacy analysis required by AG 39" would unreasonably reduce VA reserves. Similarly, the Life Risk Based Capital Working Group approved a motion after its closed-door meeting concluding that the proposal regarding the mortgage experience adjustment factor and the C-3 Phase II standard scenario were not recommended to be implemented. However, there was

absolutely no discussion by either committee in open-session as to the rationale for their conclusions. Also, the Statutory Accounting Principles Working Group reported that it was working on a counter-proposal to the ACLI's idea about DTAs, that might include a temporary suspension of SSAP 10 for 2008 and 2009 financial reporting, but little more was reported. The Reinsurance Task Force discussed the collateral issue for almost an hour in a closed session and then provided no public report as to what it had done.

Actions Taken After the NAIC's Winter Meeting

During the several weeks following the NAIC's Winter Meeting, the NAIC's technical working groups continued to meet on frequent conference calls to consider the ACLI Proposal. On December 17, 2008, the NAIC released the working groups' reports to the public and invited interested parties to submit comments by December 26, 2008. The NAIC's Executive and Plenary Committees held a joint conference call to discuss the status of the ACLI Proposal on January 2, 2009.

These meetings culminated in a public hearing on January 27, 2009 by the NAIC's "Capital and Surplus Relief Working Group" (which the NAIC established in order to evaluate and submit a recommendation regarding the ACLI Proposal to the NAIC's membership) after which the Working Group voted in favor of six elements of the ACLI Proposal, some with amendments.¹ Supporters of the ACLI Proposal felt that a significant victory had been achieved and at least some regulators appeared to be pleased that the NAIC had been able to respond in a timely fashion to the ACLI Proposal.

This apparent success turned out to be extremely short lived, because in a conference call on January 30, 2009, the NAIC's Executive Committee held a conference call and voted 16 -1 to reject the ACLI proposal primarily on the grounds that the ACLI and interested companies had not made the case that an emergency exists that necessitates adoption of the proposal outside of normal NAIC processes.² Remarkably, some of the states that voted to reject the ACLI Proposal had voted in favor of various provisions of it just three days earlier at the Capital and Surplus Relief Working Group's meeting. However, on Executive Committee's conference call it was clear from the start, however, that notwithstanding an apparent consensus among the commissioners as to the substantive merit of some elements of ACLI proposal, the commissioners had concluded that the elements of the proposal were merely good ideas and were not necessary at this point in time. Another commonly expressed concern about the ACLI proposal was that it could not be adopted uniformly among the states on an expedited basis, even if it were approved by the NAIC. Other regulators indicated that they had concluded that adoption of the proposal would be seen as diluting existing protections and would send a message that the industry needs emergency relief, at a time when most regulators felt that no such need existed broadly within the industry.

What Happened Next

Notwithstanding the Executive Committee's vote, there was a clear consensus expressed on the conference call that there was substantive value to many elements of the ACLI Proposal. Accordingly, the NAIC continued to work on addressing a number of the nine elements and over the next several months adopted some version of a number of them, including a new MEAF and an interim rule to provide more favorable accounting treatment of deferred tax assets.³ Most of these developments were not a surprise.

What was surprising, however, is that within weeks of the Executive Committee's vote, many states acted unilaterally to allow their domestic companies to use as permitted accounting practices in connection with the preparation of the companies' 2008 year-end annual statements certain of the elements of the ACLI Proposal, most often allowing companies to treat deferred tax assets more favorably. Even more surprisingly, some of the commissioners who allowed these permitted practices had voted against approving the ACLI Proposal at the Executive Committee conference call.

The actions by a number of states to allow insurers to use as a permitted practices portions of the ACLI Proposal, after the proposal was rejected by the NAIC's Executive Committee, clearly touched a nerve for many regulators. Although the NAIC has supposedly well established protocols for the use and disclosure of permitted practices, many regulators appeared to believe that those protocols were not complied with in connection with the filing of 2008 Annual Statements. A new NAIC Executive Committee Task Force was formed to examine what had gone wrong, but within months the Task Force was disbanded, without making any material findings.

¹ The proposals that were accepted, as amended by (or as to be amended by) the NAIC's technical groups, were: the life insurance proposals regarding preferred mortality tables, the change in the X factor, the revision to AG 39, the adjustment to the MEAF, and the treatment of deferred tax assets.

² The vote on the ACLI proposal was as follows: Opposed: Alaska, Florida, Iowa, Kansas, Louisiana, New Jersey, New Hampshire, New Mexico, Oklahoma, Pennsylvania, South Dakota, South Carolina, Tennessee, Utah, Wisconsin, and West Virginia; In Favor: Connecticut. The vote on the substance of the ACLI proposal came after the Executive Committee voted unanimously to consider the ACLI proposal as a single matter, rather than to take separate votes on each of the nine independent elements of the ACLI proposal.

³ The NAIC continues to look at how to account for deferred tax assets and a new proposal is being actively considered at this time.

Appendix C

Appendix C

NRRA CASE STUDY

July 21, 2011 marked the one year anniversary of the enactment of the NRRA, a subtitle within Dodd-Frank. The NRRA mandates nationwide uniform standards for certain aspects of the regulation and taxation of non-admitted insurance by: (i) conferring exclusive authority to regulate and tax the placement of insurance with non-admitted insurers on the “home state” of the insured, (ii) setting a uniform national standard for non-admitted insurers to be eligible in any given state to write insurance through licensed surplus lines brokers and (iii) allowing surplus lines brokers who represent qualifying large commercial buyers (called “Exempt Commercial Purchasers”) to access the surplus lines market without first conducting a diligent search to determine that coverage is not available from the admitted insurance market. The NRRA preempts state laws that are inconsistent with these federal reforms.

Although the NRRA mandates national standards for certain aspects of non-admitted insurance regulation, there is no federal agency empowered to oversee these reforms.¹ As a consequence, state insurance regulators are left to incorporate or implement these changes within their existing laws governing non-admitted insurance, so that the new regulatory regime for non-admitted insurance is comprised of the federal-NRRA standards and state laws that are not preempted. This provides an ideal opportunity for a living case study of federal involvement in insurance supervision. At this early stage the case study is largely undeveloped. However, there has been enough activity in the various states to provide at least a preliminary assessment. As discussed below the experience so far is fairly mixed.

Generally

Efforts by state insurance regulators to implement the NRRA generally consist of the work of the (i) NAIC, (ii) state legislation and (iii) regulations and regulatory practice which is still in the early stages of evolution.²

Late last year, the NAIC convened a special working group to consider the need for state legislation to implement the NRRA. The primary focus of the NAIC working group sessions has been on reporting and state allocation of non-admitted insurance premium taxes and in attempting to create a system for the states to share premium taxes on non-admitted insurance policies covering multistate risks. In addition, the NAIC adopted a sample NRRA implementation bulletin that outlines each of the NRRA reforms and the areas where state law is now preempted. A number of states have already issued their own bulletins based entirely or substantially on the NAIC sample bulletin.

In our view, these bulletins are an effective means to make brokers, insurers and insureds (as well as state insurance regulators) aware of the changes to the laws governing non-admitted insurance. In many respects the bulletins could probably serve as a state’s lone action in providing guidance to the market on how the state will (or should) implement the NRRA.

The NRRA reforms are self-executing and create national regulatory standards without, and notwithstanding, any state implementation or statutory amendment. Still, nearly all states have taken some legislative or regulatory action in response to the NRRA. This activity ranges from simply adopting the NAIC sample bulletin (or something substantially similar thereto), to legislation or other action only

addressing non-admitted insurance premium taxes, to legislation that seeks to incorporate much if not all of the NRRA reforms into the state's insurance laws. Legislation in at most a small handful of states fully and faithfully incorporates the NRRA reforms while legislation in others seems directly inconsistent. Given that the drafters of the legislation in some states were effectively tasked with writing federal preemption into state law, it is not incredibly surprising that the legislation might fall short on certain aspects of nationwide uniform standards and federal preemption as mandated by the NRRA. Furthermore, some states have suggested, in the actual legislation or in summaries of the legislation that the purpose of the legislation is to forestall federal preemption under the NRRA, which is obviously incorrect and of potential concern for those expecting the NRRA to achieve its legislative intent of streamlining the regulation of non-admitted insurance and achieving nationwide uniformity.

Home State / "Principal Place of Business"

The NRRA establishes the federal principle that "home state of the insured" rules apply exclusively to purchases and taxation of insurance from non-admitted. The principal feature of the NRRA is the concept of "home state." The NRRA provides in relevant part that no state other than the home state of an insured may regulate or require any premium tax payment for non-admitted insurance. The NRRA further provides that (i) the placement of non-admitted insurance shall be subject to the statutory and regulatory requirements solely of the insured's home state and (ii) any law, regulation, provision or action of any state that applies or purports to apply to non-admitted insurance sold to, solicited by, or negotiated with an insured whose home state is another state shall be preempted with respect to such application.

Thus, the NRRA reforms are largely dependent on a common definition of "home state" to be applied by all states. The NRRA has accomplished much of this task by mandating a national definition of "home state," *i.e.*, the state where a single named insured maintains its principal place of business (or residence), provided there is some insured risk in that state. For affiliated groups, the home state is the "home state" of the "member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract." The NRRA does not define "principal place of business." Some states may attempt to add their own "amplifications," "interpretations" or "clarifications" to the NRRA's definition. Some states have already taken this step, defining "principal place of business" or adding to the NRRA's "home state" definition in their statutes.³ Such state actions have the potential to frustrate the legislative intent of the NRRA because different definitions applied by different states to the placement of a single policy could lead to more than one state considering itself to be the "home state" with exclusive authority to regulate and tax the placement of that policy. In addition, legislation in some states incorporates the "home state" concept in a way that might be construed to limit federal preemption under the NRRA, which suggests that the state may interpret its authority post-NRRA differently than Congress intended.

Premium Tax

Nearly all states have historically imposed taxes based on the non-admitted insurance premium allocated to that state, rather than imposing tax based on 100% of the premium. States have commonly sought to collect tax, at their own tax rates, on their allocated share of the premium for a placement covering a multistate risk, either as surplus lines or independently procured insurance tax. The NRRA contemplates a system of tax sharing in which the home state collects tax on 100% of the premium for a

policy covering a multistate risk and allocates tax to the other states under an agreed method. This approach requires the home state to tax 100% of the premium and most, if not all, states have made that change, whether by statutory amendment or through a broader interpretation of previously existing law in light of the NRRA. However, because the NRRA does not mandate sharing, some states taxing 100% of the premium as the home state may retain all of the tax.

Under the NRRA, only the home state may require the payment of premium tax on non-admitted insurance. This mandate is intended to simplify the payment of premium taxes on multistate risks by requiring that all premium tax be paid to one state – the insured’s “home state.” The NRRA contemplates, and to a degree encourages, the several states to enter into multistate premium tax sharing agreements as a mechanism to share taxes, collected by the home state, under a uniform allocation formula to be determined. Specifically, the NRRA provides that Congress intends that each state adopt such “nationwide uniform requirements, forms and procedures” consistent with the NRRA. To facilitate tax sharing, an insured’s home state may require surplus lines brokers and insureds who have independently procured insurance to annually file multistate allocation reports with the insured’s home state. The states, however, are not required to share taxes, and some states may decide not to enter into a tax sharing arrangement.

There are currently multiple proposals being considered in the states, and it is not clear if, when or how this will be resolved.⁴ At this point, the goal of the NRRA to bring nationwide uniformity on non-admitted insurance premium tax has not been achieved – as of this writing, only 9 states have enacted SLIMPACT, and only 12 states have entered into NIMA, and it is unclear whether either will become operational in the short term. A number of states are still considering whether to participate in one system or the other, presumably to determine which, if any, is in the state’s best interest. Some states, including some of the larger commercial states, apparently have decided not to share taxes with other states. There are prospects for a compromise system with a simple allocation method that might be acceptable to both the SLIMPACT and NIMA states, but that compromise may not include some of the larger commercial states without whose participation any attempt at a nationwide tax sharing system seems destined to fail.

In addition, legislation enacted in some states to address premium tax requirements post-NRRA seems inconsistent with the NRRA. For example, some states will seek to require the broker or insured to apply the tax rates of each state where there are covered risks even if the state is not participating in a tax agreement with the home state; the home state presumably would retain the tax attributable to risks in the non-participating state at that other state’s tax rate. This is difficult to reconcile with the NRRA’s “home state” mandate and preemption of other states’ laws. A number of states also apparently will require quarterly allocation reports, even though the NRRA only permits the home state to require such reports annually.

Overall, any premium tax sharing arrangement or other system should be consistent with the NRRA’s goal of achieving nationwide uniformity and streamlining compliance and administrative requirements for brokers and insureds. The states so far have not achieved this goal.

Insurer Eligibility

All U.S. jurisdictions have enacted some form of surplus lines law allowing non-admitted insurers under certain conditions to write business in the state. Historically, for non-admitted insurers to be considered eligible, or approved, for surplus lines placements, many states required non-admitted insurers to submit applications to the state's insurance regulator, and only upon approval of such application would the insurer be deemed eligible. Other states have relied upon surplus lines brokers to determine whether non-admitted insurers met the statutory financial criteria for surplus lines placements. Regarding non-U.S. insurers, some states required that the insurer appear on the most recent Quarterly Listing of Alien Non-admitted Insurers published by the International Insurers Department of the NAIC (the "IID List").

The NRRRA provides that a state may not "(1) impose eligibility requirements on, or otherwise establish eligibility criteria for, non-admitted insurers domiciled in a United States jurisdiction, except in conformance with such requirements and criteria in sections 5A(2) and 5C(2)(a) of the NAIC Non-Admitted Insurance Model Act, unless the State has adopted nationwide uniform requirements, forms and procedures developed in accordance with section 521(b) of this subtitle that include alternative nationwide uniform eligibility requirements." Those two sections of the NAIC Model Act require an insurer to be "authorized to write the type of insurance in its domiciliary jurisdiction" and to have minimum capital and surplus measured under the laws of its domiciliary jurisdiction of \$15 million or a greater amount if required by the state where eligibility is sought. Thus, in the absence of "nationwide uniform requirements, forms and procedures" relating to eligibility for U.S. domestic excess and surplus lines insurers, the NRRRA preempts eligibility requirements for such insurers other than minimum capital and surplus and license authority in the insurer's state of domicile.

Regarding non-U.S. insurers, the NRRRA provides that a state may not "prohibit a surplus lines broker from placing non-admitted insurance with, or procuring non-admitted insurance from, a non-admitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC." Thus, insurers on the IID List are automatically eligible to write surplus lines business in all U.S. jurisdictions.

Thus, there is now a single national standard for surplus lines insurer eligibility in the U.S. To create a single national standard, the NRRRA preempts eligibility requirements for U.S. domestic insurers "other than" those in the NAIC Model Act that are specifically incorporated by the NRRRA - which means that all state eligibility requirements for U.S. domestic excess and surplus lines insurers are intended to be preempted except the referenced requirements, and the NRRRA provides that a surplus lines broker may place business with any non-U.S. insurer on the NAIC-IID list. A state legislature or regulator may not impose additional requirements for surplus lines insurer eligibility other than those outlined above and a state legislature or regulator may not prohibit a surplus lines broker from placing business with an insurer that satisfies those requirements.

The sample NAIC bulletin on NRRRA implementation expressly recognizes these reforms.⁵ Legislation in some states also generally incorporates these reforms. However, legislation in some states fails to fully recognize these changes (intentionally or not), either by not incorporating them at all or by adopting the NRRRA's uniform eligibility requirements while retaining existing authority for the regulator to declare an insurer ineligible based on any number of factors such as quality of management, financial

condition and business practices, any of which additional eligibility requirements are preempted by the NRRA.

In addition, it appears that the regulatory practice in at least a few states may continue to include an application and review process with requirements for insurers other than those set forth in the NRRA. This may occur either by states continuing to maintain “approved lists” or “white lists” and/or imposing the requirements on surplus lines brokers as licensees in the state rather than the insurers themselves, and perhaps even by states intentionally disregarding the NRRA reforms. In any case, such regulatory practice would be in conflict with federal law under the NRRA.

¹ Dodd-Frank creates a new Federal Insurance Office but that agency has no regulatory powers. The General Accountability Office will study the impact of the NRRA on the admitted and non-admitted markets.

² There is little regulatory guidance since the NRRA only took effect on July 21, 2011, and various states have only recently taken legislation and regulatory action.

³ These definitions have primarily been derived from either:

- (i) The U.S. Supreme Court’s decision in *Hertz Corp. v. Friend*, 130 S. Ct. 1181 (U.S. 2010), regarding diversity jurisdiction, where the Court held that a corporation’s “principal place of business” for purposes of federal diversity jurisdiction is its “nerve center,” which is the “place where the corporation’s high level officers direct, control, and coordinate the corporation’s activities”; or
- (ii) A definition developed by the NAIC in connection with its proposed tax sharing agreement, the Non-admitted Insurance Multistate Agreement, or NIMA. NIMA defines “principal place of business” as:
 - (a) the State where the insured maintains its headquarters and where the insured’s high-level officers direct, control and coordinate the business activities; or
 - (b) 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; or
 - (c) if the insured maintains its headquarters or the insured’s high-level officers direct, control and coordinate the business activities outside any State, the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

NIMA defines “principal residence” as:

- (a) the State where the insured resides for the greatest number of days during a calendar year; or
- (b) if the insured’s principal residence is located outside any State, the State to which the greatest percentage of the insured’s taxable premium for that insurance is allocated.

⁴ The main proposals are SLIMPACT and NIMA. SLIMPACT is a modified version of an interstate compact drafted by various stakeholders before the NRRRA was enacted that provides for the participating states to adopt certain uniform standards through a Commission. A clearinghouse would distribute taxes. Ten states or states representing 40% of all surplus lines premium must enact SLIMPACT for it to become operational.

NIMA is a contract among two or more states providing for premium taxes to be distributed by a clearinghouse under a plan of operation developed by the NAIC. If adopted as currently proposed NIMA allocation calls for collection of some data not previously required.

A number of states have enacted legislation generally authorizing a state agency to enter into a tax sharing arrangement with other states, presumably to preserve flexibility to join the system in the state's best interest.

⁵ The NAIC sample bulletin states:

For non-admitted insurers domiciled in a U.S. jurisdiction, a broker is permitted to place non-admitted insurance with such insurers provided they are authorized to write such business in their state of domicile and maintain minimum capital and surplus of \$15 million [or the minimum capital and surplus amount required in this State, whichever is greater]. [Note: If the state maintains a list of eligible insurers, the state may indicate where such information is available and/or how an insurer can be added to such a list.]

For non-admitted insurers domiciled outside the U.S., a broker may place business with such insurers provided the insurer is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC.

Appendix D – Author Profiles



L. Charles Landgraf

Partner

Charles Landgraf chairs the Legislative and Public Policy Practice Group and also is a member of the Firm's Executive Committee.

Mr. Landgraf is widely considered one of the top insurance lobbyists in Washington. In addition to leadership responsibilities for the legislative practice group, he personally represents a variety of clients in the insurance, energy and real estate industries before Congress and the Administration. As part of his insurance work, Mr. Landgraf has formed several onshore and offshore captives and has obtained amendments to various federal environmental, aviation and maritime statutes for insurer clients in recent years. He regularly practices before the executive branch, including the Departments of Treasury, Commerce, Homeland Security and Transportation, and the Office of Management and Budget.

Regulation of trade in services and international intellectual property law are also areas of concentration for Mr. Landgraf. He assisted in drafting the 1993 Russian insurance law, advised the China Insurance Regulatory Commission in 2000 and 2001, and continues to manage trademark and other intellectual property litigation in a score of international countries for a major Washington, DC-based trade association. Mr. Landgraf, who was the managing partner of LeBoeuf Lamb's London office, has a working knowledge of the Russian and Thai languages.

Representative Matters

- Representative clients include Lloyd's of London, Hannover Re, the Coalition to Insure Against Terrorism, Broadwater Energy LLC, the National Association of Real Estate Investment Trusts, World Trade Center Properties, LLC, The Real Estate Roundtable, the International Group of P&I Clubs, Montpelier Re, Partner Re, United States Aircraft Insurance Group, Associated Electric & Gas Insurance Services Limited, the Distilled Spirits Council of the United States, Green Earth Fuels LLC, the Independent Insurance Agents and Brokers of America, the New York State (Electric) Reliability Council, and the International Underwriting Association of London;
- Mr. Landgraf played a key role in the development and passage of the Terrorism Risk Insurance Act of 2002 (TRIA) and the successful efforts to renew the TRIA program in 2005 and 2007;

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Industries

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Insurance Industry

- He is similarly active in the current debate on federal reform of state-based insurance regulation, including playing a key role in development of the Nonadmitted and Reinsurance Reform Act of 2007;
- Mr. Landgraf has developed innovative solutions for insurance industry problems, including the formation of Policyholders Benefit Corporation, jointly financed by the nation's private mortgage insurers (PMI), to assume defaulted insurance obligations when the then-largest PMI insurer was put into liquidation during the S&L crisis;
- During the current 110th and prior Congresses, Mr. Landgraf has also represented a variety of energy interests in successful legislative strategies relating to electric power transmission and supply, liquefied natural gas project development, nuclear power and renewable energy regulatory and tax policy; and
- His recent pro bono activities include formation of charities responding to the 2004 Southeast Asian tsunami, contractual and liability insurance arrangements for community services in the post-Katrina Renaissance Village in Baton Rouge, Louisiana, and creation of the Dek Thai Foundation.

Selected Activities

- Vice president and director, US-Thailand Amity for Charity, 2005 – present
- Director and secretary, International Insurance Foundation, 2000 – present
- Staff member, National Commission on Superfund, 1992 – 1994

Conference Engagements

- Keynote Speaker, "Insurance Regulatory Update," CPE Conference, Society of Insurance Financial Management, New York (June 2, 2011)
- Speaker, "The Dodd-Frank Act – Seven Months Later," Association of Insurance and Reinsurance & Run-Off Companies Membership Meeting, New York (March 3, 2011)
- Speaker, "Impact of the Volcker Rule on Bank-Owned Life Insurance," PLI Securities Products of Insurance Companies in the Face of Regulatory Reform 2011, New York (January 28, 2011)
- Panelist, "US Financial Reform – Dodd-Frank & Beyond," The M&A Advisor, New York (December 14, 2010)
- Moderator, "Health Insurance and the Affordable Care Act – Key Implementation Challenges," Dewey & LeBoeuf LLP New York (December 9, 2010)

- Speaker, “The Dodd-Frank Act and Other U.S. Reform – How They Will Impact European Insurers,” Dewey & LeBoeuf LLP Annual P&C Deal Conference, London (November 11, 2010)
- Speaker, “State and Federal Regulatory and Legislative Initiatives,” The Life Insurance Council of New York, Inc., Cooperstown, NY (October 6, 2010)
- Keynote Speaker, “The State of the Insurance Industry,” 14th Annual America’s Claims Event, Las Vegas, NV (June 23, 2010)
- Panelist, “Financial Services Regulatory Reform,” Association of Life Insurance Counsel 2010 Annual Meeting, Braselton, GA (May 24, 2010)
- Speaker, “Getting Sanctions Right: Perspectives on the Iran Sanctions Legislation,” The Global Business Dialogue, Inc., Washington, DC (May 12, 2010)
- Speaker, “Hot Topics I: Solvency II, Federal Issues & Financial Guaranty Insurance,” Current Issues in Insurance Regulation 2010 co-sponsored with ABA/TIPS Insurance Regulation Committee & The Insurance Federation of New York, Inc., New York City (April 16, 2010)
- Moderator, “Climate Change, Understanding the Legal Issues,” American Bar Association, Section of Public Utility, Communications and Transportation Law, Washington, DC (March 15, 2010)
- Webcast panel participant, “Credit crisis and the insurance industry,” presented by Ernst & Young (November 24, 2008)
- Speaker, The Twentieth Annual Executive Conference for the Property-Casualty Industry, presented by National Underwriter, New York (November 20-21, 2008)
- Speaker, The Nineteenth Annual Executive Conference for the Life Insurance Industry, presented by National Underwriter, New York (November 13-14, 2008)
- Speaker, “Making the Economy Safe for Cross-Border Reinsurance,” International insurance Foundation’s Annual Symposium, Washington, DC (November 7, 2008)
- Panel participant, “Insurance and Financial Services Regulation: The New Reality,” Legislative Planning Conference, Chicago (October 14, 2008)

Awards and Recognitions

- Named one of the top ten insurance lobbyists in Washington, DC, by *The Hill*, the leading newspaper for and about Capitol Hill (July 2004).

Education

- New York University School of Law, 1978, J.D.
- Rice University, 1975, B.A.

Languages

- Thai

Bar Admissions

- District of Columbia



John S. Pruitt

Partner

John Pruitt has been with the firm for more than 20 years and is co-chair of the Insurance Regulatory Department. Mr. Pruitt has wide-ranging experience in the field of insurance regulation and in corporate transactions involving insurance companies. His experience includes insurance company acquisitions and restructurings, formation and licensing of insurance companies and producers, advice and assistance on insurance Holding Company Act compliance (including multistate Form A filings), purchases and sales of specific blocks of business, insurance insolvency proceedings, formation and licensing of managing general agencies and negotiation of agency agreements, and general advice on compliance with insurance laws and regulations.

In addition, Mr. Pruitt has been extensively involved over the years in the review, negotiation, and drafting of reinsurance agreements and has advised clients and drafted documentation in connection with structured insurance programs. Mr. Pruitt has also advised and assisted clients with the drafting of various commercial property and casualty policy forms, including general liability, directors and officers liability, professional errors and omissions, and property forms.

In recent years, Mr. Pruitt has been actively involved in internal investigations and regulatory enforcement actions relating to a variety of matters, including relating to broker compensation practices, finite risk insurance and reinsurance and sales and marketing practices.

Publications

- Co-author, "Country Q&A: Insurance and Reinsurance in the United States," *PLC Cross-border Insurance and Reinsurance Handbook 2011*.
- Co-author, "Country Q&A: Insurance and Reinsurance in the United States," *PLC Cross-border Insurance and Reinsurance Handbook 2010*.

Education

- Cornell Law School, 1987, J.D.
- Hamilton College, 1984, B.A., *magna cum laude*

Bar Admissions

- New Jersey
- New York



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Expertise

Contracts
Insurance Law
Torts

Tom Baker

Deputy Dean and William Maul Measey Professor of Law and Health Sciences

Tom Baker, a preeminent scholar in insurance law, explores insurance, risk, and responsibility using methods and perspectives drawn from economics, sociology, psychology, and history. He is author of *The Medical Malpractice Myth* (Chicago, 2005), in which he attacks misperceptions behind the tort reform movement and proposes an evidence-based approach to medical liability reform. His latest book, *Ensuring Corporate Misconduct* (Chicago 2010), coauthored with Sean Griffith, examines relationships among directors' and officers' liability insurance, corporate governance, and securities litigation. His latest article, *Health Insurance, Risk, and Responsibility after the Affordable Care Act* (Pennsylvania Law Review 2011), describes the new U.S. health care social contract as embodying a fair share approach to paying for the cost of health care and a responsibility to be as healthy as you can.

His current research seeks to use insights from behavioral economics to improve health insurance regulation. He is the Reporter for the American Law Institute's Principles of Liability Insurance Project and is active in the Law and Society Association.

Representative Professional Positions

- Penn Law - Deputy Dean (2010-); William Maul Measey Professor of Law and Health Sciences (2009-); Professor (2008-09)
- University of Connecticut – Connecticut Mutual Professor of Law and Director, Insurance Law Center (1997-08)
- Visiting Professor – Vanderbilt, Columbia, Hebrew University of Jerusalem
- University of Miami – Associate Professor (1992-97)
- Law Clerk to the Hon. Juan Torruella, U.S. Court of Appeals for the First Circuit (1986-87)

Representative Publications

- Keynote Speaker, "Insurance Regulatory Update," CPE Conference, Society of Insurance Financial Management, New York (June 2, 2011)
- The Law and Economics of Liability Insurance: A Theoretical and Empirical Review, in HANDBOOK ON THE ECONOMICS OF TORTS (Jennifer Arlen, ed.) (forthcoming)

- Transparency through Insurance: Mandates Dominate Discretion, in *TRANSPARENCY IN THE CIVIL JUSTICE SYSTEM* (Joseph Doherty & Robert T. Reville eds.). (forthcoming 2011)
- *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*, __ U. PA. L. REV. __ (forthcoming)
- *ENSURING CORPORATE MISCONDUCT: HOW LIABILITY INSURANCE UNDERMINES SHAREHOLDER LITIGATION* (University of Chicago Press, 2010) (with Sean Griffith)
- Insurance in Sociolegal Research, 6 ANN. REV. L. & SOC. SCI. 433 (2010).
- Liability Risks for After Hours Use of Public School Property to Reduce Obesity: A 50 State Survey, 80 J. SCH. HEALTH 508 (2010) (with Hania Masud).
- Allowing Patients to Waive the Right to Sue for Malpractice: A Response to Thaler and Sunstein 104 Nw. U. L. REV. 233 (2010) (with Timothy Lytton).
- Tontines for the Invincibles: Enticing Low Risks Into the Health-Insurance Pool With an Idea From Insurance History and Behavioral Economics, 2010 WIS. L. REV. 79 (with Peter Siegelman).
- *Bonded Import Safety Warranties*, in *IMPORT SAFETY: REGULATORY GOVERNANCE IN THE GLOBAL ECONOMY* (Cary Coglianese, Adam Finkel & David Zaring, eds., Univ. Pa. Press, 2009).
- *International Association of Insurance Supervisors*, in *HANDBOOK OF TRANSNATIONAL ECONOMIC GOVERNANCE REGIMES* (Christian Tietje and Alan Brouder, eds., 2009) (with Eryn Mathews)
- *Government as Risk Manager*, in *PRINCIPLES OF REGULATION* (John Cisternino & David Moss, eds., Tobin Project, 2009) (with David Moss)
- *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*, 76 J. RISK & INS. 197 (2009) (with Patricia Born and Kip Viscusi)
- *Liability Insurance at the Tort-Crime Boundary*, in *FAULT LINES: TORT LAW AND CULTURAL PRACTICE*, (David M. Engel and Michael McCann, eds., Stanford Univ. Press 2009)
- *How the Merits Matter: D&O Insurance and Securities Settlements*, 157 U. PA. L. REV. 755 (2009) (with Sean Griffith)
- *Insurance Law and Policy: Cases, Materials and Problems* (Aspen Publishing 2003; 2d ed. 2008)
- *Liability Insurance, Moral Luck, and Auto Accidents*, 9 THEORETICAL INQUIRIES IN L. 165 (2008)

- *Embracing Risk, Sharing Responsibility* (Symposium: Risk and Responsibility in the Twenty-First Century), 56 DRAKE L. REV. 561 (2008)
- *The Medical Malpractice Myth* (University of Chicago Press 2005) (paperback 2007)
- *The Missing Monitor in Corporate Governance: The Directors' and Officers' Liability Insurer*, 95 GEO. L.J. 1795 (2007) (with Sean Griffith)
- *Predicting Corporate Governance Risk: Evidence from the Directors' and Officers' Liability Insurance Market*, 74 CHI. L. REV. 487 (2007) (with Sean Griffith)
- *Offer of Judgment Rules and Civil Litigation: An Empirical Study of Automobile Insurance Litigation in the East*, 59 VAND. L. REV. 155 (2006) (with Albert Yoon)
- *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETHICS 501 (2005)
- *Liability Insurance as Tort Regulation: Six Ways that Liability Insurance Shapes Tort Law in Action*, 12 CONN. INS. L.J. 1 (2005)
- *The Virtues of Uncertainty in Law: An Experimental Approach*, 89 IOWA L. REV. 443 (2004) (with Alon Harel and Tamar Kugler)
- *Embracing Risk: The Changing Culture of Insurance and Responsibility* (Contributing Editor, With Jonathan Simon, University Of Chicago Press 2002)

Current Working Papers

- *The Shifting Terrain of Risk and Uncertainty on the Liability Insurance Field* (SSRN: 2011) (forthcoming)
- *Jackpot Justice and the American Tort System: Thinking Beyond Junk Science* (with Herbert M. Kritzer and Neil Vidmar) (SSRN: 2008)
- *Insurance Against Misinformation in the Securities Market* (SSRN: 2007)

Honors and Awards

- Appointed Connecticut Mutual Professor of Law (September 1997)
- Elected to American Law Institute (October 2000)
- 29th Annual Lecture of the Geneva Association (September 2003)
- University of Connecticut Provost's Research Fellowship Leave (Spring 2005)
- Appointed William Maul Measey Professor of Law and Health Sciences (July 2009)
- Hawley Lecture at Iowa College of Law (August 2010).

Education

- Harvard Law School, Magna Cum Laude, 1986, J.D.
- Harvard College, Magna Cum Laude, 1982, B.A. in Sociology

Bar Admissions

- District of Columbia (inactive)
- Commonwealth of Massachusetts (inactive)
- Commonwealth of Pennsylvania

