Consumer Ramifications of an Optional Federal Charter for Life Insurers

A Report by the University of Massachusetts Isenberg School of Management

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Executive Summary

The University of Massachusetts Isenberg School of Management has completed its comprehensive study of the consumer ramifications of an optional federal charter for life insurers. This research was supported by unrestricted grants from life insurers and the ACLI. The nearly year long study included surveys disseminated to state insurance commissions, federal bank regulators, and insurers; field visits to state and federal regulators; and extensive interviews with consumer groups, academics, government officials and industry representatives.

We conclude that the NAIC and state insurance commissions are led and staffed by highly qualified professionals who are committed to protecting consumers through vigorous financial and market conduct regulation. However, our research also suggests that the current multi-state system is structurally resistant to needed reforms, even in the face of broad consensus that greater uniformity and centralization is needed in the oversight of life insurance products.

Because of the NAIC's lack of legal authority over individual commissions, it lacks leverage to force agreement on uniform standards. Even if agreement could be reached, it would be up to individual state legislatures to adopt model legislation, which they seem unlikely to do, at least without also adopting their own modifications. The NAIC's proposed Interstate Compact has the potential to circumvent some of the bureaucratic impediments to uniformity in product approval standards; however, while this innovative proposal has been making progress, it's fate is uncertain.

As a consequence, this report concludes that federal action is necessary to prompt needed improvements in the regulation of life insurance. Properly structured federal regulation of insurance patterned after the dual banking system could provide significant benefits to consumers.

- Survey data suggest that multiple state reviews of product filings are cumbersome and inefficient. High workloads – 208 per staff person per year --combined with limited resources in small states raise concerns about the quality of product filing reviews. A federal regulator could provide for a single point of review, easing costs associated with new product development and providing greater resources to hire expert staff to review policy forms.
- Many individual states have made great progress in streamlining product review. However, the average *cumulative* amount of time insurers report for securing product approvals from states is significant: 6 to 9 months to secure major approvals from the five largest states in which they do business. Difficulties and time delays in securing form filing approvals inhibits the ability of life insurers to modify products in response to consumer demand and impairs competition with banks and securities firms which do not have to undergo advance merit review of permitted product offerings.

- Survey data indicate that significant progress has been made in shortening the non-resident producer licensing process. However, this has largely been achieved through reciprocity arrangements, instead of development of national, uniform standards. Insurance commission survey data indicate extremely high caseloads for staff assigned to review producer licensing applications – 1,284 new applications per staff per year -- suggesting that such applications may be receiving only cursory review. These issues are particularly problematic given the fact that producer misconduct generates the largest volume of complaints. Through centralized processing, uniform standards, and greater staff resources, a federal regulator would be in better position to review producer applications and conduct multi-state background checks against national databases.
- Survey data also indicate significant delays in multi-state company licensing, further inhibiting the ability of smaller companies to expand operations to the benefit of larger companies with pre-established multi-state infrastructures. A federal regulator could promote competition by making it easier for smaller companies to expand. Survey data indicate that under the current system, regulatory costs are proportionately higher for small insurers.
- Regulatory costs could be reduced through centralization, though dollar savings for individual policyholders would be insignificant. However, consumers would benefit if savings were used to enhance "back-end functions," including more frequent, periodic solvency and market conduct exams along the lines of bank regulation. Industry survey data show that insurers now spend 65% of their regulatory dollars on "front-end" regulation presumably due to the need to deal with multiple jurisdictions in company and producer licensing and product filings.

Dual Chartering of life insurers would not lead to a "race to the bottom." The ability to switch between federal and state charters is seldom used among banks and we were unable to find any instance of a bank switching charters to avoid regulatory requirements. If anything, state/federal competition has contributed to efficiency and served as a check *against* lax regulation by either system. However, to assure against regulatory arbitrage, time limits could be placed on the ability of insurers to switch between charters.

Any preemption of consumer laws should be coupled with the enactment of strong federal standards. Areas that should be addressed through strong national standards include: the small face life market, suitability, rate of return disclosures, reporting requirements, credit scoring, and single premium credit life insurance. Federal standards should "raise the bar" to the benefit of consumers.

In the Near Term, Elimination of Prior Approval Requirements For Many Products Should not be Undertaken: Prior approval requirements should be retained, pending development of strong federal standards to improve disclosure, policy simplification and institute more frequent, routine financial and market conduct exams as is done with bank oversight. Elimination of prior approval may be justified for term life, high-end products, or variable annuities registered with the SEC.

Dual chartering could strengthen the state insurance system. Competition between federal and state bank regulators has made both systems stronger, more efficient regulators. Optional federal chartering for insurance, combined with state retention of premium taxes, would reduce state insurance commission workloads while preserving an importance source of funding for regulation.

A federal regulator could achieve better integration of life insurance in the development of federal policies. Federal officials expressed interest in expanding availability of annuity products and long-term care coverage to middle income Americans. Key issues were the transparency of such products, competitive pricing, and integrity of solvency oversight. A federal regulator may be better equipped to work with federal policy makers on these issues, than multiple state regulators.

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I. INTRODUCTION

In the spring of 2003, the University of Massachusetts Isenberg School of Management initiated a comprehensive research study on the consumer ramifications of an optional federal charter (OFC) for life insurers. This study was prompted by growing interest and support for legislation creating a "dual chartering" system for insurance companies along the lines of that which has long existed for the banking industry. Insurance is the only sector of the financial services industry not subject to federal regulation, a fact that has led to competitive disparities between life insurers and federally regulated banks and securities firms that offer products serving similar needs. Most major life insurers have embraced optional federal regulation as a means to promote a more "level playing field," improve efficiency through creation of uniform regulatory standards and enhance their ability to bring products to market more quickly. Many small insurers have also expressed interest in an OFC as a less expensive means to expand their operations to multiple states. Though most life insurers and their trade groups have come to embrace federal regulation as in their competitive interests, the School of Management undertook to separately consider the impact this change in regulatory structure would have on consumers.

The project was launched in the summer of 2003 and consisted of the following components:

- A survey of the life insurance industry covering areas such as regulatory costs and allocations of cost, solvency and market conduct examinations, product approval processes and variations, complaint handling, and competitive impact of the multi-state system;

- Surveys and questionnaires submitted to the state insurance commissions, the NAIC, and federal bank regulators covering such areas as examination processes, complaint handling, budget and resource allocations, and as applicable, licensing and product approval processing;

- On-site visits to the NAIC and state insurance commissions;[2]

- A review of extant literature on the issue of optional federal chartering for insurers, as well as the history of insurance and banking regulation and previous proposals to establish a federal presence over insurance regulation;

- Extensive interviews with regulators, consumer representatives, industry officials, federal policy makers and academics.

[2] The state insurance departments in Florida, Iowa, New York, New Jersey, and Texas were visited by our project team, in addition to the NAIC's offices in Kansas City. Several conference calls were also held with the insurance department in California. However, the diverse locations of its offices throughout the state made an on-site visit impractical.

We did not undertake a consumer survey because we felt it unlikely that most consumers could provide meaningful input on an issue as arcane as regulatory structure. However, we did seek to interview consumer advocacy groups with expertise in life insurance and federal/state financial regulatory structures. A list of consumer groups contacted for this report is included in the Appendix, and we have sought to include their input and perspective throughout our discussion and analysis.

Based on the information gathered, we hope we have provided some insight as to the consequences for consumers of an optional federal insurance regulator – using bank regulation as our structural model. In conducting this analysis, we have made no assumptions as to whether the creation of a federal regulator would lead to greater deregulation of the insurance industry. On the contrary, our analysis has led to the conclusion that in several areas, such as examinations, an insurance regulator patterned after federal bank regulators would provide more extensive oversight and requirements. We also conclude that in the short term, there should be no wholesale conversion to so-called "file and use" without compensating improvements in disclosure and form simplification and market conduct supervision. This report is not about deregulation, but about the potential design and ramifications of a *structural* change enabling insurers to convert from a multiple to a single regulator with a national as opposed to a state-based venue.

A. The Debate Over Optional Federal Chartering[3]

In February 2000, The American Bankers Insurance Association (ABIA) became the first industry trade group to call for an optional federal charter for insurance. The American Council of Life Insurers followed them in 2001, demonstrating remarkable agreement between two trade associations who have historically been fierce rivals.[4] A number of other trade groups representing both the life and P&C industries have since endorsed optional federal chartering. These include the American Insurance Association, the Financial Services Coordinating Council, the Financial Services Roundtable, the Council of Insurance Agents + Brokers, and most recently, the National Association of Insurance and Financial Advisors. Market based grassroots organizations, such as the Citizens for a Sound Economy, have also embraced optional federal chartering as a means to promote competition and improve regulatory efficiency, which they believe will result in lower costs to consumers. Several bills have been introduced in Congress, which are summarized in the Appendix.

Industry supporters have modeled their calls for federal regulation after the dual chartering structure long in place for banks. They believe the existence of an optional

[3] An excellent compilation of articles pro and con surrounding the OFC debate can be found Peter J. Wallison, ed., (2000) *Optional Federal Chartering and Regulation of Insurance Companies.* Washington, D.C.:The AEI Press. Congressman Richard Baker (R LA) has also held a comprehensive series of hearings on this issue which can be accessed on the House Financial Services Committee website at http://financialservices.house.gov/.

[4] While the ACLI supports an OFC, it also strongly supports state-based modernization reforms and gives equal attention to state-based initiatives, the so-called "dual track" approach.

national charter for banks has been instrumental in fostering competition, regulatory efficiency and product expansion in the banking sector. They argue that for large insurers, the need to deal with multiple state regulators and differing product approval standards unnecessarily raises costs for their policyholders and puts them at a competitive disadvantage to other, federally regulated financial service providers. They also argue that the need to deal with myriad state regulatory agencies – particularly with regard to licensing and product approval – creates barriers to entry for small, growing domestic insurers.

In addition, they feel that the need to secure approval from multiple jurisdictions impedes innovation and inhibits consumer product choice. Consumers are further disadvantaged by the lack of uniform consumer protections from state to state – a particular problem for life products in our mobile society - and the difficulty of understanding and comparing policies because of varying state requirements. Finally, industry has argued that they have been disadvantaged in the development of federal policies and international trade negotiations. Because they lack a federal regulator, they do not have a seat at the table in these policy discussions. [5]

Defenders of the current state system include the National Association of Insurance Commissioners (NAIC), individual state regulators, some major property and casualty insurers and trade groups such as the National Association of Mutual Insurance Companies (NAMIC), the National Association of Independent Insurers (NAII) and the Alliance of American Insurers (AAI), and some insurance agent groups, such as the Independent Insurance Agents and Brokers of America. Traditional consumer groups, led by the Consumer Federation of America, also adamantly oppose *optional* federal chartering, though, as discussed below, they have left the door open to a mandatory federal regulator. Opponents of the OFC argue that effective consumer protection relies on knowledge of local and regional needs. They believe that a federal regulator would create confusion among consumers because they would not know where to lodge complaints. In addition, a remote federal regulator would not be as responsive to consumer complaints as a state official.

Opponents have also charged that competition between state and federal regulators would create a "race to the bottom" with regulators competing with each other over who could write the most industry friendly rules. They believe that a federal regime would have the upper hand in such competition, leading to the ultimate demise of the state system. They feel that preserving the state system is important as a laboratory for regulatory innovation. Successful state innovations can spread to other jurisdictions and bad policies can be contained; a bad decision by a federal regulator, however, is felt nationwide. Finally, an OFC for insurers would require creation of a costly new federal bureaucracy and that a better, cheaper approach is to support NAIC efforts to streamline the state system.[6]

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[5] Ibid.

[6] The New York State Insurance Department provided a highly eloquent defense of the current system in response to our survey of state insurance regulators (summarized in Section III). "[C]osts and bureaucracy will increase under a federal framework. There is no evidence that a federal insurance regulator is going to

Many traditional consumer groups are frustrated by what they believe to be insufficient commitment on the part of state insurance commissions and legislators to consumer protections. They believe that consumers could benefit from high quality national standards. At the same time, they are strongly opposed to industry proposals for optional federal chartering, believing that the ability to switch back and forth between state and federal regimes will give industry leverage to force regulators to lower their standards. Some have viewed favorably legislation introduced by Senator Fritz Hollings (D. SC) which would adopt a unitary federal regulatory system for interstate insurers, leaving states to regulate intrastate insurers. [7] At the same time, while they can see benefit in high quality national standards, some are skeptical of the ability of a federal regulator to be as responsive to the interests of consumers as a state-based regulator.[8]

B. Why "Life Only"?

This study was limited to life insurers, and the four product lines of basic life, disability income (DI), annuities and long term care (LTC)[9]. This report makes no conclusions about the ramifications of optional federal chartering for other types of insurers. We should note that life insurers have been working closely with their counterparts in the property and casualty (P&C) industry on OFC legislation and that many similar issues have been raised in the P&C industry about perceived inefficiencies in the current system.

Given the breadth of the issues associated with an OFC, we decided to limit our research to the life sector. This decision was based on a number of factors.

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depart from the tradition of creating an expensive and inefficient government program. Also, each state has its own unique tort laws that significantly affect insurance. Federally licensed insurers would have to tailor products to accommodate each state's tort laws. Not doing so would significantly hamper gaining efficiencies from a federal system.

The cost to consumers will inevitably rise as well. Currently, states derive significant income from premium taxes, which exceed the cost of regulation. The cost of a new layer of federal regulation must be accounted for somehow. The necessary funds must either come directly from the federal budget, or from fees assessed to insurers. Since taxes and fees must be passed on to consumers, they will have to pay for two regulatory systems, unless the states forego premium tax revenue. Considering the current condition of most state budgets, it is hard to imagine that they would do so voluntarily. Also, given the fact that globalization is squarely upon us, it is difficult to see why giving the industry a choice of a federal or state charter supports the insurance industry's need to compete internationally..."

[7] Testimony of Bob Hunter, "State of Insurance Regulation" before the Senate Committee on Commerce, Science and Transportation (Oct. 22, 2003). Interview with Birnie Birnbaum, Consulting Economist, Center for Economic Justice. (December 11, 2003) Mr. Birnbaum is an uncompensated NAIC Consumer Liaison.

[8] Interview with Prof. Mila Kofman, Assistant Research Professor, Georgetown University (March 18, 2004) Prof. Kofman is a funded NAIC Consumer Liaison Committee and expressed skepticism over the benefits of federal regulation. Bonnie Burns, Training and Policy Specialist with the California Health Advocates in California, also a funded NAIC Consumer Liaison, opposes federal regulation.

[9] References to "life products" in this report include products in these four categories.

First, life insurers offer products that are highly similar in economic function to products offered by banks and securities firms, which are federally regulated. Thus the lack of federal regulation presents a more acute "level playing field" problem for life insurers than it does for other insurance sectors.

Second, rate deregulation has been closely tied to optional federal chartering for P&C insurers. Consumer issues associated with rate deregulation – while meriting study -- are highly complex and beyond the scope and available resources for this project. Basic life and annuity products are, for the most part, not subject to rate regulation under the current state system, and there appears to be broad support for preserving rate regulation for disability income and long-term care products, as well as products where there is the potential for customer abuse, such as credit insurance.

Finally, life insurance products are integrally related to the well-defined federal interest in retirement income policy, a public policy issue of increasing importance and urgency. To the extent federal regulation of life insurance could promote expanded availability of defined benefits plans or long-term care insurance, it may deserve priority consideration.

"The case for an optional federal charter for life insurers is stronger on several dimensions," acknowledges Dr. Scott Harrington, who has authored several articles critical of an OFC for insurance companies.[10]

[10] Dr. Harrington is the W. Frank Hipp Professor of Insurance at the University of South Carolina's Moore School of Business. He was recently appointed as a funded NAIC Consumer Liaison.

II. ISSUES REGARDING STATE REGULATION OF INSURANCE

A. The History of Insurance Regulation[11]

The Commerce Clause of the United States Constitution explicitly authorizes the federal government to regulate "interstate commerce." The 10th Amendment to the Constitution states that all powers not delegated to the federal government are reserved to the states. Until the mid 20th century, federal regulation of insurance was precluded under Paul v Virginia, 231 U.S. 495 (1869), a case which involved a challenge to Virginia's licensing requirements by an out-of-state agent. In that case, the Supreme Court upheld the Virginia law, finding that insurance was not "interstate commerce," and thus the states, not the federal government, had the power to regulate it. During the 75 years following Paul, the insurance industry grew and developed under exclusive state oversight. The industry came to accept state regulation, and the state-based system became well entrenched.

In the early 1900's, the insurance industry was subjected to several state investigations of corruption and abuse. The most prominent of these was the New York Legislative Insurance Investigation Committee, named the "Armstrong Committee" after its chairman. Abuses uncovered by the Armstrong Committee included interlocking directorates, use of subsidiaries to evade investment restrictions, proxy voting to impede policyholder control of mutuals, and "twisting" by agents.[12] As a result of this investigation, the New York legislature passed a number of reforms that spurred enactment of similar laws in other states. Among the most significant of the Armstrong Committee reforms were restrictions on stock purchases, the encouragement of mutual companies and restrictions on demutalization, corporate governance reforms, policy standardization, and limitations on agent's commissions.

Complaints of price fixing among fire insurance companies in the early 1940's threatened the stability of the state structure. In 1942, responding to a request from the Missouri attorney general, the U.S. Justice Department launched an antitrust investigation of a large ratings bureau known as the South-Eastern Underwriters Association (SEUA). As a result of its investigation, the Department filed suit against SEAU and its member companies, alleging numerous violations of the Sherman Antitrust Act. Though the district court dismissed the case citing Paul, the Supreme Court ultimately reversed, holding that fire insurance transactions across state lines did constitute interstate commerce. In so holding, the Court stated:

> No commercial enterprise of any kind, which conducts its activities across state lines, has been held to be wholly beyond the regulatory power of Congress under

[11] For excellent discussion of the history of insurance regulation see, e.g., Scott Harrington, "The History of Federal Involvement in Insurance Regulation" in Peter J. Wallison, ed., (2000) *Optional Federal Chartering and Regulation of Insurance Companies.* Washington, D.C.:The AEI Press.

[12] "Twisting" refers to the practice whereby agents misrepresent and libel rival insurers to convince policyholders to replace their existing policies with one offered by the agent.

> the Commerce Clause. We cannot make an exception of the business of insurance.[13]

The response to the SEUA decision was strong and immediate. The insurance industry lobbied Congress for legislation to provide them with an exemption from federal antitrust laws. State regulators, led by the NAIC, proposed alternative legislation that provided only a partial exemption from federal law. Under the NAIC proposal, the federal government would not regulate insurance until January 1, 1948, when federal antitrust and fair trade laws would apply "to the extent that such business is not regulated by the states." On December 18, 1944 Senators Pat McCarran and Homer Ferguson introduced the NAIC proposal and the bill was signed into law on March 9, 1945. In short, Congress reaffirmed its right to regulate insurance, but agreed to delegate that right back to the states so long as they adequately regulated the industry.[14] The McCarran-Ferguson Act expressly recognized that insurance was "subject to the laws of the several states which relate to the regulation or taxation of such business" and that no federal law besides the antitrust laws could be construed to "invalidate, impair or supersede" any state law regulating insurance[15].

In the wake of McCarran-Ferguson, most states moved quickly to enhance oversight of ratings bureaus, usually by making property-casualty rates subject to prior regulatory approval. Beginning in the late 1950's, states began to ease rate restrictions, and by the mid-1960's, a significant number had eliminated prior approval requirements. States were slower to adopt unfair trade practices legislation as conditioned by McCarran-Ferguson's exemption from the Federal Trade Commission Act, though eventually all did adopt some form of statute designed to prohibit unfair trade practices. Following FTC studies of the insurance industry in the 1970's, Congress exempted the insurance industry from the FTC's investigative and reporting powers (while preserving the FTC's antitrust authority).

Federal interest in regulating insurance surfaced in the late 1960's, primarily in response to insolvencies by several property-liability insurers specializing in auto-liability insurance for low-income individuals. These insolvencies prompted the NAIC to adopt model legislation for state guaranty funds, and also spurred the first legislative proposal for dual federal and state regulation. Introduced by Senator Edward Brooke (R MA), the Federal Insurance Act would have allowed optional federal chartering of insurers with full preemption of state law[16].

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) that established regulatory requirements for employer-sponsored retirement plans, as well as other benefits such as medical insurance, life and disability insurance. ERISA established reporting requirements for such plans, as well as fiduciary standards for the management of assets used to support employer-sponsored benefits. Congress provided

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[13] United States v South-Eastern Underwriters Association, 322 U.S. 533 (1944).
[14] The McCarran-Ferguson Act 15 USC, 1945
[15] Ibid.
[16] S. 3884, Federal Insurance Act (introduced Oct. 1976)

that ERISA's substantive requirements would supersede any otherwise applicable state insurance regulations. Administered by the Department of Labor and enforced through the Internal Revenue Code, ERISA has had a significant impact on the design of employee group insurance programs.

Federal interest in insurance regulation picked up again from the mid-1980's to the early 1990's in response to several more major insurance company bankruptcies, among property-casualty, life and health insurers. Life insurer insolvencies, including that of the "infamous" Executive Life, were primarily attributable to losses in high-risk investments such as junk bonds, combined with substantial cash withdrawals by policyholders who had become concerned about the safety of their funds. Congressional interest was particularly trained on the effectiveness of state solvency regulation, as expressed in a scathing report issued in 1990 "Failed Promises: Insurance Company Insolvencies." Issued by the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, and known as the "Dingell Report" after its principal author, Committee Chairman John Dingell (D MI), the report found "the present system for regulating the solvency of insurance companies is seriously deficient."[17] Building on the report's findings, Chairman Dingell introduced legislation to create a dual federal/state system for solvency regulation, which would have also created a federal guaranty fund for nationally certified insurers. Momentum for such legislation subsided as the NAIC and states acted quickly to make needed improvements in solvency regulation. Among the most important of the NAIC's initiatives were the adoption of risk-based capital requirements, following the example of banking regulation, a financial regulation accreditation program, and an initiative to codify statutory accounting principles.

In the late 1990's, the issue of federal regulation surfaced yet again, but this time, was driven by insurance industry concerns over cost inefficiencies and delays arising from the multi-state structure, rather than any weaknesses in oversight. Thus, while previous efforts at federal regulation of insurance had been resisted by the industry, insurers began to lead the charge.

Though Congress has so far declined to create a federal insurance regulator, it has made its presence increasingly felt in areas where it has found a need for national policy. In these instances, the Congress has relied on the NAIC and its members to provide resources and expertise. For instance, the Gramm-Leach-Bliley Act (GLBA) contained a number of provisions related to insurance. Most significantly, it provided clear authority for banks to affiliate with insurance companies through a financial holding company, while preserving functional regulation of insurance by states. It also mandated that states achieve uniformity or reciprocity in producer licensing by a certain date or confront federal intervention. GLBA further imposed the same customer privacy protections on insurers that it did on federally regulated financial institutions. In the aftermath of the September 11 terrorist attacks, Congress extended the anti-terrorist financing provisions of the USA PATRIOT Act to insurers.

[17] U.S. House. (1990) "Failed Promises: Insurance Company Insolvencies." Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce (Dingell Report)

Thus, in the years since the SEUA decision, the federal government has repeatedly involved itself in insurance regulation.[18] The prospect of federal regulatory intervention has on more than one occasion served as a prod to state action, particularly in the area of solvency regulation. With the 1974 enactment of ERISA, and more recently, the GLBA, and USA PATRIOT Act, the federal government has dictated its own requirements on insurers in specific areas[19]. However, in the case of GLBA and the USA Patriot Act, it has looked to the NAIC and state insurance commissions to implement and enforce those requirements. Insurance may already be on the slippery slope to federal oversight. But the question remains, how far and how fast Congress will act. As Assistant Secretary of the Treasury Wayne Abernathy has stated, "Federal regulation of insurance may be an issue whose time is coming, but it has not yet come." [20] House Financial Services Committee Chairman Mike Oxley (R OH) recently dealt a blow to advocates of federal insurance regulation by expressing his opposition to both an optional chartering approach, as well as a mandatory system. He instead plans to develop legislation to prompt targeted reforms under the state-based system.[21]

B. The Current System[22]

Each state has a commissioner of insurance[23] that is responsible for the regulation of insurance. In most states, this official is appointed by the governor and serves in the Executive branch of the state government. The commissioner is responsible for administering state insurance laws, promulgating regulations, and supervising the business of insurance. Each of the nation's 55 insurance commissioners belongs to the National Association of Insurance Commissioners (NAIC). Founded in 1871, the NAIC is a non-profit trade association that is the primary vehicle by which the state insurance commissions exchange information and coordinate regulatory activities. Though it has no legal power over insurance regulation, its recommendations for policy and legislation generally carry great weight with its membership. However, its recommended models for legislation can and are frequently subject to change when adopted by individual state legislatures.

Insurance regulation can be generally divided into two broad categories. *Financial* or s*olvency regulation* is aimed primarily at preventing insurer insolvencies and mitigating consumer losses should insolvencies occur. M*arket regulation* focuses on insurer

[18] This section discusses the history of insurance regulation as is relevant to life insurance. In the property and casualty sector, Congress has enacted a number of other discrete federal programs in areas such as crop, flood, and riot insurance and most recently, terrorism, with the enactment of the Terrorism Risk Insurance Act (TRIA).
[19] Employee Retirement Income Security Act of 1974 (ERISA)
[20] Interview with Wayne Abernathy (December 9, 2003)
[21] Power Point Presentation of Rep. Mike Oxley "State-Based Insurance Regulatory Concepts", Address to the NAIC (March 16, 2004).
[22] For good descriptions of state regulation see Vaughan (2003); Robert W. Klein. (1999) *A Regulator's Introduction to the Insurance Industry.* National Association of Insurance Commissioners Educational and Research Foundation; and George E. Rejda. (2001) *Principles of Risk Management and Insurance. Seventh Edition.* Boston: Addison, Wesley, Longman.
[23] Titles vary by state. In some states, this official may be called a "director of insurance" or "superintendent of insurance."

practices, independent of solvency concerns, which might be detrimental to policyholders, such as deceptive advertising, unfair policy terms, or discriminatory treatment.

Examples of financial regulation include financial reporting, risk-based capital rules, solvency examinations and the regulation of reserves and investments. Examples of market conduct regulation include unfair trade practice laws and regulations, consumer assistance, and privacy rules. Some regulatory functions relate to both. For instance, company licensing will generally focus on the financial stability and capitalization of the applicant company, though review will also be made of the company's management and organizers for any past record of customer abuse or unfair dealing. Similarly, review of policy forms will focus on customer fairness, though in some cases, review can also be made of the pricing to make sure the insurer is not making commitments that could threaten its solvency.

Certain aspects of financial regulation have already become highly uniform as a result of the leadership of the NAIC. In 1990, the NAIC created its Financial Regulation Standards Accreditation Program, which sets standards for a system of solvency regulation and provides for NAIC certification of states that meet the requirements of the program. By most accounts, the NAIC Accreditation Program has made great progress in enhancing the quality of solvency oversight and promoting uniformity with regard to examinations, reporting, risk-based capital, reserve valuation and liquidations. Before receiving accreditation from the NAIC, states must adopt a number of model rules and laws affecting regulation of insurance holding companies, managing general agents, reinsurance intermediaries, credit for reinsurance, examination processes and liquidations.[24]

State insolvency regulation is buttressed by the NAIC's Financial Regulatory Services Division (FRSD) to monitor the financial performance of "nationally significant companies." This Division reports potential problems to the Financial Analysis Working Group (FAWG), which conducts peer review and queries the domiciliary regulator about the financial condition of the insurer and regulatory actions that have been taken. While FAWG is focused on the largest insurers, the NAIC's Analyst Team Survey (ATS) reviews data on all companies. The NAIC also plays a central role in analyzing financial data, by maintaining a financial database and scoring companies under its Financial Analysis Solvency Tracking System (FAST) to help states prioritize company for further review.

[24] An important component of the current system's solvency regulation is the existence in each state of an insolvency guaranty mechanism. These are designed to compensate members of the public who suffer loss because of the insolvency of an insurance company. Guaranty mechanisms have not been included in this report's analysis of the impact of an OFC. All proposals for an OFC contemplate that insurers would continue to participate in state guaranty mechanisms, regardless of whether they are state or federally chartered, though some proposals also provide for a federal guaranty mechanism as an alternative to state systems that do not meet minimum federal standards. The issue of insurance guaranty mechanisms in the context of federal regulation may warrant further study, including the budgetary consequences and contingent taxpayer exposure from a federal insurance guaranty.

The NAIC has been less successful in achieving uniformity in other areas. For instance, in the area of company licensing, insurance companies must receive a license from each state in which they plan to do business. The licensing standards can vary significantly from state to state and companies seeking licenses in multiple states must ascertain and comply with each of their requirements. Before licensing a company, the insurer must have a certain amount of capital or surplus, which can be relatively small in some states and quite substantial in others. The insurance commissioner will also review the fitness and competency of the company's management and board of directors, in addition to its business plan, product lines, and market conduct.

Another area where standards vary widely from state to state is the process for reviewing and approving policy forms. In most states, insurance products must be approved in advance before they can be brought to market. Prior approval requirements are based on the complexity, and technical nature of insurance contracts, making them difficult to understand by the average consumer. States differ significantly in their standards for review and approval. In some states, certain products are only subject to "file and use" requirements, meaning that they can be marketed upon filing. In most states however, prior approval requirements are the standard.

The market conduct examination process also lacks uniform standards. Some states such as California, perform in depth, standardized examinations on a routine basis, while others perform few, if any such examinations. As a result, some companies will receive multiple examinations from many different states in a given year, and others will receive none over an extended multi-year period.

Finally, agent or "producer" licensing can be subject to divergent state requirements. All states require a license from those who wish to sell insurance within their borders. The licensing process will typically require passing an examination, as well as background checks and in some states, fingerprinting. The multi-state licensing of insurance producers has been streamlined in recent years through reciprocity arrangements and greater utilization of the NAIC's National Insurance Producer Registry, electronic appointments and terminations. Less progress, however, has been made in achieving greater uniformity in the licensing standards applied by each state. A key obstacle to uniform treatment is the lack of a centralized database to conduct criminal background checks that is integrated with the federal law enforcement databases.

Industry advocates have complained that variations in licensing and product approval requirements can be burdensome and costly to large, national companies, as well as for small companies wanting to expand to additional jurisdictions. First, a company must receive a license from each state in which it wants to conduct business, then it must seek advance approval for each of its products in each of those states, and then it must obtain licenses for each producer in each state who will sell its products.[25] Large, national companies are already licensed in all states and have the resources to hire staff to write

[25] Joseph J. Gasper. (2002) Testimony before the Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises of the Committee on Financial Services of the United States House. Chairman, ACLI. June 11.

and handle multiple product filings throughout the country. Small insurers lack the same infrastructure.

C. Strong Support for National Standards

There appears to be little, if any disagreement, that greater uniformity is needed in the regulation of life insurance. Interviews with state insurance regulators, consumer groups, industry representatives and others revealed broad recognition of the potential benefits of high quality national standards, particularly regarding products and consumer protections that apply to life insurance products. Consumer groups in particular feel that high quality national standards would assist consumers in their ability to understand and compare policies and pricing. They also believe that minimum protections applicable to policyholders should not vary from state to state, emphasizing that life insurance policies can be held for many years during which time the policyholder may move through multiple jurisdictions. These views were expressed by the traditional consumer advocates[26] as well as market based citizen advocacy groups.[27] State insurance regulators similarly embraced the goal of uniform regulation of life products. As Ernst Csiszar, Director of Insurance in South Carolina testified recently before Congress, "this is one of the few areas that has generated a true national consensus for reform among all segments of industry, consumers, and regulators."[28]

It should be emphasized that while industry, regulators and consumer groups agree on the desirability of uniform standards, consumer groups condition their support on the existence of *high quality* standards.[29] "I would rather have state-by-state variance than weak federal regulations," says CFA's Bob Hunter. In addition, they believe that any national standards should be a floor, not a ceiling, and that states should have the ability to impose requirements unique to their jurisdictions if the result is to enhance consumer protections.[30] They also believe prior approval requirements should be kept in place to help prevent detrimental products from coming to market. But they would also like to eliminate inefficiencies in the product approval process, and have worked with the NAIC on a 30-day total product approval package. [31]

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[26] Robert Hunter Inteview. (Nov 19, 2003) Consumer Federation of America. Interview on November 19. AARP. Birnie Birnbaum. (December 11, 2003) Center for Economic Justice.
[27] Wayne Brough. (November 18, 2003) **.** Citizens for a Sound Economy.
[28] Ernst Csiszar. (2003) Testimony of the NAIC before the Committee on Commerce, Science and Transportation, United States Senate. October 22.
[29] Robert Hunter. (2003) Testimony of the Consumer Federation of America before the Committee on Commerce, Science and Transportation, United States Senate. October 22. And Hunter (2003) Interview.
[30] Interview with Mila Kofman, Assistant Research Professor, Georgetown University (March 18, 2004) Prof. Kofman is a member of the NAIC's Consumer Liason Committee. A skeptic of federal regulation, she points to the widespread availability of community based care in certain states as an example of local conditions that might warrant variations or special disclosures in long term care policies.
[31] Id.

D. Efforts to Date of the NAIC to Achieve Uniformity

The NAIC has been grappling for many years with the need for greater uniformity in the regulation of life products, as well as in producer and company licensing requirements for all lines of insurance. In March 2000 it adopted the "Statement of Intent: The Future of Insurance Regulation" which was designed to be its roadmap in the modernization of insurance regulation. Following adoption of the "Statement of Intent", NAIC has undertaken a number of initiatives to improve efficiency. However, its progress has been frustrated by lack of agreement among state commissioners as to the appropriate standards and the fact that many of the variations among states derive from legislative requirements that cannot be easily changed.

Product Regulation: Initially, the NAIC sought to streamline the regulation of certain life and health products through the creation of the Coordinated Advertising, Rate and Form Review Authority (CARFRA). Established as a pilot project in May 2001, CARFRA consisted of regulators from 10 states who agreed to provide centralized review of term life, individual annuities and individual medical supplements based on a set of uniform standards along with consideration of individual state deviations from those standards. The goal was to approve products within 30 days if they adhered to the uniform standards, and 60 days for filings needed to reflect state deviations. After CARFRA's approval, each state still had the option of rejecting the product.

The CARFRA process has not been significantly utilized. Recognizing this, the NAIC decided to move forward with an Interstate Compact proposal, building on the processes and standards under CARFRA. Spearheaded by former NAIC head Terri Vaughan, Iowa Insurance Commissioner, the Compact is grounded in the recognition that the financial services marketplace is changing, that life product lines face increased competition from other sectors, that the population is becoming increasingly mobile, and that most of the risks associated with life products are not local in nature.

In December of 2002, state regulators formally proposed for comment an exposure draft for the Interstate Insurance Product Regulation Compact (Compact) model law for the approval of basic life, annuities, disability income and long term care products.[32] In a presentation to the NAIC in May 2003, Vaughan forcefully laid out the case for the Compact. These include the benefits to consumers from a more effective use of limited regulatory resources by leveraging the collective expertise of states in a single, high-quality product review.[33] In September of 2003, the NAIC approved the model law.

The Compact establishes a commission that is responsible for the development of uniform approval standards for products and product-related advertisements. It also establishes a self-certification process for products so designated by the Commission. It is not intended as the exclusive mechanism for product filings; insurers can still file with individual compacting states insurance departments. The Compact also allows states to

[32] NAIC. (2002) "Nation's Top Insurance Regulators Support Interstate Compact." Press Release. December 8.
[33] Power Point Presentation Terri Vaughan, Iowa Insurance Commissioner (NAIC Meeting May, 2003)

opt out of a uniform standard by legislation or regulation. The Compact becomes effective and binding upon enactment of the model law by two compacting states legislatures. The Commission becomes effective for purposes of adopting uniform standards after twenty-six states, or states representing more than 40% of premium volume in the relevant products, enter the Compact.[34]

The Compact has been endorsed by the National Conference of State Legislatures (NCSL) as well as the National Council of Insurance Legislators (NCOIL). The American Council of Life Insurers has also endorsed the Compact. However, that group does not believe it will ameliorate the need for an optional federal insurance charter because of its "opt-out" features as well as the fact that it only addresses the need for uniformity in the product approval area. The Compact has run into resistance from the Attorneys General in the states of California, Minnesota, Missouri and Oklahoma who have questioned its constitutionality and what they view to be weak consumer protections. However, the NAIC has worked to address their concerns. Some state legislatures have also questioned its constitutionality, though the NAIC feels it has addressed these questions. Major consumer groups such as the Consumer Federation of America (CFA) and the American Association of Retired Persons (AARP) have withheld support, expressing concerns about the adequacy of consumer protections. It has been reported that a number of state insurance commissions opposed the Compact when the exposure draft was adopted in December of 2002.[35] At the NAIC's September 2003 meeting, the NAIC adopted a Reinforced Commitment: Insurance Regulatory Modernization Action Plan projecting that the Compact would be approved by 30 states or states representing 60% of premium volume in the relevant products by year-end 2008.[36] To date, the compact is law in Colorado and Iowa, and is pending governor's signatures in Utah, New Hampshire and West Virginia. A stated NAIC goal is to have the national standards for each product line drafted by the end of the year.

Recently, three states – California, Florida and Texas – announced that they had reached agreement to develop a consistent set of product approval standards and allow for submission of a single filing that would make it possible for products to be marketed immediately in those three states. The three states have characterized the initiative as consistent with the Compact, though insurers have complained that it creates mixed signals. Texas Insurance Commissioner Jose Montemayor spearheaded the agreement, and was also a leader in the development of the Interstate Compact. With the three party states representing 26% of the population, the agreement could represent a significant step forward in streamlining product filings. Critics complain that the three states have not created uniform standards. However, according to NAIC staff, there is already a remarkable degree of standardization among these states and that where there are differences, the states default to the "higher" standard.

[34] Terri Vaughan. (2003) Remarks before the NAIC by Iowa Insurance Commissioner. May. Also, the NAIC's website at www.naic.org contains detailed descriptions of the Compact.
[35] Kevin Hennosy. (2003) "Waist Deep in the Big Muddy." *Rough Notes Magazine.* February.
[36] NAIC. (2003) *A Reinforced Commitment: Insurance Regulatory Modernization Action Plan.* September.

The NAIC is enjoying significant success with its System for Electronic Rate and Form Filing (SERFF). SERFF offers a standardized electronic platform for new product filings with states. Launched in 1997, the NAIC reports that at the end of 2003, 49 states, the District of Columbia, Puerto Rico were capable of accepting filings through SERFF and more than 1200 insurance companies were licensed to use the system. For all of 2003, 76,000 filings were channeled through SERFF, as compared to 25,528 in 2002, demonstrating nearly a 300% increase in the system. Though SERFF appears to be improving the efficiency of processing rate and form *filings*, it does not address variations in substantive requirements imposed by the various states. In addition, one major state, Florida, continues to maintain its own electronic filing system, I-File, though an effort is underway to build an interface between SERFF and I-File.

Producer Licensing: Another area where NAIC has been highly active is in streamlining the licensing process for producers who want to sell insurance products in more than one state. Difficulties producers experience in obtaining licenses in multiple states because of varying regulatory requirements prompted Congress to address the issue in the Gramm-Leach-Bliley Act (GLBA). Specifically, the GLBA called for a majority of states to either adopt uniform non-resident producer licensing laws or reciprocate with other states in the licensing process by November 12, 2002. If the requisite number of states did not meet that deadline, GLBA provided for the establishment of a body called the National Association of Registered Agents (NARAB) that would take over non-resident producer licensing functions from the states. By year-end, 2002, 36 states had implemented State Licensing Reciprocity (SLR) thus exceeding the GLBA mandate. According to the NAIC's website, forty-eight states have adopted the Producer Licensing Model Act (PLMA) developed by NAIC to help states comply with GLBA or have adopted regulations to satisfy GLBA reciprocity. However, the largest state, California, has yet to do so. A key obstacle to the development of uniform standards is the lack of a centralized system for conducting criminal background checks, which could access the FBI's database.[37] NAIC points out that such access requires Congressional action, which has not been forthcoming.[38]

Through the National Insurance Producer Registry (NIPR), efforts have been made to streamline the process of licensing nonresidents and appointing producers, including programs that allow electronic appointments and terminations. There are 30 states and the District of Columbia accepting electronic non-resident licensing applications through NIPR and 38 states, plus the District of Columbia, accepting electronic appointments and termination through NIPR.

Company Licensing: Much of the NAIC's work on streamlining company licensing has focused on the Uniform Certificate of Authority Application (UCAA). The UCAA offers

[37] Chairman Oxley (R OH) of the House Financial Services Committee has sought to address this problem through federal regulation and is likely to renew his push in this Congress. Interview with Robert Gordon.
[38] The NAIC developed a draft authorization for a Criminal History Record Check Model Act and continues to have informal discussions about access to the FBI and continues to have discussions with the FBI. While some states are currently able to obtain access to the FBI database through the adoption of proper legislative authority, federal law prohibits states from sharing criminal history record information with each other.

companies a web-based, electronic application form to obtain a license in any state. However, as is the case with SERFF and the product approval process, the states have yet to agree on a common set of review and approval criteria for granting company licenses. Insurers must still separately submit supplemental information to individual states, which offsets the benefits of using the UCAA form. In its reinforced commitment, the NAIC has pledged to develop a Company Licensing Model Act to establish standardized filing requirements by December 2004 and develop baseline licensing review procedures that "ensure a fair and consistent approach to admitting insurers" and that provide "for appropriate reliance on the work performed by the domestic state in licensing …" [39]

Market Conduct Reviews: In its recent report, "Common Standards and Improved Coordination Needed to Strengthen Market Regulation[40]" the GAO found that the lack of nationwide standards for the coordination of market conduct examinations has resulted in "inconsistent and often spotty coverage from state to state and potential gaps in consumer protection." The Report went on to find that "These inconsistencies in performing market conduct examinations make it difficult for the states to depend on each other for regulation, leaving each state with the virtually impossible task of examining every company within its borders." It concluded further "with each state conducting its own examinations, some insurance companies find themselves undergoing simultaneous examinations by several states, while other companies may not be examined at all."[41]

In response to issues raised about market conduct examinations, the NAIC recently published and adopted a revised market conduct examination handbook[42], and has called upon the states to implement uniform training and certification of standards for all market regulation personnel. The NAIC, however, has not undertaken an accreditation program along the lines of that which it has successfully implemented for financial regulation. In defense of its position, NAIC has stated that market conduct regulation is more difficult to harmonize than financial regulation because of differing consumer protection laws and variances in insurer behavior from state to state.[43] Thirty-six states have self-certified compliance with the NAIC's Market Conduct Uniform Examination Outline which specifies market conduct exam procedures. The National Conference of Insurance Legislators initially recommended a market conduct regime that would vest primary responsibility for performing market conduct surveillance on the domiciliary regulator and place heavy reliance on self-certification by insurers.[44] However, NCOIL reconsidered that approach in response to criticism from consumer groups and questions

[39] NAIC. (2003) *A Reinforced Commitment.*
[40] "Market conduct regulation" refers to the oversight of insurance company practices affecting consumers in areas such as selling and underwriting. In contract, "financial regulation" generally refers to oversight of a company's financial health and solvency.
[41] GAO. (2003) *Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation.* September.
[42] NAIC. (2003) *Market Conduct Examiners Handbook.* 2003 Edition. Kansas City: NAIC. NAIC formally adopted the handbook in December 2003.
[43] GAO. (2003) *Insurance Regulation.* p. 39
[44] See, "The Path to Reform –The Evolution of Market Conduct Surveillance Regulation" (Insurance Legislator's Foundation July 10, 2003)

by some in the industry.[45] It has worked with NAIC to develop a new model law, with the goal of having it adopted this summer.

III. THE RESULTS OF THE STATE REGULATOR SURVEY AND ON-SITE REVIEWS

Though there is extensive anecdotal information about inefficiencies and redundancies built into the current system, little academic research has been conducted to attempt to quantify costs and delays perceived to be inherent in the system. As a consequence, our project team set out to gather survey data from state regulators and industry about the costs and quality of the current insurance regulatory regime, and to obtain comparative data from federal bank regulators in areas such as budget allocation, examinations, complaint handling, and enforcement processes. Three sets of surveys were sent to state regulators, life insurers and federal bank regulators. On-site reviews were also conducted of selected insurance regulators. This section will summarize the results of the state regulator survey and on-site reviews.

A. The Results of the State Regulator Survey

We sent questionnaires to insurance commissions in all fifty states and the District of Columbia, covering the key areas of budget, company and producer licensing, product approval, examinations, complaint process, and their views of OFC proposals. Twenty responded. Respondents were dispersed geographically and by size. Four were among the top 10 commissions in terms of budget size.

Geographic Distribution of the Insurance Departments

	Actual Responses	Population	%
Atlantic	5	11	45.5%
North Central	2	7	28.6%
North Eastern	3	7	42.9%
South Central	3	9	33.3%
Western	7	17	41.2%
Total	**20**	**51**	**39.2%**

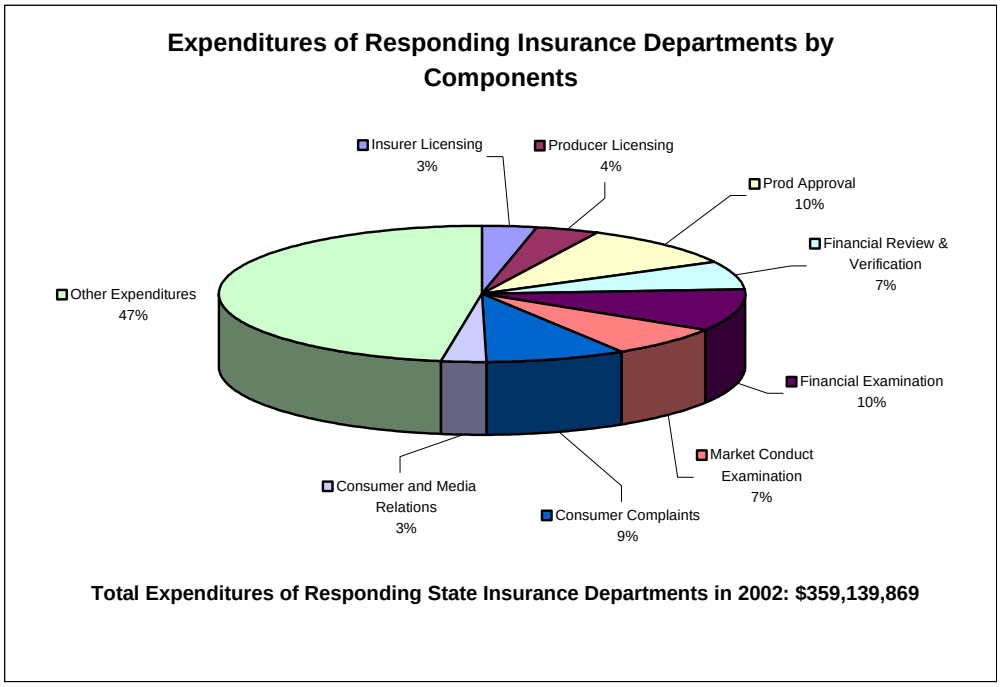
[45] Hunter (2003) Interview. See also, "Insurers Weigh in on Market Conduct," The National Underwriter (January 26, 2004)

Budget Distribution of the State Insurance Departments			
	Actual Responses	Population[(1)]	%
Budget			
$1-5 million	2	6	33.3%
$5-10 million	9	22	40.9%
$10-25 million	6	14	42.9%
$25-50 million	1	5	20.0%
$50-200 million	2	4	50.0%
Total	**20**	**51**	**39.2%**

Note:
1. Information about the insurance departments' budgets in 2002 comes from the 2002 NAIC Insurance Department Resources Report.

Budget allocations reflected significant amounts devoted to “front-end” areas such as company and producer licensing and product approval. Of front-end costs, product approval accounted for the largest portion, followed by producer licensing and insurer licensing.

Expenditures of Responding Insurance Departments by Components



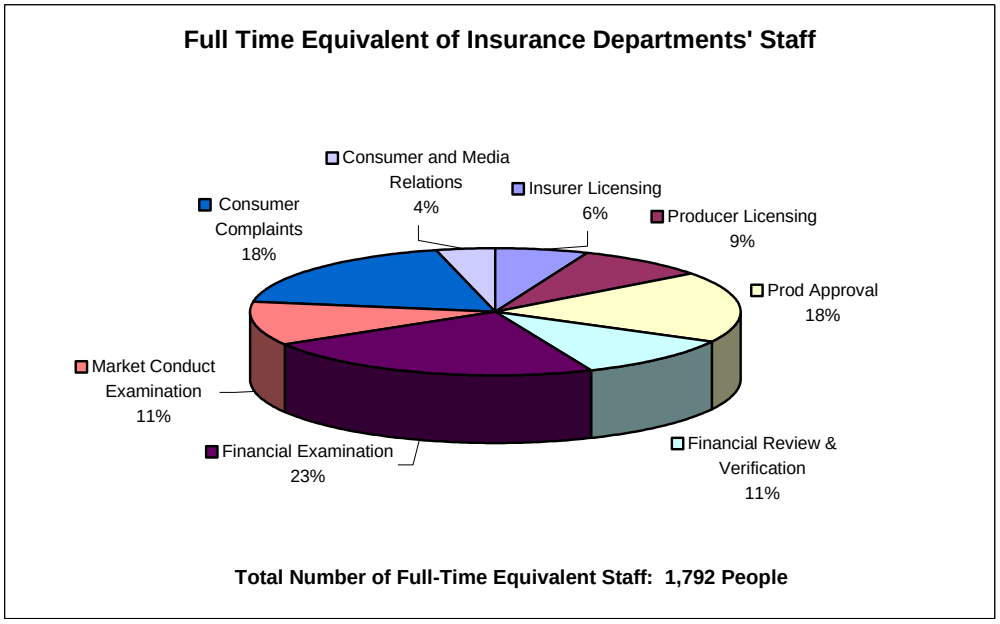
Notes:

1. Six states were not able to break down their expenditures by components because they did not capture expenditures at this detailed level. Exhibit 43a is based on Reponses provided by the other 14 states that were able to break down their expenditure

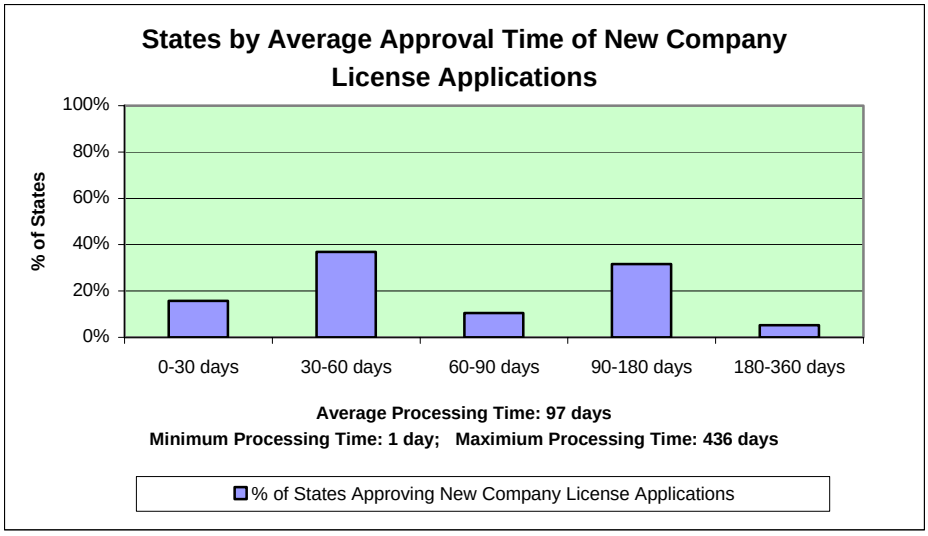
2. A new category *Other Expenditures* was created to capture the expenditures of the states that reported that there were other expenditures that could not be allocated in any one of the eight categories, i.e. expenditures related to various administrative activities such as: salaries of senior staff, regulatory coordination, legislative liaison, accounting, procurement, market enforcement responsibilities for insurance agents, consultant and actuaries, information system support, etc.

3. One state reported total expenditures and allocation of expenditures for FY2003 since for that state the accounting of expenditures in 2002 was on an insurance department level only. The state reported that in general the expenditures do not change much from year to year, and in FY2003 the expenditures were slightly lower than in FY2002.

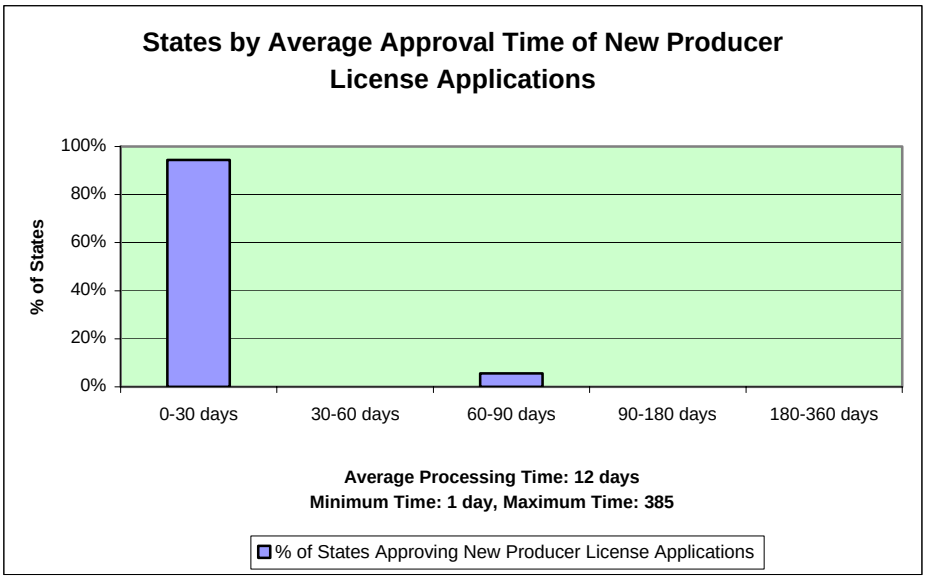
Staff allocations were concentrated, with 33% of staff FTEs devoted to front-end oversight.



Weighted average processing times for company licenses averaged 97 days, the shortest reported company license approval was 1 day; the longest was 436. New business line applications were significantly shorter, averaging 32 days, with the range of processing time spanning 1 to 373 days. Nearly 70% of reporting states required license renewals, with weighted average processing times of 7 days.



Consistent with industry survey data, processing times for producer licenses were the shortest, with a weighted average approval time of 12 days and almost all applications being processed in less than 60 days.



Short turnaround times for producer applications were accompanied by extremely high workloads per FTE assigned to review such applications. Specifically, new producer applications averaged 1,284 per FTE per year; renewals totaled 2,507 per FTE, and appointments totaled 12,829 per FTE, for a combined total of 16,619 filings per FTE in single year. This suggests that overburdened staff have little time to conduct more than a cursory review of producer applications.

Regarding the processing of filings for life, annuities, DI and LTC products, insurance regulator responses presented a markedly different perspective from that presented by the industry survey. The states reported a weighted average processing time of 22 days, with several reporting minimums of 1 day and most with maximums of less than 90 days.[46] However, 62.5% of responding states indicated that "on occasion" form filings took longer than one year to process. The data indicated a high workload for product filing review staff – about 208 per person per year.

These survey data reflect form processing as significantly more expeditious than reflected in the industry survey discussed below. There are several possible explanations for the discrepancy. First, states were unable to separate minor changes to existing products from new products and major changes. Thus, approval averages may be shortened because of the inclusion of routine, technical changes. Second, each of the states is reporting its own

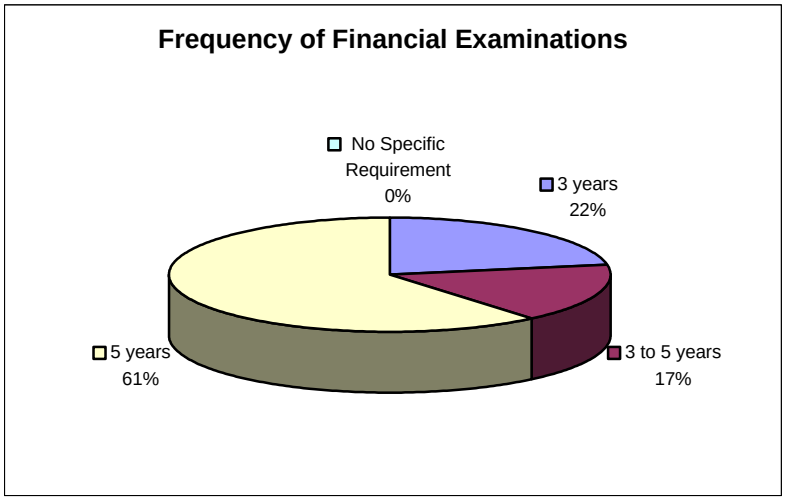
[46] One state reported a maximum of 120, another, a maximum of 200 days, and third – a maximum of 365 days.

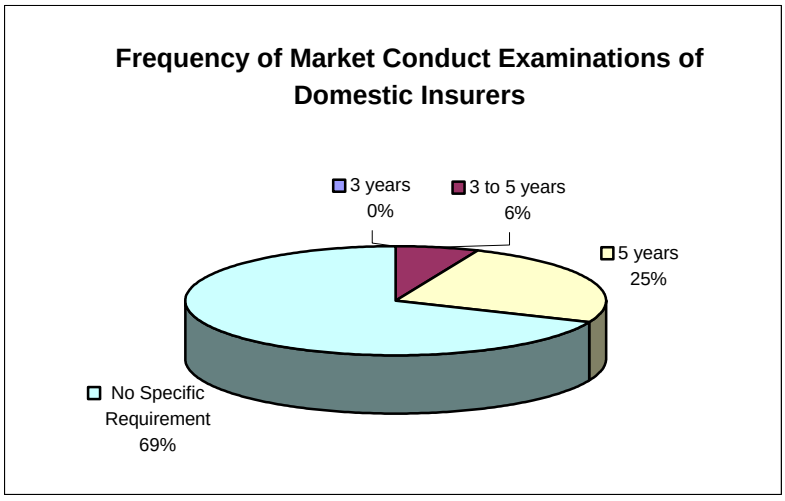
individual experience, while much of the industry data reflects insurers cumulative experience with multiple states. Third, while industry respondents reported on the processing time from the date of filing to final approval, some states only track how long it takes to "act" on a filing. [47] The "action" might be a comment letter or request for information, which would prompt another "filing" from the insurer, with the tracking process starting anew from that stage. Fourth, only two of the 10 largest states provided us with data on this question, though industry survey data suggest the longest delays occur in the larger states. Finally, states with faster approval times may have been more inclined to respond to our survey (with the reverse being true of industry survey respondents). Indeed, three indicated that they had already converted to a "file and use" system for certain life products.

Regarding frequency of examinations, 61% of states reported that they conducted financial exams every 5 years. Most states had no set schedule for conducting market conduct exams.

[47] The NAIC and state regulators point out that insurers sometimes submit incomplete filings, expecting the insurance commission staff to help them correct the deficiencies. This will inevitably add to product approval delays. Insurers on the other hand complain that regulatory staff will some times try to "game" the system by arbitrarily requesting information to "stop the clock." In the industry survey, we asked insurers to omit time delays caused by their failure to provide information in response to reasonable requests from regulators. To obtain a complete perspective on the cumulative amount of time it takes an insurer to secure approvals in multiple states, it was necessary to seek data from the industry. The NAIC does not track that data and individual states could only provide us with data on their own approval times.

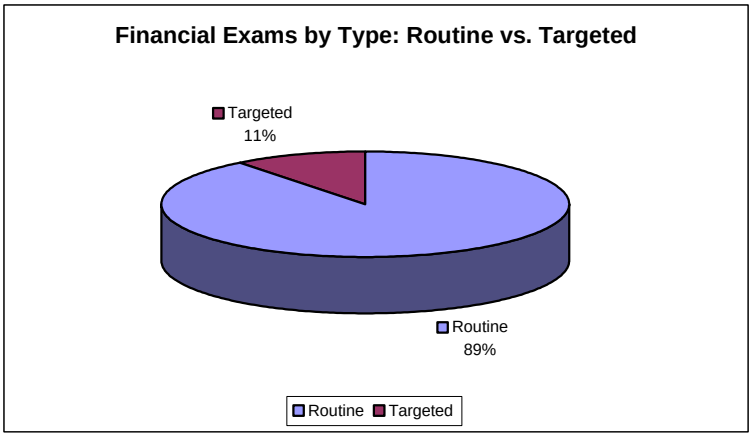
Frequency of Financial and Market Conduct Exams

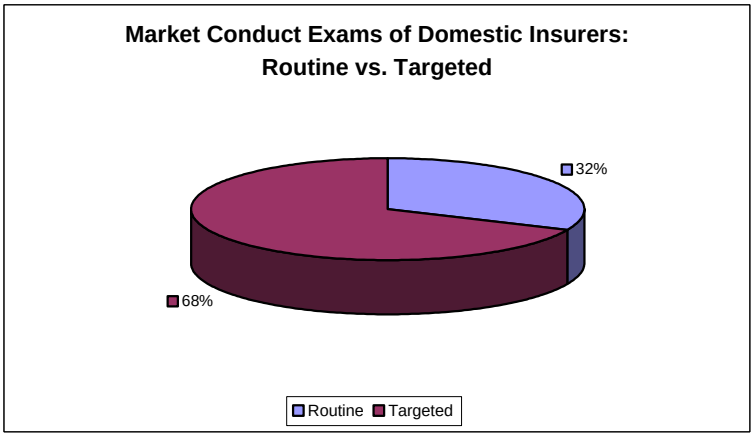


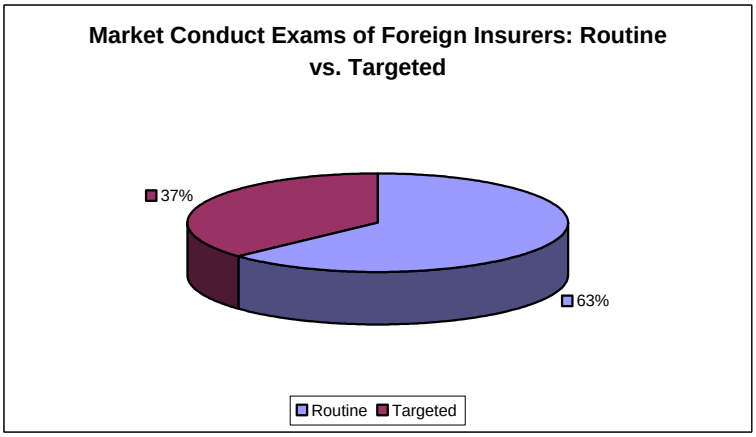


Consistent with industry responses, the overwhelming majority of financial exams were routine, while the majority of market conduct exams for domestic insurers were targeted. Interestingly, insurers reported that most market conduct exams of foreign insurers were routine.

Financial and Market Conduct Exams by Type: Routine vs. Targeted







An average of 3 staff were assigned to each financial exam, with the average exam duration being 190 days. In contrast, market conduct exams of domestic insurers averaged 2 staff and lasted an average of 92 days. Market conduct exams of foreign insurers lasted somewhat longer. Market conduct exams cost about half as much as financial exams.

Average Staff, Duration and Cost of Financial and Market Conduct Exams

	Fin Exams	Mar Exams			
	Insurers	Domestic Insurers	Foreign Insurers	Resident Producers	Non-Resident Producers
Number of Staff Included in an Exam	3	2	2	2	NA
Average Duration of Exams	190	92	122	18	NA
Average Exam Cost to DOI	$85,925	$33,180	$38,150	$1,000	NA

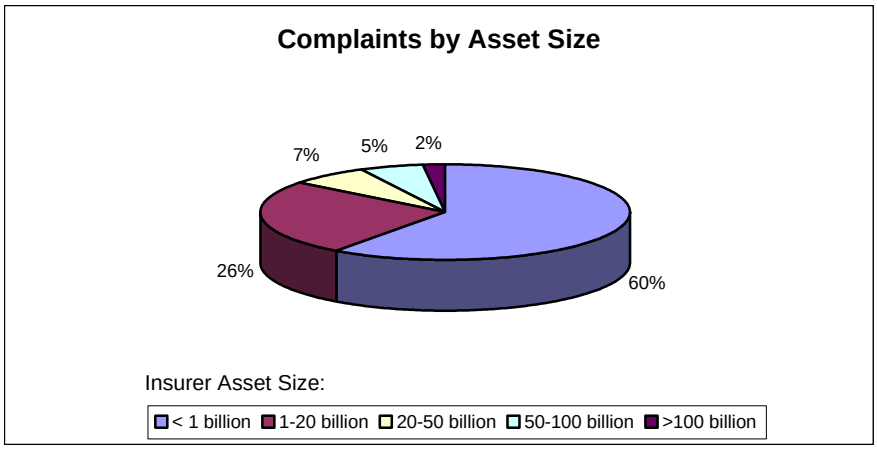
Respondents reported significant complaint volume: 223,974 were received in 2002, 12% of which were associated with the four product lines subject to our study. A total of 198,368 complaints were investigated and 181,083 were closed, with a weighted average resolution time of 59 days. Small companies accounted for the majority of complaints: 60% were generated by companies with assets of less than $1 billion.

Complaints	
Total Complaints	**223,974**
Investigated Complaints	**198,368**
Closed Complaints	**181,083**
Life Complaints	**27,678**
Compalints Resolved within 30 days	**82,462**
Number of Commissioner and Staff Meetings	**7,960**

Complaints (%)	
% of Investigated Complaints	89%
% of Closed Complaints	81%
% of Life Complaints	12%
% of complaints resolved within 30 days	37%
Weighted Average Time to Resolve a Complaint	59 days
Range of Average Time to Resolve a Complaint:	21 to 108 days

Notes:

1. Three states were only able to investigate 2%, 3% and 18% of complaints received in 2002.
2. Average complaint resolution time is weighted based on the number of complaints closed by each state.



All states required regular follow-up on all complaints, all required insurers to respond in writing to referred complaints, and all sent consumers a letter informing them of the resolution of their complaint. Ninety-five percent maintained a complaint activity base, and 85% made complaint data available to the public. Respondent states appeared to do a good job in getting the insurer to respond in detail to consumer complaints.

We also asked state regulators their views on a variety of issues related to our study. Most were pleased with the current regulatory structure, believing that its greatest strengths were consumer protections, the accessibility of local regulators, and the opportunity for policymakers to personally interact with consumers. Most states reported meeting with several hundred consumers each year. Also mentioned as prime strengths were the ability to communicate and draw from other state insurance commissions, and the ability to understand local needs and market conditions.

Weaknesses in the current system included lack of uniformity in certain areas, and inability to approve policy forms in a timely manner; artificial state borders in urban

areas where two different sets of state laws are applicable. Some also cited the lack of regulatory authority in jurisdictions where illegal actions were taking place.

Though lack of uniformity was most frequently mentioned as the chief weakness of the state system, all respondents were quick to add that they thought that issue was best addressed through the NAIC's modernization efforts. Most also pointed out that delays in licensing and form approvals frequently were caused by the insurer not providing complete information or being slow to respond to requests for additional information, though it was also noted that staff shortages were at times responsible for delays. Some expressed the opinion that product review diverted resources away from areas that were more important from the consumer's perspective.

All expressed numerous concerns about converting to a dual chartering system, the most frequently expressed being duplicity and costs associated with setting up a new structure. Most also felt that the regulatory playing field would be "uneven" between state and federal regulators, and were concerned about a "race to the bottom." Many felt the creation of an optional federal regulator would reduce state leverage and effectiveness in dealing with the industry on consumer issues, that there would be confusion among consumers about the appropriate official to handle their complaints, and that a federal regulator would lack of sensitivity to local needs.

Finally, we asked state regulators to rank in importance each of their component regulatory activities from the consumer's standpoint. Financial oversight was the overwhelming top choice of respondents in priority, followed by complaint processing and market conduct reviews. Ranked next were producer licensing, product regulation, and enforcement actions, with company licensing ranking last.

B. Summary of On-Site Visits

Onsite visits to the NAIC and selected state insurance departments were an important component of this project. The goal of these meetings was to gather evidence about the established processes in insurance regulation on a state level, the degree of uniformity in these processes, and the cooperation among the state insurance departments. The head offices of the NAIC, and the state insurance departments of Florida, Iowa, New Jersey, New York, and Texas were visited by the research project team. In addition, conference calls were held with the insurance department of California, whose disperse locations made it impractical for a visit to be organized. The six insurance departments were chosen because of their size and geographic diversity.

Six areas of insurance regulation were discussed with the NAIC and the insurance departments: company licensing, producer licensing, product approval, financial and market conduct regulation, and consumer services.

The meetings disclosed that a significant degree of uniformity has been achieved in financial regulation, producer and company licensing. However, in areas such as product approval and, especially, market analysis and market conduct examinations, states had

very different approaches. Under the leadership of Greg Serio, the NY State Insurance Department has been at the forefront of modernization efforts. "We're trying to get away from the 'substituted judgment' philosophy that used to characterize oversight, " says Serio. "We're trying to put more emphasis on making sure the consumer knows the options and relative costs and then letting the consumer decide."[48]

Financial Regulation

In financial regulation, uniformity has been achieved through the Financial Regulation Standards Accreditation Program that was established in 1990s, with highest uniformity realized in risk-based capital, holding company regulation and financial reporting.

All states indicated that they perform financial analysis of their domestic companies, with more limited attention given to non-domestic insurers depending on their financial condition, market presence or size. Similarly, the insurance departments reported that they conduct examinations of domestic insurers only, except California, New Jersey and New York, which also examine non-domestic insurers when necessary. All states indicated that their financial analysis and examination activities were based on the NAIC Financial Analysis, and Financial Condition Examiners handbooks; however they also indicated that they had developed other analysis and examination procedures.

Exam staffing differed among the states. Some indicated that they included only department staff in the exam teams, while at least two states (California and New Jersey) communicated that they also involved external consultants because of their expertise or because of the inadequate pay scale at the department for this type of specialist.

Regarding their participation in multi-state examinations, the states indicated that they used the NAIC's systems to call such exams, but rarely participated in exams called by other states mostly because of limited staff availability.

Asked about the future priorities in financial regulation, the insurance departments of New Jersey and New York disclosed their intentions to develop a more advanced risk analysis approach. New York and Iowa co-chair the NAIC's Risk Assessment Working Group and have taken a leadership role in developing a risk-focused surveillance framework to obtain a more dynamic view of insurers financial condition and create greater efficiency by better targeting resources to problem companies.[49]

Company Licensing

All states felt that with regard to company licensing, significant uniformity in application format had been achieved in the last 3-4 years through the Uniform Certificate of Authority Application (UCAA) process. All six states accepted the UCAA uniform applications, and two of them (Iowa and New York) no longer accept the previously used

[48] Interview with Greg Serio (Nov. 24, 2003)
[49] Presentation of Michael Moriarty, Director, Capital Markets Bureau, NYID, to the NAIC Symposium on State Insurance Regulation (Washington, DC February 24, 2004)

state-specific applications. Despite the achieved uniformity in the application format, all states said that there were additional state-specific admission requirements that had to be considered by insurers when applying for a company license.

Although the UCAA process allows insurers to submit copies of the same application for admission in numerous states, it does not control the review process of the states. The states explained that the goal of the NAIC for timeliness in processing primary and expansion applications was respectively 90 and 60 days, with it understood that the clock stopped once additional information was requested. Asked about the average time for approval of a primary application, the states provided estimates that varied between 45 days (Iowa) and 210-360 days (California).

Insurance departments indicated that improvement in the company licensing process was necessary and they were ready to cooperate with other states. Texas thought that a licensing model act was needed, and New Jersey was in discussions with states in the North East zone about increasing reciprocity in company licensing.

Producer Licensing

Producer licensing has been significantly streamlined as a result of the post-GLBA initiatives of the states, especially in the area of licensing of non-resident producers. Discussions with the state insurance departments and the NAIC disclosed that issues, such as fingerprinting and bond requirements for producers selling surplus line products, still awaited their resolution.

States were separated evenly in terms of adoption of the Producer Licensing Model Act (PLMA). Iowa, New Jersey and New York communicated that they had already adopted the act, and Texas and Florida indicated that the only requirement that prevented them from passing the PLMA was the fingerprinting requirement. California is the state that most significantly deviates from the PLMA, but the recent changes to the California Insurance Code made the state about 60% compliant with the act.

The approval times of new producer license applications ranged between 2 days (New York) to two weeks (California and Texas). States indicated that approval times were strongly dependent on the availability of a system for online filing and review, as well as on the number of insurance department staff.

The staff of all six insurance departments believed that reciprocity among states worked well and uniformity in all areas of producer licensing was not necessary. It was felt that uniformity in continuing education and pre-licensing requirements might further improve the process, however few benefits were seen in uniformity of licensing fees, licensing and appointment cycles.

Product Approval

The initiatives of the state insurance departments in the product approval area included transformation of the paper-based filing into an electronic process (SERFF), and development of standards for multi-state coordinated product review (CARFRA and Interstate Insurance Product Regulation Compact).

Four of the states (Texas, New York, New Jersey, and Iowa) communicated that they were CARFRA-member states; however the total number of applications that they jointly received was about ten. The states indicated that there had been a general lack of interest in insurers to use this alternative filing process mainly because state statutory and regulatory filing requirements still differed and a single contract could not be issued.

Except for California, the states supported the creation of the interstate product regulation compact. Iowa was the only one that had adopted the compact legislation. California communicated that the state had voted against the compact because it could not participate in agreements that did not adhere to the minimum statutory standards adopted by the state legislature.

In terms of approval process, two states (Iowa and Texas) indicated that they had established a file-and-use regime for some life products. The other four states (California, Florida, New Jersey and New York) had established a prior approval system with alternative submission procedures intended to speed the approval process. In general, these alternative submission procedures include: deemer approval process, prior approval with certification or triage.

All six states, except for Florida and California, are licensed to use the SERFF product filing system. In 2002 Florida introduced its new I-File system, where filing and transmission to reviewing staff are both performed electronically. California disclosed that in the past it had used SERFF, but had experienced problems with it and had discontinued its use. The staff of the California Department of Insurance (CDI) indicated that it was possible for the CDI to do a pilot project with SERFF, however interest was also expressed in Florida's I-File system.

Market Conduct Regulation

The lowest degree of uniformity had been achieved in the area of market analysis and market conduct examinations. States indicated that the issues still needing resolution included: uniformity in data collection and analysis, uniformity in the examination process, development of a centralized database, better coordination of exams, and better automation to support the pre-examination and examination processes.

All six state insurance departments performed some form of market analysis of both domestic and non-domestic insurers, with wide variations due to the established market specifics in each state.

None of the states, visited by the research team, had a statutory requirement for the frequency of market conduct examinations. In Iowa and New York market conduct exams were performed together with financial exams for the purpose of achieving expediency and efficient resource utilization. In Florida, all of the market conduct exams were performed by external contractors, which according to the insurance department's staff ensured the most efficient utilization of available resources and time.

Asked about their participation in multi-state exams, the states indicated that on occasion they would participate in such exams. Iowa communicated that it had entered into a market conduct reciprocity agreement, which provided that the state would accept the comprehensive market conduct examinations performed by the member states, currently, Kansas, Nebraska, North Dakota and South Dakota.

All six states believed that significant improvements in market conduct regulation should be made, and they could be achieved through the collaborative efforts of the states.

Consumer Services

In the area of consumer services, all states have established very good procedures for complaint handling, consumer advice and assistance, and consumer outreach.

The six insurance departments appeared very efficient in terms of accepting complaints, sending complaint information to insurers and informing complainants about the final resolution. All had developed sophisticated complaint databases that allow them to track the market conduct activities of both insurers and producers, and to identify patterns in the complaint data. The complaint information, generated by the insurance departments is used not only by consumer services divisions, but also by other divisions within the departments responsible for the regulation of insurers and producers. All states indicated that that the complaint information, and the producer and company actions are submitted to the NAIC.

IV. THE INDUSTRY SURVEY

The Scope of the Survey

The survey was disseminated through the assistance of the American Council of Life Insurers (ACLI)'s to its database. Survey responses were sent directly from insurers to the UMASS research team. A total of 383 companies were sent questionnaires, representing 85% of the life insurance market.[50] Of these, 129 companies, or 33.7% of the population responded, representing 19 stand-alone companies and 110 individual companies within 30 different fleets. The response population was well dispersed geographically and by asset size. Response data was for the fiscal year 2002.

[50] The database included all ACLI members and the 10 largest life insurer non-members.

Asset Size Distribution as a Percentage of the Population

	Actual Responses		Population	%
	Stand-Alone Companies	Fleets	Stand-Alone and Fleets	Actual Responses/ Population
Less than 1 billion:	13	6	102	18.63%
1 billion - 18 billion:	6	12	70	25.71%
18 billion - 55 billion:	0	4	15	26.67%
More that 55 billion:	0	8	15	53.33%
Total Companies:	**19**	**30**	**202**	**24.26%**

Asset Size Distribution of Individual Companies

Asset Size	Actual Responses
	Individual Companies
Less than 1 billion:	64
1 billion - 18 billion:	52
18 billion - 55 billion:	8
More that 55 billion:	5
Total Companies:	**129**

Geographical Distribution of Individual Companies

Regions	Actual Responses
	Individual Companies
Atlantic	21
North Central	36
North Eastern	30
South Central	17
Western	24
Canada	1
Total Companies:	**129**

A. Regulatory Costs and Their Allocation

The first section of the survey sought to elicit data on the direct and indirect costs of the current state regulatory structure. Direct costs were defined to include "all fees, charges or other payments to state insurance departments and the NAIC, and state assessments to support insurance regulation." *Premium taxes were excluded*. Though premium taxes levied on insurers are significant – representing 88% of revenues collected from insurers in 2002[51] – all proposals for optional federal chartering contemplate that insurers would continue paying premium taxes, even if they opted for a federal charter. Thus, for purposes of this study, we assumed that optional federal chartering would achieve no savings in state-imposed premium taxes. For similar reasons, we requested that state guaranty fund assessments be excluded from cost calculations given the fact that most OFC proposals contemplate continued participation in these funds by all insurers, including those who choose federal chartering.

Indirect costs were defined to include "all in-house personnel, outside consultants and systems costs related to regulatory compliance." Essentially, indirect costs were defined as any costs incurred for regulatory compliance that were not paid directly to the state. Thus we considered costs such as continuing education for producers to be indirect costs because they are required by regulation and the payments are made to the service

[51] NAIC. (2003) 2002 Insurance Department Resources Report.

providers, not the state. We also considered payments made to outside consultants retained by state regulators to conduct market conduct examinations to be indirect costs.

In asking survey respondents to seek to quantify indirect costs, we also requested that they provide *total, not incremental* costs. We felt it would be too difficult and subjective for firms to try to further identify what part of their indirect regulatory costs might be justified as having independent value to their company, regardless of regulatory requirement. Our purpose in collecting cost data was to try to gain some insight as to the potential cost savings to an insurer in converting from multiple regulators to a single regulator, using the company's domiciliary regulator as our proxy for a single regulator. Thus unlike other regulatory cost studies which have sought to separate "dead weight" regulatory costs from those having business justification – our goal was to try to quantify the cost differential between the current multiple regulator system with a hypothetical single regulator regime.[52]

The inherent difficulties in seeking to quantify "indirect" regulatory costs must be acknowledged. In defining indirect regulatory costs, we consulted with a technical committee of industry advisors.[53] Only 7% of survey respondents indicated that they could rely on accounting records for ascertaining indirect costs; thus the overwhelming majority relied on good faith estimates. Notwithstanding the lack of uniform accounting conventions for indirect costs, we felt we needed to make some effort to quantify them, given general acknowledgement that indirect costs drive regulatory cost burden.[54] Our survey data showed that average indirect costs were twice that of direct costs. Our confidence in this data is bolstered by the large size of the response population combined with the level of detail we sought to provide in our guidance to respondents.

We also asked survey respondents to provide information on the allocation of their regulatory costs among the categories of company licensing, producer licensing, product approval, solvency examinations and market conduct examinations. Our purpose in asking about regulatory cost allocation was to shed light on the extent to which regulatory dollars are concentrated on "front-end" regulation, e.g., licensing and product approval given complaints about regulatory inefficiencies in those processes and concerns that a disproportionate amount of resources are expended on them at the expense of examinations and ongoing supervision.

As is summarized in Exhibit 2a, respondents reported aggregate total regulatory costs of $302,766,148, of which $201,801,529 were indirect costs and $100,964,619 were direct. This amounted to an average of $2,729,343 per company, or about $2,559 per 1,000 policyholders. Regulatory costs fell the hardest on the smallest companies, with per policyholder costs equaling $4.79 for companies with less than $1 billion in assets as

[52] See, e.g., J.R. Franks, S.M. Shaefer, and M.D. Staunton. (1998) "The Direct and Compliance Costs of Financial Regulation." Journal of Banking and Finance. December. Vol. 21, 1547-1572.
[53] Technical committee members were: William Fisher, MassMutual, Gary Hughes, ACLI, Wendy E. Cooper, Equitable Life, Steve Rahn, Lincoln National, Michael Youngman, Northwester Mutual, Merle Pederson, Principal Financial, and George Coleman, Prudential Insurance.
[54] See footnote 38.

compared to $3.48 for companies with assets exceeding $55 billion. Companies with assets ranging between $1-18 billion had the lowest per policyholder costs of $1.69, while companies with assets ranging between $18-55 billion had per policyholder costs of $3.18. However, for all insurers, regulatory costs represented less than 1% of premium income.

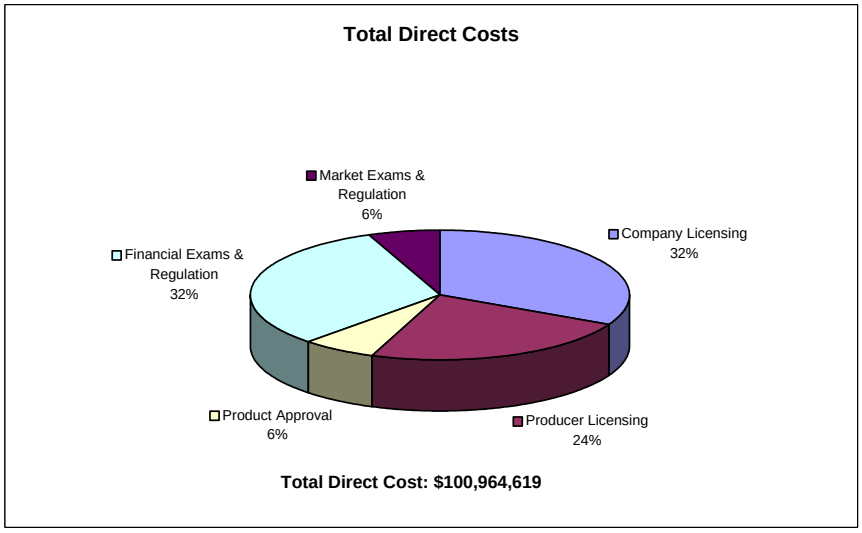
Company Costs per Policyholder

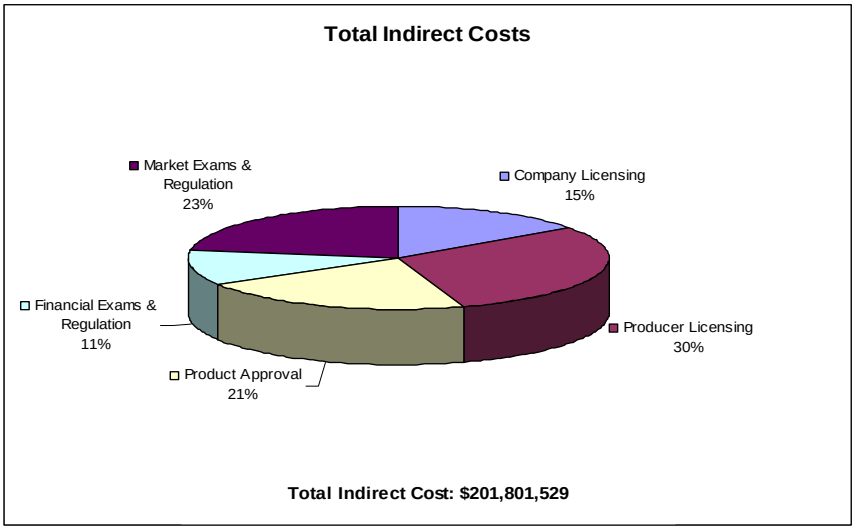
Asset Size Group	Average Direct Cost	Average Indirect Cost	Average Total Cost
	Per Policyholder		
Less than 1 billion	$2.56	$2.23	$4.79
1 billion - 18 billion	$0.61	$1.08	$1.69
18 billion - 55 billion	$1.30	$1.88	$3.18
More than 55 billion	$0.79	$2.69	$3.48
Average per Company per Policyholder	$0.82	$1.74	$2.56

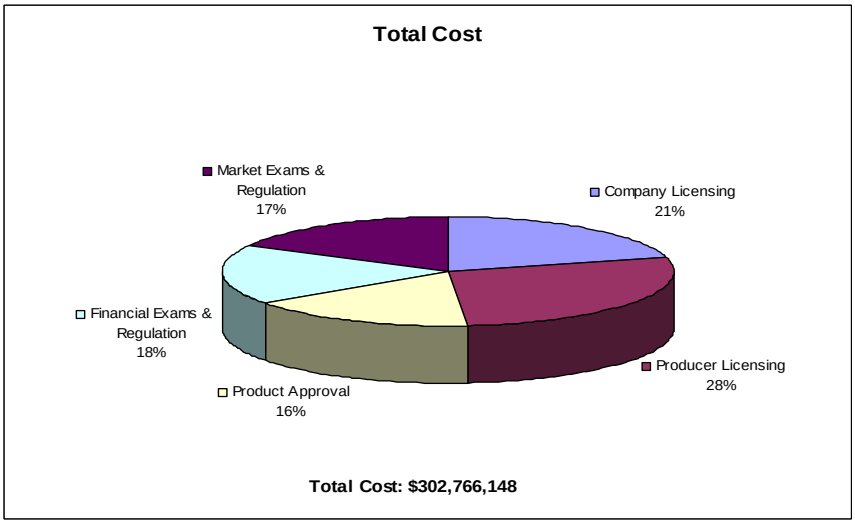
We also sought to make an industry-wide projection of total regulatory costs based on our survey responses. Total assets of insurers responding to our survey represented 31.5% of assets of all life insurers offering the four product lines subject to our study. The total premium income of our respondents represented 33.9% of premium income for all life insurers. Applying the survey respondents' ratio of regulatory costs to assets to total industry assets results in aggregate industry-wide costs of $961,120,648. Applying survey respondents' ratio of regulatory costs to premium income to total industry premium income results in aggregate industry-wide costs of $892,320,747.[55]

Regarding cost allocation, the overwhelming majority of direct costs – 62%-- were spent on "front-end" regulatory requirements, i.e., company and producer licensing and product approval, with 32% spent on solvency regulation and only 6% spent on market conduct supervision. Sixty-six percent of indirect costs were spent on "front-end" processes, with the remaining 34% spent on financial and market conduct regulation. Surprisingly, though market conduct regulation only accounted for 6% of direct costs, they accounted for 23% of indirect costs. In terms of total costs, front-end regulation accounted for 65%, the most costly category being producer licensing, while financial and market conduct regulation accounted for 35%. Total costs for market conduct regulation came to $51.2 million, or 17%, as compared to $52.2 million, or 18% spent on financial oversight.

[55] We believe this is a conservative estimate based on previous research done in this area. For instance, a study based on 1997 data placed total regulatory costs at $4.5 billion for life, health, property & casualty. See, Grace and Klein. "Efficiency Implications of Alternative Regulatory Structures for Insurance" in Peter J. Wallison, ed., (2000) *Optional Federal Chartering and Regulation of Insurance Companies.* Washington, D.C.:The AEI Press.


Total Direct Costs
Market Exams & Regulation 6%
Company Licensing 32%
Financial Exams & Regulation 32%
Product Approval 6%
Producer Licensing 24%
Total Direct Cost: $100,964,619


Total Indirect Costs
Market Exams & Regulation 23%
Company Licensing 15%
Financial Exams & Regulation 11%
Producer Licensing 30%
Product Approval 21%
Total Indirect Cost: $201,801,529


Total Cost
Market Exams & Regulation 17%
Company Licensing 21%
Financial Exams & Regulation 18%
Producer Licensing 28%
Product Approval 16%
Total Cost: $302,766,148

Survey respondents were also asked to provide the total costs of regulation by their home state or domiciliary regulator as the best available proxy for a single regulator. Aggregate total costs for home state regulation were $77,616,385, representing a potential savings of $225,149,763 or about $1.76 per policyholder. The greatest potential costs savings were with the smallest and mid-sized companies: $3.61 per policyholder for companies with assets of less than $1 billion and $3.01 for companies with assets between $18 and $55 billion.

Costs and Cost Savings per Company per Policyholder

Asset Size Group	Average Total Cost	Average Domestic Cost	Potential Savings
Less than 1 billion	$4.79	$1.18	$3.61
1 billion - 18 billion	$1.69	$0.64	$1.04
18 billion - 55 billion	$3.18	$0.18	$3.01
More than 55 billion	$3.48	$1.03	$2.46
Average per Company per Policyholder	$2.56	$0.80	$1.76

It is very likely that direct costs associated with a single federal regulator would be higher than those associated with an insurer's home state regulator. First, producer-licensing fees would be paid exclusively to the federal regulator, whereas under the current system they are dispersed among the various states where the producers conduct business. Second, as is later discussed in more detail, direct costs are likely to be higher for federal regulation than they are for the state of domicile, based on what we believe to be the likelihood of more frequent financial and market conduct examinations. This assumption is supported by cost data obtained from the Office of the Comptroller of the Currency (OCC), which shows that direct fees imposed by the OCC on national banks exceed nationwide direct costs for insurers in all asset categories, with the exception of those with assets of less than $1 billion, where OCC fees are just 54% of direct costs reported by survey respondents. (Exhibit 9)

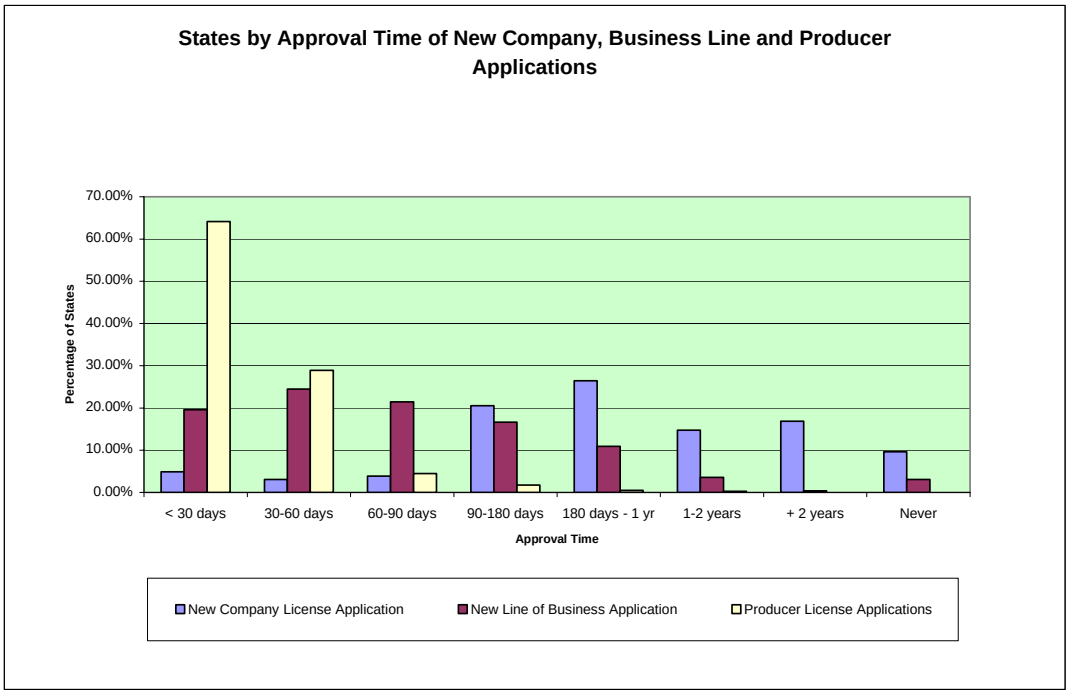
Observations Regarding Regulatory Costs and Their Allocation: Though home state regulatory costs are likely to be lower than the costs that would be associated with a federal regulator, the data suggests that insurers could achieve significant aggregate savings by converting to a single, national regulator. Even if the costs of a federal regulator were double that of domiciliary regulation, or $145.2 million, it would still be roughly half as expensive as the current system. Though these potential savings when viewed in comparison to regulatory costs are significant, they represent a small percentage of assets and premium income, and translate into only a few dollars per policyholder.

Perhaps more significant from the consumer's perspective were costs reported by respondents stemming from lost premium income because of product approval delays. We asked companies to separately estimate the lost premium income they experienced from product approval delays exceeding 60 days. Nineteen companies responded, reporting losses that were, on average, twice as high as their regulatory costs. Four companies reported lost premium income ten times higher than regulatory costs. Costs associated with lost premium income might have a greater impact on individual policyholders, to the extent these costs impact the price of the product(s) subject to the delay.

Most relevant from the individual consumer's perspective is the potential for more effective use of regulatory resources through streamlined, uniform regulation. Providing for a single point of filing, combined with uniform standards, could achieve significant reductions in the large proportion of costs currently allocated to company and producer licensing and product approval thus freeing up more resources for examination and ongoing supervision. At the same time, providing uniform standards for market conduct reviews could help achieve better utilization of the sums currently being spent on market conduct exams. As discussed below, survey data indicates wide variations in each states approach to market conduct supervision, and wide disparities in the frequency of market conduct examinations, consistent with a previous study recently completed by the GAO.

B. Approval Times for Company and Producer Licensing Applications

Survey responses indicated that the process of approving new company licenses is a lengthy one. Using 1997-2002 as the time horizon, on average, companies reported that it took 58% of states over 6 months to approve new company licenses, with 17% taking more than 2 years. New business line applications were more streamlined, though 15% of states still took over 6 months to approve them. Producer licensing applications appeared to be the most efficient of the "front-end" processes examined, with 64% of states approving applications in less than 30 days, and less than 3% taking more than three months. This is no doubt due, in part, to producer applications being less complex than new company licenses. It seems likely that the NAIC's ongoing efforts in this area, backed by the threat of NARAB, are also contributing factors.



C. Product Filing Approvals

So-called "speed to market" data for product filings has been a source of disagreement among industry and regulators. The NAIC has pointed to increased use of its SERFF system to argue that real progress has been made in improved handling of product filings. According to NAIC data, from January to October 2003, there were 53,616 SERFF filings for life/health products.[56] Of these, 30,997, or 58%, were completed by states in less than 20 days. Only 30% took longer than 30 days, and only 13% took longer than 60 days. States' average approval time for all SERFF filings was 17 days. The NAIC has also pointed out that delays can occur because insurers do not submit complete filings. They note that there is a "review standards checklist" that provides insurers with a straightforward roadmap for form filings, and that if insurers take the time to meet all the required steps in the checklist, they can greatly expedite form review.

Industry advocates argue that the NAIC numbers underestimate the time required to secure approval of their product filings because they can include minor changes to existing products as well as the relatively fast turnaround times of several small states which represent only a small fraction of their customer base. They argue that delays typically occur in the larger states, and that the more meaningful number is the amount of time it takes to reach a significant portion of their customer base. Also, a majority of filings are still processed outside the SERFF system, with New York having the highest

[56] NAIC. (2003) Staff Document. December 3. The NAIC does not track life insurance products separately from health products.

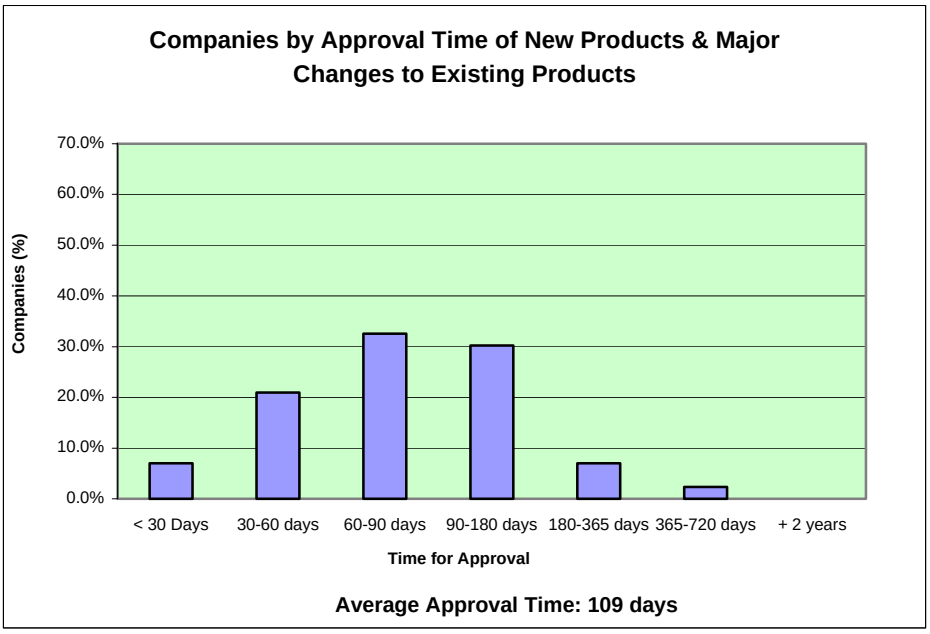
utilization rate – 40% of its filings now go through SERFF. In addition, usage of SERFF is proportionately higher for P&C filings than it is for life products.

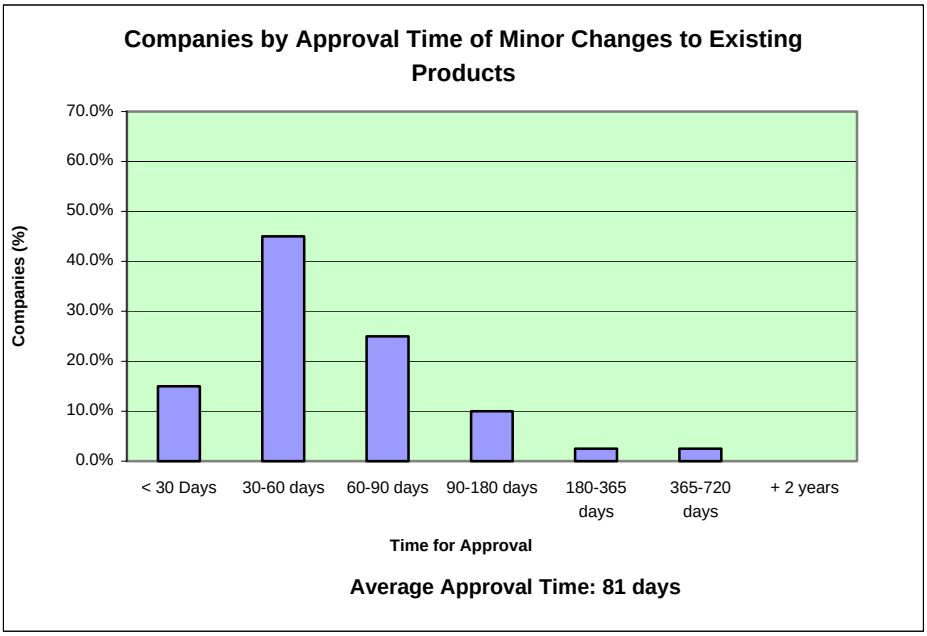
There is no doubt that the NAIC has made tremendous progress with its SERFF system. However, its utilization rate for life products is low. In addition, it only tracks each state's average processing time, not the cumulative amount of time it takes for multiple states to approve form filings. Thus, we decided to ask insurers for "speed to market" data from three different perspectives. For each set of data, we asked insurers to exclude any delays caused by their own failure in responding to reasonable requests for information from regulators.

First, we asked survey respondents to tell us how long, on average, it took them to secure approval of product filings reaching 75% of their customer base[57] in the four product lines subject to this study. We further asked them to distinguish between new product filings or major changes to existing products, and minor changes. In response to this line of questions, only 7% of the companies reported that their average approval time for new products or major changes to existing products was less than 30 days.[58] Twenty-eight percent said, on average, that they could reach this percentage of their customer base in less than 60 days; 33% said it would take between 60 and 90 days. Nearly 40% said it would take over three months. These time frames were somewhat improved for the approval of minor changes to existing products, though 85% of minor changes took in excess of 30 days to reach 75% of customers, with 15% of minor changes taking over 3 months.

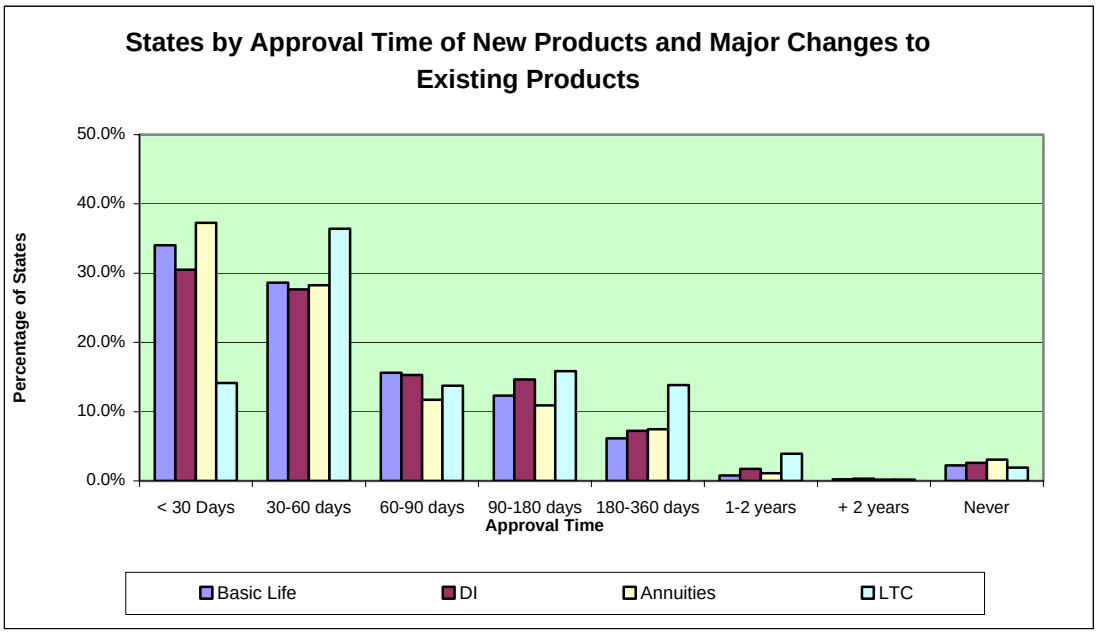
[57] The 75% benchmark was based on input from the Technical Committee that most insurers view 75% as "critical mass" for a new product launch or change.

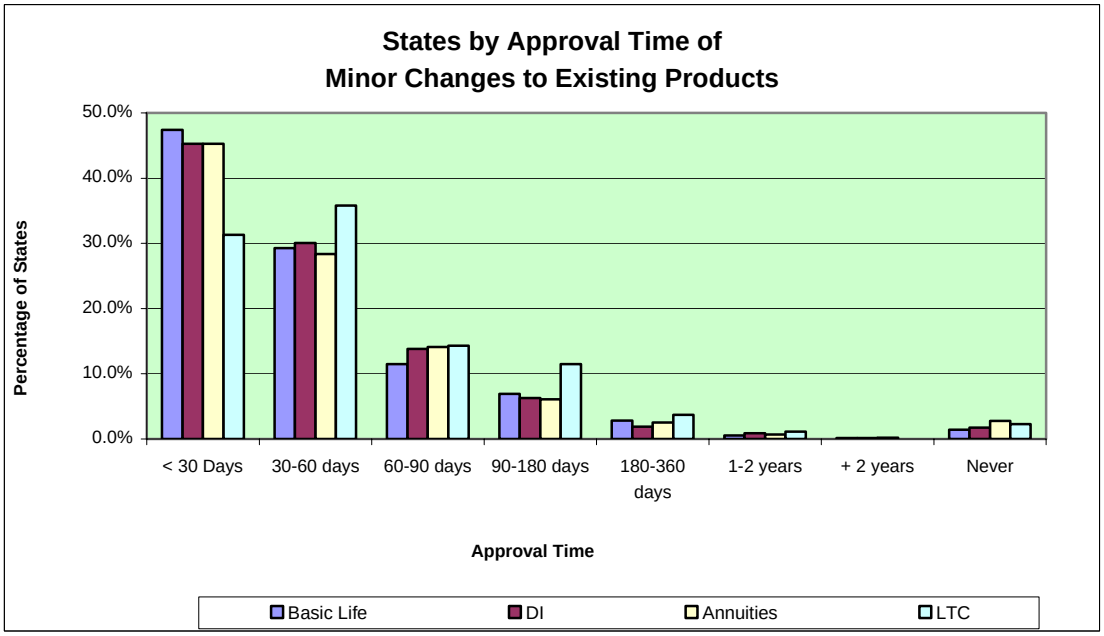
[58] A 30-day benchmark has been embraced as the goal by the NAIC under CARFRA and in its proposed Interstate Compact.


Companies by Approval Time of New Products & Major Changes to Existing Products
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Companies (%)
< 30 Days
30-60 days
60-90 days
90-180 days
180-365 days
365-720 days
+ 2 years
Time for Approval
Average Approval Time: 109 days



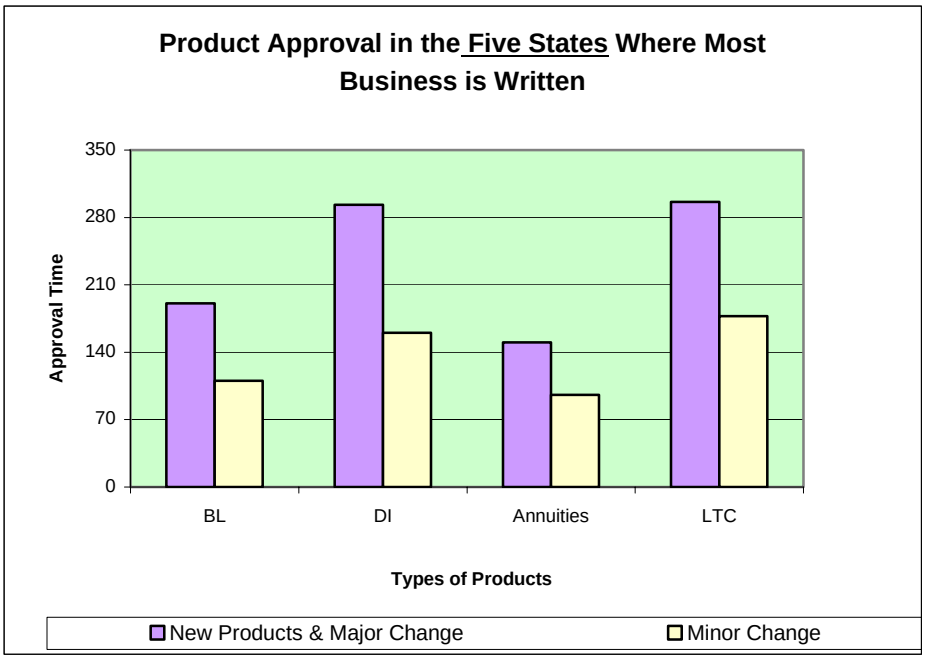
Next, we asked respondents to give us the percentage of states that, on average, approved major product filings within specified time frames, beginning with 30 days or less. Not surprisingly, the picture improved somewhat with this line of questions. For basic life products, respondents answered that 34% of states approved major filings in less than 30 days; the figure was 30.5% for DI policies; and 37.3% for annuities. Only 14.7% met this target, however, for long-term care. Interestingly, for even minor changes, a majority of states took longer than 30 days to approve product filings.



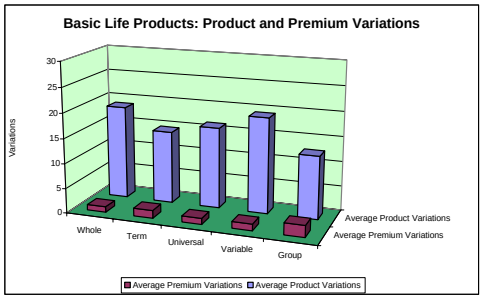


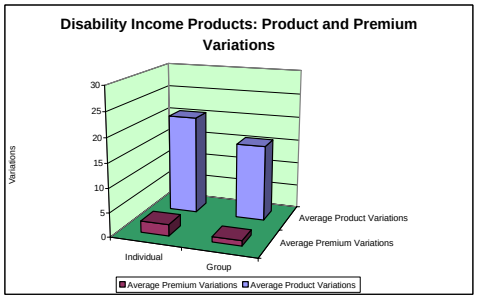
Finally, we asked for data regarding the speed of product approval filings for those states where the insurer had the largest number of policyholders. Responses seemed to buttress the notion that delays are concentrated in the states where insurers conduct the most business. For instance, it took insurers an average of 6 months to secure approvals for major filings in basic life products from the five states where most of their business was written. For annuities, it took over five months. For DI and long-term care products, the

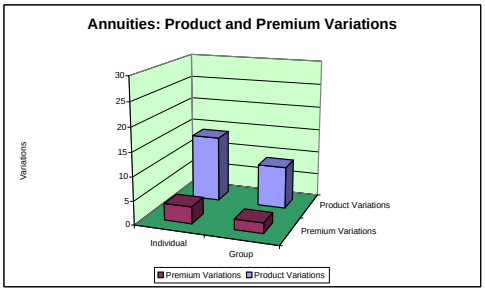
timeframe was over 9 months. Even for minor changes, approval times ranged from 3 to 6 months.

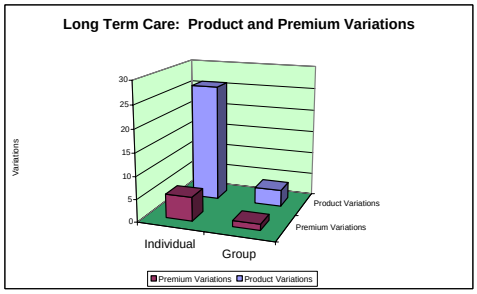


We also asked respondents to identify the number of product and premium variations necessitated by different regulatory approval standards among states, in light of concerns that lack of uniformity contributes to product complexity and inhibits consumers' ability to understand and compare policies. Respondents reported significant variations in policies, with the highest number for individual long-term care policies – though only a small number of premium variations.









The data also suggest that product variations may stem more from differences in statutory and regulatory requirements, than staff interpretations. Nearly 30% of reporting companies said that less than 10% of these product variations were caused by staff interpretations.

D. Specific Examples of Delays in Licensing and Product Approvals

In an effort to document and ferret out reasons for extreme delays in licensing and product approvals, we asked survey respondents to share with us specific experiences they had with delays in the processing of licensing and product approval.

Company Licensing: Respondents provided 16 examples of company licensing applications that took in excess of one year, with the longest delay being 13 years. One state accounted for 7 of the 16 cases cited. The most frequently cited reasons for the delays were backlogs of applications; lost, misplaced, or out-of-date applications, and insufficient regulatory personnel to review them.

Producer Licensing: A few isolated incidents of delay were reported by respondents, but for the most part, it appeared applications to license or appoint non-resident producers were being handled in an expeditious manner. Several respondents attributed this, at least in part, to NARAB, while noting that many states—particularly the larger ones – continued to have differing requirements. They attributed success primarily to reciprocity arrangements, however, and indicated that much work still needed to be done to achieve uniformity in producer licensing standards. Large, multi-state insurers

pointed out that the continued lack of uniformity among states created excess costs in licensing resident producers in each state where they did business.

Product Filings: Respondents provided 63 specific examples of product filings that took longer than a year to approve. Of these, 30 reported a resultant adverse impact on market share. Disability and long-term care products were the most likely to be the subject of delay, followed by basic life and annuities products. The states most frequently requiring product variations according to respondents tended to be the larger states.

Other: MassMutual offered an interesting case study of differing state interpretations concerning its LifeBridge program. Under LifeBridge, MassMutual offers a previously approved $50,000 term life insurance policy free of charge to working parents of low-income families. If the worker dies, the policy proceeds will be used to help pay for educational costs of his or her children. As of this writing, the LifeBridge program is available in approximately 30 states. Before introducing LifeBridge in a state, MassMutual notifies the Insurance Commissioner. MassMutual reports that about one-third of the notified states have requested additional information or raised concerns about LifeBridge based on differing interpretations of substantially similar state laws.

E. The Examination Process

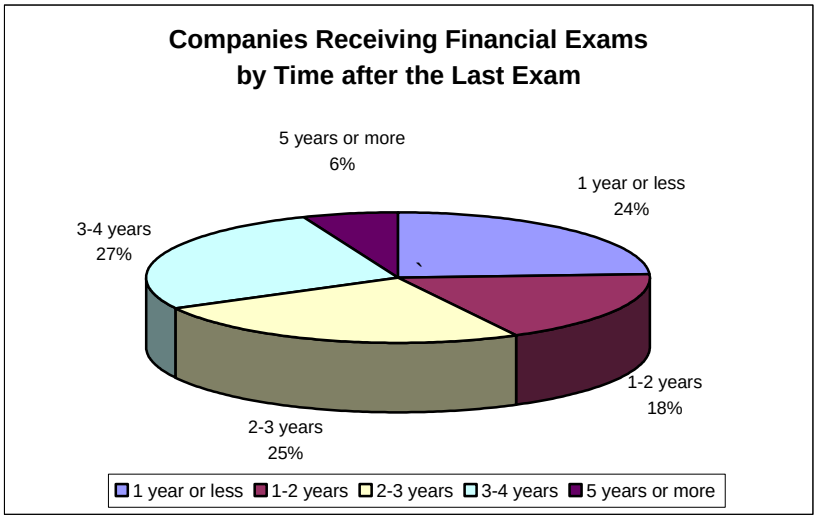
We asked survey respondents for information on the quality and quantity of financial and market conduct examinations that they had received over the past five years.

There were marked differences in companies' experiences with financial examinations versus market conduct reviews, presumably because the former is subject to uniform standards under the NAIC's accreditation program, while no such accreditation program exists for the latter. In general, financial exams occurred on a more routine basis, were full scopes as opposed to targeted, and were conducted of all insurers. Market conduct examinations, on the other hand, were done less routinely, were frequently targeted as opposed to full-scope, and tended to be concentrated, with some insurers receiving multiple examinations, and a few receiving none at all. As a consequence, the more comprehensive financial exams were, on average, significantly costlier to the companies than market conduct exams:

Average Exam Costs			
	Average	Max	Min
Financial Exams	$388,537	$2,500,000	$2,000
Market Conduct Exams	$107,148	$1,400,000	$392

The NAIC recommends that the states conduct financial exams of insurers domiciled within their state every three to five years, while emphasizing that some companies may

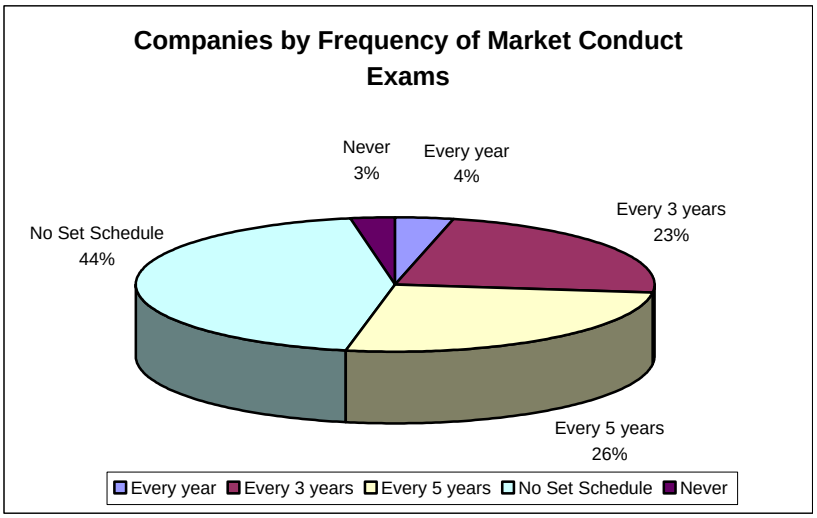
need more frequent exams.[59] As the following chart shows, 67% of respondents had received financial exams within the last three years, with 27% receiving their most recent exam within 3 to 4 years. Only 6% had not received an exam in five years or more:



As would be expected, large companies appeared to receive financial exams more frequently than smaller companies. All companies with assets in excess of $18 billion had received a financial exam within at least the past 3 to 4 years. Forty percent of companies with assets in excess of $55 billion had received an exam within the past year.

In contrast, for market conduct examinations, 44% of respondents indicated that such exams occurred on no set schedule. Three percent stated that they had never received a market conduct exam. Only 4% reported receiving a market conduct examination every year.

[59] Memorandum from Julie Gann, NAIC Financial Examination Manger, to University of Massachusetts Isenberg School of Management (August 6, 2003)



All financial exams received by respondents within the last five years were full scope routine exams, whereas only 58% of market conduct exams were full scope, with the remaining 42% being targeted. Seventy four percent of market conduct exams were combined with financial exams.

Consistent with this, financial exams tended to be of longer duration and involved more staff. For instance, the average on-site portion of a financial exam lasted 168 days, whereas the market conduct exams lasted only 75 days. Financial examination staff averaged 6.3. In contrast, the market conduct review teams averaged 2.4 staff. [60]

Though financial examinations were longer and more comprehensive, market conduct examinations were more numerous. Respondents reportedly received three times as many market conduct exams (338) as financial exams over the past five years. Moreover, though financial exams were routinely done of all companies, market conduct exams tended to be concentrated on particular companies. For instance, 34 of our respondents accounted for 212 market conduct exams.

Several companies reported receiving multiple market conduct examinations from several different states in the same year. This contrasts with the financial exam process whereby the company's domiciliary regulator takes primary responsibility for solvency oversight and other states are expected to consolidate their efforts with the home state supervisor. As previously mentioned, though the GAO has recommended that the NAIC institute a similar accreditation program for market conduct reviews, it has declined to do so, leaving each state to monitor the activities of an insurer within its borders. Of all the states, California is by far the most active in conducting market conduct exams. Of the

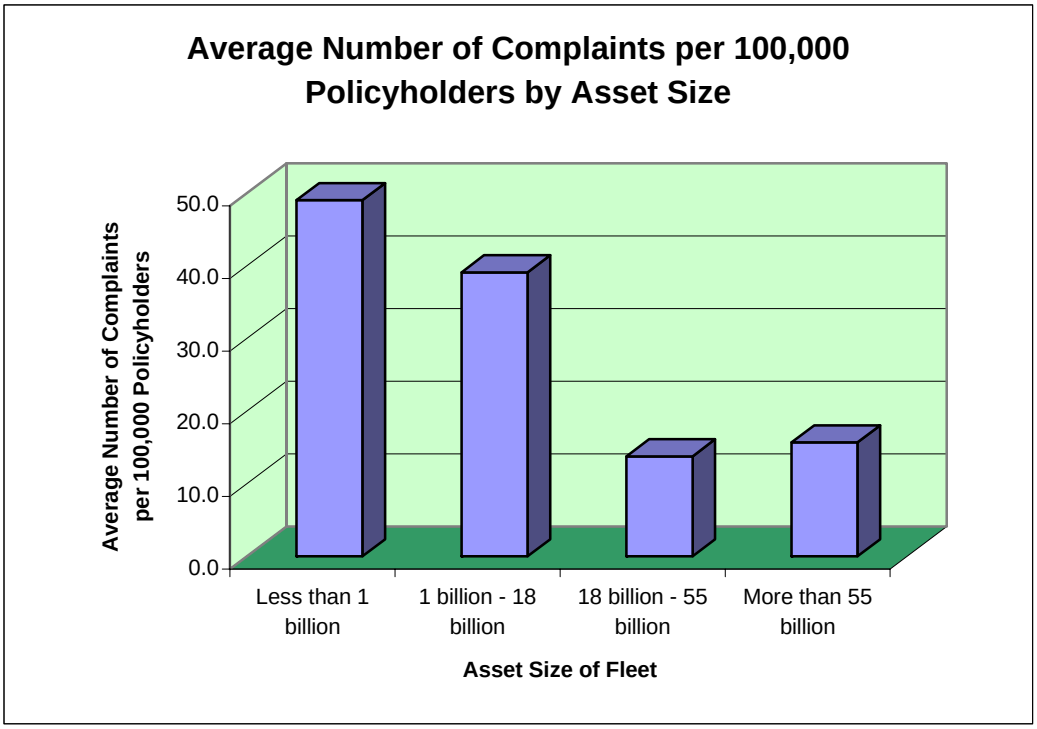
[60] It should be noted that market conduct reviews are limited to an insurer's activities within the state conducting the exam, whereas financial exams extend to an insurers entire operations.

338 market conduct reviews reported by our respondents, 73 were done by California. (See Exhibit 27)

F. Complaint Processing

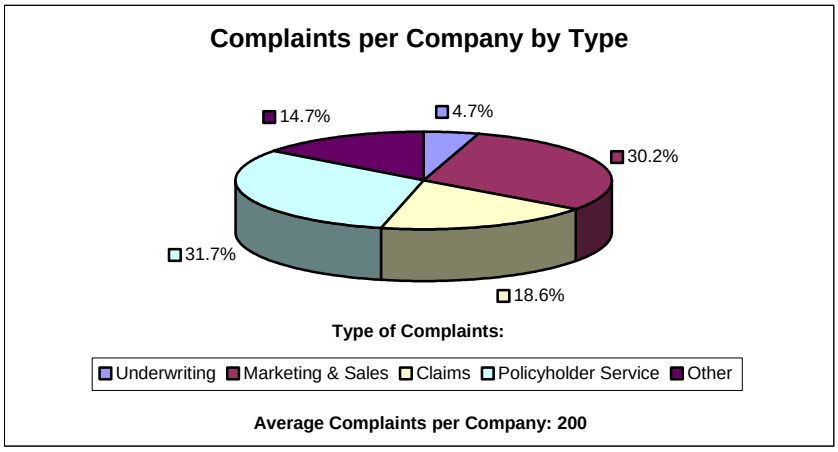
Defenders of the current state system frequently point to complaint processing as one area where local regulators can do a much better job than a remote federal agency. We asked respondents for information about the volume and nature of the complaints they receive, their procedures for handling them and the role of state insurance departments in resolving customer disputes.

Survey data did not suggest a large volume of complaints for the product lines that were the subject of this report. Average complaints per company for 2002 equaled 19 per 100,000 policyholders. Companies with assets in excess of $55 billion averaged 15.7 complaints per 100,000 policyholders; companies with less than $1 billion averaged 49 complaints per 100,000 policyholders.

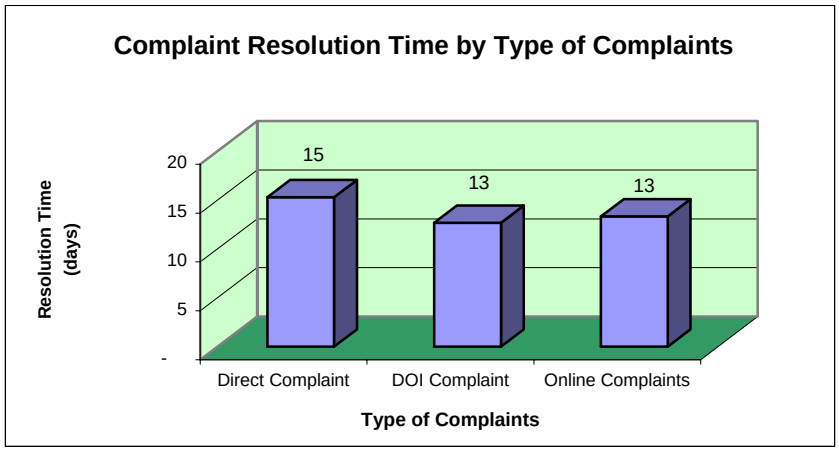


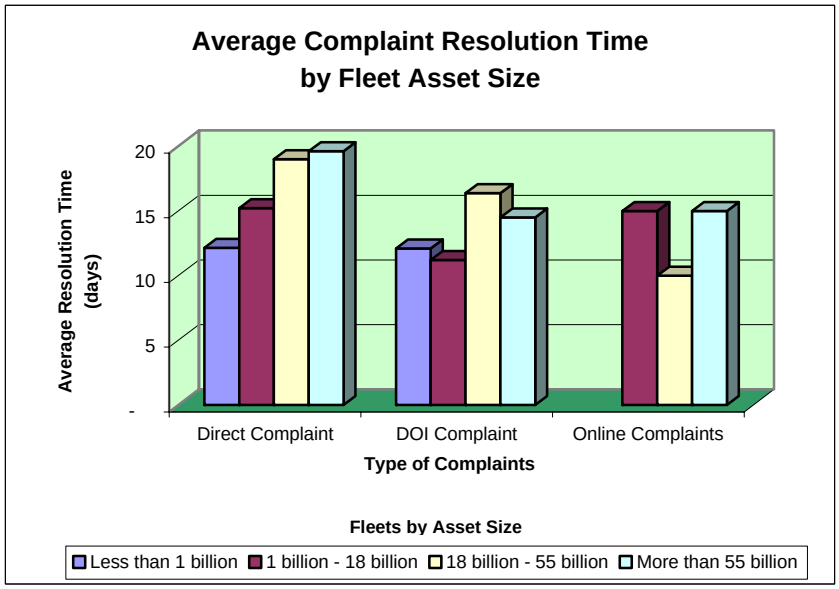
Of complaints received, respondents indicated that on average 39% were referred from a state department of insurance. Respondents indicated that only 23% of complaints required some type of corrective action, with the overwhelming majority being resolved through a satisfactory explanation to the complainant. In 14% of the cases, respondents indicated that a state insurance department had taken active action, defined as a phone call, visit, or investigation, to help resolve the complaint. Marketing and sales and policy

holder service were the most likely causes of customer complaints, followed by claims disputes and underwriting.



Complaints referred from an insurance department were resolved in slightly less time (13 days) than complaints filed directly with the company (15). The ability to file complaints on-line also reduced resolution time to 13 days. Smaller companies tended to resolve their complaints more quickly than large companies.





G. Community Reinvestment

A significant outstanding issue regarding federal regulation of insurance is whether Congress would impose community reinvestment requirements on insurers, as they have done with both federally and state chartered banks. Enacted in 1977, the Community Reinvestment Act (CRA) is designed to encourage banks to provide credit in low- and moderate- income (LMI) communities where they operate. It requires bank regulators to periodically evaluate an institution's record in this regard, and take that record into account in considering an institution's application for deposit facilities, including mergers and acquisitions. Consumer groups would likely push vigorously for CRA type requirements in any legislation creating an optional federal charter for life insurers.

We asked respondents whether they currently invested in LMI areas and to what extent this was required or encouraged by state insurance regulators. They split evenly, with fifty percent reporting that they invested in LMI neighborhoods, and 50% reporting that they did not. Those making such investments tended to be the larger companies, with the average investment amount being $44.2 million in 2002. Respondents indicated that only a handful of states encouraged them to make such investments, with the overwhelming majority having "no impact" on a company's decision to invest. The most frequently cited state programs encouraging LMI investments were the California Organized Investor Network (COIN) and the Massachusetts Capital Resource Corporation (MCRC) and the Life Insurance Industry Community Investment Initiative. Respondents overwhelmingly expressed opposition to a federal mandate for LMI investments, believing LMI investments should remain voluntary. Opposition among small companies was notable. As one small company noted "it is very difficult for a small company to make LMI investments which provide acceptable returns for its portfolio, have acceptable asset structures for the company's liability structure, and are cost effective."

H. Barriers to Entry

We asked respondents their views as to whether the current multi-state system imposed barriers to entry, and their average costs in expanding into additional states. The following chart summarizes average incremental costs in expansion:

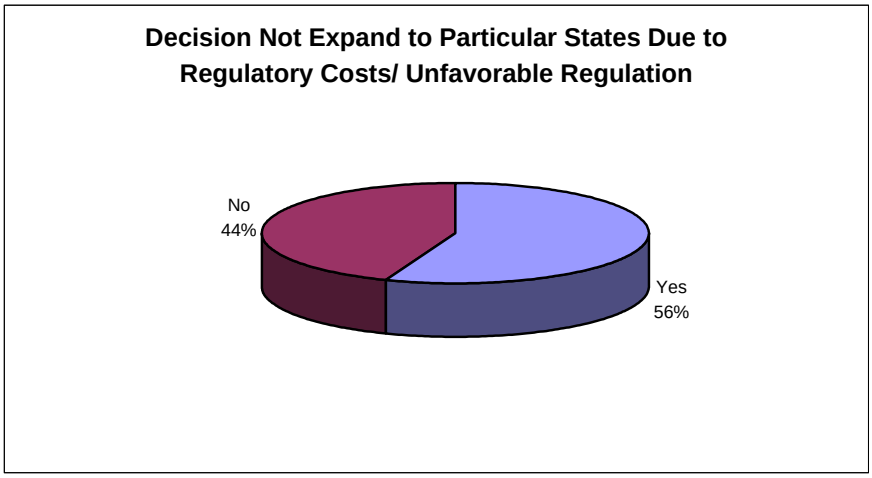
	Per Fleet		**Per Company**	
Average Cost of Licensing in an Additional State	$23,279		$8,673	
Average Cost of Producer Licensing in an Additional State[61]	Per Agent $136	Total $28,199	Per Agent $36	Total $11,280
Average Cost of Product Approval in an Additional State	$12,348		$4,715	

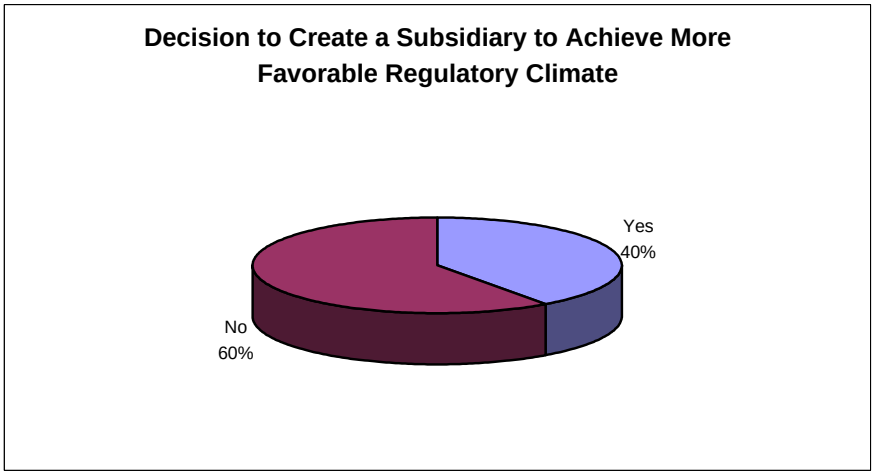
Fifty-two companies said they would expand into additional states if they could become federally chartered. The average number of states to which the respondent companies would expand was 11.52 states.

Just over 55% of respondents indicated that there were states into which they would not expand because of an unfavorable regulatory environment. Forty percent of respondents indicated that they had created a subsidiary in order to achieve a more favorable regulatory climate for certain products. Over two-thirds saw the current system as providing barriers to entry, particularly for smaller companies. Larger companies acknowledged that they had an advantage in already being "in the system" over small companies. All companies, large and small, complained of costs entailed in product filings and ongoing administrative costs in complying with varying regulatory standards.

[61] Regarding Producer Licensing Costs: One company projected 2002 producer licensing costs of several million dollars because of major expansion plans. This data was not included in the average.

Several companies complained that the current system for processing product filings inhibits product modification and expansion because of its inflexible, cumbersome nature.

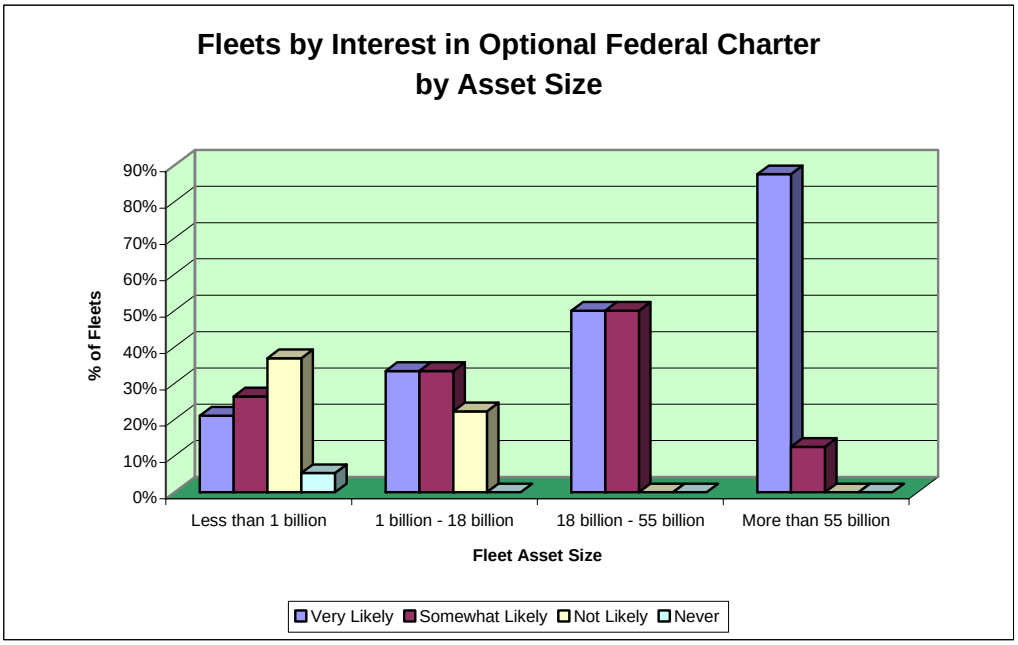




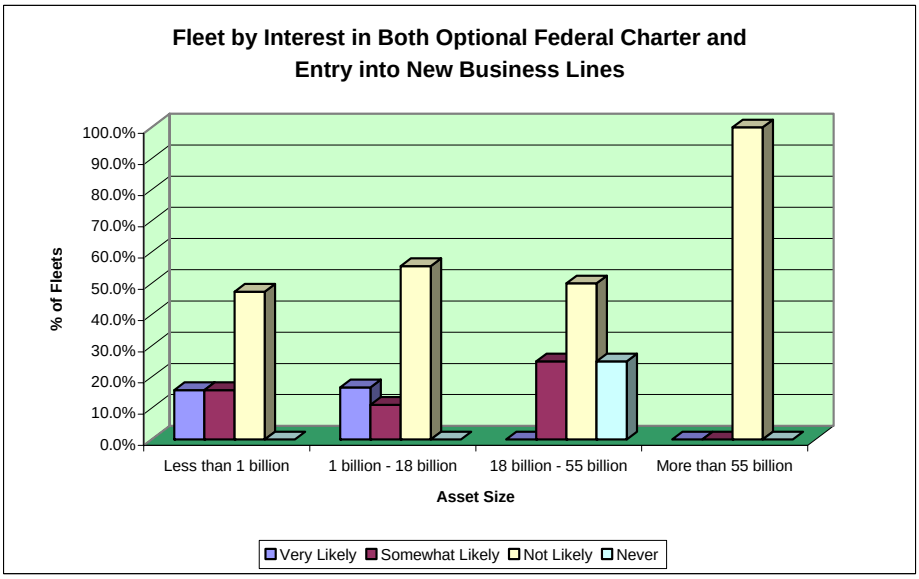
I. Interest in an Optional Federal Charter

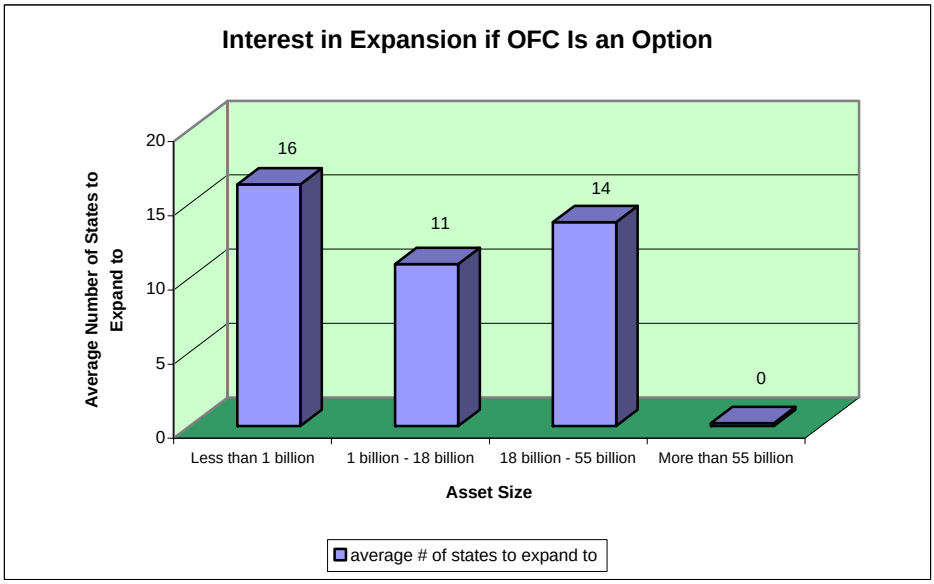
We asked companies if they would opt for a federal charter if that regulatory venue were to be available. Almost three quarters of the respondents indicated that they were "very likely" or "somewhat likely" to choose a federal regulator, with the remaining quarter saying that they were "not likely" or would "never" opt for a federal charter. Not surprisingly, virtually all those fleets with assets in excess of $55 billion said they were very likely or somewhat likely to chose a federal charter. For stand-alone companies and fleets with assets of less than $1 billion, slightly less than half said they were very likely

or somewhat likely to choose federal regulation. That percentage rose to 60% for stand-alone companies or fleets with assets between $1 and 18 billion.



Smaller companies and fleets were more inclined to say that a federal charter would cause them to consider new business lines, though their primary interest in a federal charter was to expand existing lines into new states.




Interest in Expansion if OFC Is an Option
Average Number of States to Expand to
20
15
10
5
0
16
11
14
0
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion
Asset Size
average # of states to expand to

V. FEDERAL BANK REGULATION

A. Background on the Dual Banking System[62]

The dual banking system finds its origins in the National Bank Act of 1863 (NBA). At the time of the NBA's enactment, a state-chartered banking system had become well established, but Congress' previous efforts to charter a single national bank were less successful.[63] Congress was interested in enticing state chartered banks to convert to federal charters for use as federal depositories, to help develop a national currency, and most importantly, to create a market for federal bonds to finance the civil war. The NBA did not displace states banks, nor did it seek to create another single, national bank. Rather it drew upon the "free banking" laws in New York and other states, which allowed incorporation of a bank by any group without the need for a special legislative act. It did, however, set up much more stringent requirements for a national charter in the maintenance of reserves, issuance of national bank notes, loan and capital restrictions, and real estate ownership. It also gave state banks the authority to convert without the consent of the state in which it was chartered, but made no provision for a nationally chartered bank to switch to a state charter.

Federal hopes that most state-chartered banks would convert did not materialize, primarily because federal chartering requirements were so much more stringent than those of the states. As a result, in 1865 Congress tried a more heavy-handed approach: it increased the tax on state bank notes, making state banks so unprofitable that by 1870, the number of national banks was five times that of state banks. Twenty years later, however, state banks regained their dominance, primarily because of the growth in the use of state banks as depository accounts gave them sufficient funding to continue operations independent of bank note issuance.

The early national banking system was deficient in many ways. Issuance of national notes was dependent on the ability of banks to obtain them from the Treasury department, not the bank's business needs. As a consequence, national banks were unable to meet cash demands during the panic years of 1873, 1893, and 1907. Yet, the early system made important contributions to bank regulation. It provided for central supervision through the Treasury Department's Office of the Comptroller of the Currency, and also imposed minimum capital requirements and restrictions on loans and bank borrowing to help assure safety and soundness.

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[62] There are any number of excellent histories of the dual banking system. These include Ken Scott's "The Dual Banking System: A Model of Competition in Regulation" (Issues in Financial Regulation McGraw-Hill 1978); "National Banks and the Dual Banking System" (OCC September 2003); Howell Jackson, Regulation of Financial Institutions (Westlaw 1999).

[63] The First Bank of the United States operated from 1791 until its charter expired in 1811. It was revived by Congress in 1816 as the Second Bank of the United States. It survived until 1836, when President Andrew Jackson blocked renewal of its charter, spurred by populist suspicion of the bank and opposition to it among the states.

The federal government made one final attempt to overcome the state banking system in the early 1900's. It did so mistakenly by easing capital requirements, resulting in the chartering of a number of small, weak banks. This effort did not succeed in destroying the state banking system, though it did result in the subsequent failure of a number of poorly capitalized national banks.

With the creation of the Federal Reserve System in 1913, Congress sought to address problems with the inelasticity of the money supply and the funding needs of banks by providing a means of rediscounting commercial paper. It also sought to enhance bank regulation by giving the Federal Reserve Board supervisory powers. The Federal Reserve Act required national banks to become members of the Federal Reserve System, while state banks were given the option. State banks were wary of taking on a new federal supervisor, however, and only 37 had joined the system by 1916.

The Federal Reserve Act also added a proviso to the National Bank Act stating that state-chartered banks could not switch to a national charter in contravention of state law. As a result, national banks lacked authority to switch to state charters, and states could block their chartered institutions' from converting to a national bank. Though this could have inhibited charter competition – a touchstone of the dual banking system – a number of states enacted provisions authorizing state banks to switch charters. National banks found a way around their lack of authority to switch, through voluntary dissolution and reorganization as a state bank. In 1950, the banking industry persuaded Congress to enact a conversion statute allowing them to convert or merge with a state-chartered bank without the permission of the Comptroller.[64]

For most of the early history of the banking system, there were no bright lines dividing banking, securities, and insurance. Some banks originated as insurance companies. The free banking acts sought to limit state-chartered banks to "core" banking activities as a result of early problems with banks' securities activities. [65] However, after the Civil War, state-chartered banks won the right to conduct securities activities as part of their trust powers. National banks undertook securities activities through unregulated affiliations with investment banks. These dealings gave rise to the financial scandals widely viewed as contributing to the Great Depression, which in turn, led to enactment of the Banking and Securities Acts of 1933.

The Banking Act of 1933, commonly referred to as Glass-Steagall after its principal authors, generally required the separation of commercial and investment banking. When banks later began circumventing this restriction by forming holding companies, Congress responded with the enactment of the Bank Holding Company Act of 1956 (BHCA). The BHCA authorized the Federal Reserve Board to regulate bank holding companies and to restrict or prohibit affiliations with nonbank entities, including insurance companies.

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[64] Scott, at fn 52.

[65] When the Second Bank of the United States' charter expired in 1836, Pennsylvania chartered it as the United States Bank of Pennsylvania and required to invest in public works. The bank invested heavily in the stocks and bonds of projects to which it had also loaned money. The resulting concentrations in exposure ultimately led to the banks demise.

Restrictions on nonbanking affiliations were gradually eroded over the years through regulatory action, and finally repealed with the 1999 enactment of the Gramm-Leach-Bliley Act (GLBA).

The 1933 Banking Act also initiated a greater interrelationship between the federal and state banking systems through the establishment of the Federal Deposit Insurance Corporation (FDIC). Though deposit insurance was initially made available only to members of the Federal Reserve System, nonmember state banks have long since been able to join the FDIC, and virtually all have done so. Moreover, through its authority over the FDIC, Congress has been able to heavily influence the laws and policies under which all state-chartered banks operate.

As part of its Depression era reforms, Congress also created the Federal Home Loan Bank system, to provide funding to support mortgage lending by thrift institutions. An independent entity, the Federal Home Loan Bank Board (FHLBB), was created to charter federal thrifts and provide safety and soundness oversight of the system's regional banks and their members.[66] Weaknesses in the regulatory structure of the FHLB System were widely credited with contributing to the savings and loan debacle of the late 1980's. In 1989, Congress passed the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA), which abolished the FHLBB and created a new agency, Office of Thrift Supervision (OTS), to charter and regulate federal thrifts. [67] The Congress modeled OTS after the OCC, making it an independent bureau of the Treasury Department, with similar powers and strong emphasis on safety and soundness oversight.

Thus the federal bank regulatory structure as its exists today consists of four primary agencies:

- The OCC, which serves as lead regulator for national banks and their subsidiaries;
- The OTS, which serves as lead regulator for federally chartered thrifts and their holding companies[68];
- The Federal Reserve Board, which serves as lead federal regulator for state-chartered member banks, as well as bank holding companies, including those operating as financial holding companies.
- The FDIC, which insures deposits for virtually all state and federally chartered banks and serves as lead federal regulator for non-member state-chartered banks.

Regulatory responsibilities for state chartered banks are shared between the state bank supervisor and the FRB, for member banks, and the FDIC, for nonmember institutions. For federally chartered institutions, the OCC and OTS are the lead regulators.

[66] "Home Owners Loan Act (HOLA) of 1933." 48 St. 134.
[67] Another independent agency, the Federal Housing Finance Board, was created to regulate the FHLB system's regional banks.
[68] The OTS also regulates state chartered savings associations, which belong to the Savings Association Insurance Fund (SAIF), administered by the FDIC.

As is clear from the following discussion of bank regulator responses to our survey, the federal bank regulatory culture is markedly different from that of state insurance regulators. Modern banking regulation places much less emphasis on "front-end" regulation, with the bulk of regulatory resources concentrated on examinations and enforcement. Chartering applications, for instance, only consumes 3% of the OCC's budget. Prior approval requirements are virtually nonexistent for permissible banking products. At the same time, examinations are conducted on a much more frequent and routine basis, and include not only safety and soundness oversight, but "compliance reviews" as well, which focus on bank adherence to a wide range of consumer protection laws. These requirements are generally applicable to all FDIC insured institutions and include:

- Community Reinvestment Act (CRA): The CRA requires regulators to evaluate a bank's record in serving the credit needs of communities that it serves and to take that record into account in passing on applications for deposit facilities, including mergers and acquisitions.

- Truth in Lending Act (TILA) which requires banks and other creditors to disclose the finance charge, Annual Percentage Rate (APR), amount financed, and total of all payments to consumers for closed-end credit loans.

- Equal Credit Opportunity Act, which prohibits discrimination in consumer or commercial credit transactions, and the Fair Housing Act, which prohibits discrimination in all aspects of residential real estate transactions.

- A variety of disclosure and data reporting requirements related to mortgage lending, including the Home Ownership and Equity Protection Act (HOEPA), which requires certain disclosures in addition to TILA for high costs mortgage loans and the Home Mortgage Disclosure Act (HMDA), which requires banks and other mortgage lenders to report detailed mortgage lending data by zip code.

- Privacy Requirements under Title V of the GLBA which require clear disclosure by all financial institutions regarding the sharing of non-public personal information with both affiliates and third parties, and opportunity for consumers to "opt-out" of information sharing arrangements with unaffiliated parties.

Banks examiners also monitor for compliance with the Bank Secrecy Act, as recently amended by the USA PATRIOT ACT, which places affirmative obligations on banks to monitor and report for potential illegal money laundering and terrorist financing activity.

Notably, Congress has made the anti-terrorist financing requirements under the USA PATRIOT ACT, as well as the GLBA privacy provisions, apply to all financial institutions, including insurance companies, while preserving authority to oversee and enforce these requirements with state insurance commissions.

The focus of most federal consumer protections laws has been on enhanced disclosure, based on a bipartisan consensus that informed consumers are better able to evaluate the merits of financial products than regulators. Congress has not hesitated to proscribe specific activities where it appears market mechanisms cannot be relied upon, though it has generally declined to require advance merit review of federally regulated bank products, or to prohibit specific products.

B. Results of the Federal Bank Regulators' Survey and Some Comparative Observations

For the purposes of this research project, we primarily based our analysis on the OCC and the national banking system to determine the potential impact of a dual chartering of insurance on consumers. However, we also surveyed other federal banking regulators (FDIC, FRB, OTS) to help obtain a full perspective on how the national government approaches bank regulation. In the late summer and fall of 2003, we submitted two questionnaires to all four federal banking regulators; one covering safety and soundness examinations and enforcement issues; the second covering consumer complaint processing and compliance examinations.[69] A complete summary of responses to these questionnaires is available in the appendix.

Budget

Cost comparisons between federal bank regulators and insurance regulators are difficult because of the differences in regulatory structure and the nature of the businesses that are regulated. Below is a rough comparison of budgetary information supplied by OCC, OTS, and the NAIC reflecting regulatory budgets as a percentage of assets, and on a per institution basis. The data reflects that while budget expenditures as a percentage of assets are higher for insurance regulation, they are lower on a cost per institution basis. This likely reflects the prevalence of larger institutions among federally chartered banks and thrifts, whereas state insurance commissions are responsible for a larger number of smaller institutions.

Financial Institution Regulatory Costs, 2002

	Number of Regulated Institutions	Total Budget (in millions)	Total Assets of Regulated Institutions (in billions)	% Budget/ Assets	Cost per Institution	Average Asset Size of Institution
DOIs and NAIC	7,173	$993	$4,778	0.0208%	$138,464	$666,176,371
OCC	2,203	$422	$3,900	0.0108%	$191,739	$1,770,313,209
OTS	958	$164	$1,400	0.0117%	$170,668	$1,461,377,871

[69] A compliance examination assesses a financial institution's fulfillment of federal law and regulations, with emphasis on consumer protection and non-discrimination.

All four federal regulators are self-funded. OCC and OTS both receive the vast majority of their funding, 96.2% and 90% respectively, from assessments charged to regulated institutions. OCC also has a small percent of funding from investment income on U.S. Treasury Securities.

Self-funding is generally viewed as a sign of regulatory independence. The ability to control its own budget contributes stability in funding, and less susceptibility to political pressure being exerted through the legislative appropriations process. NAIC's 2002 Annual Report indicates that the majority of insurance commissions are also funded primarily through fees and assessments, though 14 states continue to rely on general revenue for a significant source of funding.[70]

OCC's and OTS budgets are overwhelmingly concentrated on "back-end" examinations and enforcement. OCC tracks its budget by 4 major program areas: supervise, charter, regulate, and analyze risk. The supervise area includes 3 subprograms: examining, enforcing, ensuring fair access and fair treatment. The supervise program is 85% of OCC's budget. If the regulate and analyze risk programs are added in, OCC's back-end costs amount to 97% of its budget. Expenses for the front-end charter program, which includes organizing and licensing, represent about 3% of its overall budget. Similarly the OTS spends the majority of its budget on back-end regulatory activities such as examinations. The FRB and FDIC budgets reflect lesser percentages on examinations because of these agencies' significant non-regulatory functions. However, interviews with these agencies' regulatory staff indicate that they also rely on examinations and enforcement as their main supervisory tool in assuring compliance with financial and consumer protection requirements.

Examination Personnel

OCC's supervisory emphasis is also apparent in the number of staff involved in examinations. The majority of OCC full-time equivalent staff (FTEs) are bank examiners.

[70] NAIC. (2003) 2002 Insurance Department Resources Report. Table 10. In some states, even though the insurance commissions are funded through assessments and fees, the state legislature may still control the proportion of those amounts that can be included in the insurance commissions' budgets. Thus, the commission cannot control its budget outside of the political process.

Safety & Soundness Examination Staff

	Total # of FTEs Supporting S&S Exams	Total # of Examiners	Total Assets of Regulated Institutions	Total # of Institutions Regulated
FDIC	**2,758**	**1,755**	**$33.4 billion**	
FRB	**2,584**	**1,234**	**$1.9/$8.2 trillion** (a)	**950/5,128** (a)
OCC	**2,372**	**1,882**	**$3.9 trillion**	**2,150/53** (c)
OTS	**730**	**526**	**$1.4 /$5.3 trillion** (b)	**958/1,021** (b)
TOTAL	***8,444***	***5,397***	***$7.2/$17.4 trillion*** (a) (b)	

(a) The first number is for FRB-regulated, state-chartered member banks, the second for bank holding companies, including those operating as financial holding companies.
(b) The first number is for OTS regulated thrifts, the second for thrift holding companies.
(c) The first number is for national banks and the second is federal branches of foreign banks.

In contrast, according to the NAIC, state insurance commissions employ a total of 962 financial examiners, 375 market conduct examiners and 435 financial analysts. The lesser concentration of staff resources on examinations and analysis reflects the state insurance commissions greater reliance on front-end regulation and longer exam cycles.

Examiner Pay

	Avg. Years of Examiner Experience	Avg. Examiner Pay	Range in Examiner Pay
FDIC	**12 to 20 years** (a)	**$68,477**	**$36,849-$111,020**
FRB	**13.7 yrs.**	**$74,743**	**$53,133-$104,023**
OCC	**15.5/16.6 yrs.** (b)	**$79,578**	**$30,000-$150,000**
OTS	**19.3 yrs.**	**$82,029**	**$34,600-$147,242**

(a) This range was given as "average tenure", so average years of experience is likely to be less.
(b) The first number is for years of OCC experience, the second for total government experience.

These salary ranges significantly exceed that available to most state insurance commission staff. Reflecting more limited revenues available to individual state insurance commissions, top examiner salaries in most states do not exceed $75,000.[71]

[71] NAIC. (2003) 2002 Insurance Department Resources Report. Table 7.

All four federal banking regulators have accreditation requirements for examiners. Fifth year OCC examiners take the uniform condition exam to get accreditation. Currently 79% of OCC examiners are accredited. The percentages of accredited examiners are even higher at the FDIC and OTS.

Examiners primarily join the OCC through entry-level positions. The average entry-level examiner has a B.A. in accounting or business. The first six months consist of rotations and highly structured classroom training. Prior to examination OCC primarily prepares examiners through on the job training. A minority of examiners are hired for experience in specialized career areas, specific skill sets, and industry background, such as derivatives analysis. OCC examiners who focus on derivatives analysis are usually credit experts with experience in capital markets. Additionally, these examiners may attend specialized training courses such as the FFIEC Capital Markets course.

Enforcement Staff

	Total # of FTEs Supporting Enforcement	**Avg. Years of Experience**
FDIC	**238**	**15 yrs.**
FRB (a)	**-**	**-**
OCC	**39**	**25/10** (c)
OTS	**11**(b)	**22 yrs.** (d)

(a) FRB did not provide information regarding Enforcement Staff level or years of experience
(b) 11 FTEs are exclusively devoted to enforcement, and another 7 FTEs in regional offices engage in some enforcement activities.
(c) Examiners in the OCC's Special Supervision Division average 25 years experience, while attorneys in the Enforcement & Compliance Division average 10 years.
(d) Average given specifically for attorneys.

The OCC has enforcement staff in the special supervision division who specialize in problem banks and in the enforcement division focused on legal issues. The regulator does not require enforcement training, but does encourage staff to attend FFIEC bank fraud, FFIEC White Collar Crime, and other courses such as deposition training and trial advocacy.

Safety and Soundness Examinations

Federal regulators generally conduct safety and soundness examinations annually. All four regulators note that some small institutions receive examinations on 18-month intervals under specifically delineated conditions. OCC may extend the schedule to a longer period for a bank with the following attributes: less than $250 million in assets, well-capitalized, well-managed, outstanding composite ratings, no enforcement actions, and no change in control in the last 12 months.

OCC occasionally combines safety and soundness examinations with compliance examinations. While the FDIC and FRB may also combine exams, the OTS has begun to conduct a regular melded examination, with both safety and soundness and compliance functions.

The average length of time for safety and soundness examinations and on-site visits varies by regulator. The related data for the other regulators is in the appendix. All OCC safety and soundness examinations include on-site visits for institutions.

OCC Safety and Soundness Examinations for Institutions of Different Asset Sizes

	Avg. Length of Exam (a)	Avg. Length of an On-Site Visit	Avg. # of Examiners for On-Site Visit
Assets >$10 billion	Continuous	Continuous	20-30
Assets $1-10 billion	Continuous	Continuous	-
Assets< $1 billion	-	2-3 weeks	3-10

(a) Length measured from notification of exam to issuance of final report.

OCC has 20-30 in-residence staff at the 10 largest banks it regulates. Staff include an examiner in charge (EIC) and team leaders. At the EIC level there is a formal rotation on a 3-5 year cycle. The rotation is important because of the complexity, the need to learn new areas and to re-evaluate and look at institutions in different ways. Team leaders are also rotated though less than EICs. Additionally there are at-large teams in geographic regions that flow from one large bank to another to supplement the work at particularly points.

Compliance Examinations

All four federal regulators conduct examinations on two different cycles for smaller and larger banks. FRB and FDIC use the CRA definition of small banks: institutions with less than $250 million. Small banks with high supervisory ratings receive a compliance exam every 4-5 years; small banks needing improvement can receive such exams every 12 months. Large banks are generally on a 12-24 month cycle, depending on their compliance rating.

OTS combines its safety and soundness examinations with its compliance reviews. Institutions with assets over $250 million received annual examinations; smaller institutions receive exams every 18 months. OCC uses an integrated risk-based approach to its examination process. One supervisory plan covers the assessment of all bank activities, including compliance. OCC implements the supervisory plan for community banks either annually or over an 18-month cycle, for banks in good condition. For larger banks OCC carries out the review plan for compliance over a three-year cycle with supervisory activities conducted throughout that cycle. Resident staff at OCC's 5 largest banks carry out continuous compliance supervision.

Compliance Examinations in 2002

	Total # of Examinations	# of Routine Examinations	# of Targeted Examinations
FDIC	1,838 (a)	-	-
FRB	369	369	0
OCC	739 (b)	739	31/27 (c)
OTS	386	373	13
Total	**3,332**	**1,481**	**71**

(a) FDIC's records do not distinguish between routine and non-routine examinations.
(b) OCC opened 739 compliance exams in 2002, but not all may have concluded in that year.
(c) OCC lists targeted exams that are in addition to the routine examinations. The first number is for expanded scope money laundering and the second is for expanded scope fair lending exams.

By way of comparison, in 2002, 1,333 market conduct exams were initiated by state insurance commissions and 465 combined financial/market conduct exams were launched.[72]

The overwhelming majority of compliance examinations are full-scope, routine exams. OCC has some non-routine expanded scope examinations for money laundering and fair lending. In 2002 the specialized examination program focused on banks identified as high-risk for terrorist financing. Similarly for fair lending exams, the OCC has a process to identify banks with high risk in this area. Risk assessment factors include the strength of the fair lending compliance program, underwriting and decision-making processes, loan product mix, and pricing and marketing practices. Additional sources of information are HMDA and market share data, consumer comments, and other regulators.

Regarding exam duration, OCC may complete a compliance exam cycle in larger banks over a 3 year period, but supervision is continuous -- there is no "one-time" event known as a compliance examination. For community banks, OCC does sometimes complete a one-time compliance examination. The average duration for such exams is 53 workdays.

The FRB, OCC, and OTS all report that 100% of compliance examinations include on-site visits in all asset groups. FDIC usually has an on-site component for examination with the exception of some targeted processes.

Complaint Processing

For the purposes of this survey, the definition of complaint included customer communications expressing a grievance and did not include an inquiry or a request for information.

The1975 Federal Trade Commission Improvement Act required the federal banking regulators each to create a separate office to respond to complaints about supervised

[72] NAIC. (2003) 2002 Insurance Department Resources Report.

institutions. An Executive Order in 1979 further required these offices to track, investigate, and reply to complaints, and then to include complaint analysis in the development of supervisory policy.

Complaint Processing

	# of FTEs in Complaint Processing	# of Complaint Offices	Avg. Duration of Complaint Resolution	% of Complaints Resolved in 30 Days
FDIC	36	8	20 days (b)	73% (b)
FRB	46 (a)	13	60 days	17%
OCC	40	1	41 days	25%
OTS	14	4	55 days	N/A

(a) FRB's number includes both Board and Reserve Bank staff.
(b) FDIC's complaint resolution data includes referrals to other appropriate supervisory agencies.

OCC has a centralized complaint office in Houston, Texas. The other three federal regulators have complaint staff in various regional offices. OTS did not provide data for the percentage of complaints resolved within 30 days. However, OTS noted that its practice is consistent with FDIC and OCC policy of resolving complaints within 60 days.

2002 Consumer Complaints

	# of Complaints Received	# of Complaints Closed	# of Complaints Investigated by Regulator	# of In-Person Meetings with Consumers
FDIC	8,408/4008 (a)	8,257/3,815 (a)	2,763	Not tracked
FRB	5,730	5,711	2,757	18
OCC	38,840	38,738		Approx. 24
OTS	6,273	5,399	7,026 (b)	N/A

(a)The first number represents complaints received by the FDIC, including those forwarded to appropriate federal regulators with the supervisory responsibility for the institutions involved. The second number indicates complaints identifying financial institutions supervised by the FDIC.
(b) OTS includes both complaints initiated in 2002 and those filed earlier but resolved in 2002.

In contrast, state insurance commissions received 496,272 complaints in 2002, but also employed 793 complaint analysts.[73] The average caseload for complaint handlers was significantly lower for the state insurance commissions than it was for the OCC: 626 per FTE for the states, as compared to 971 per FTE at the OCC. The FDIC had the lowest average complaint caseload: 111, followed by the FRB with 124.

OCC follows a review process for all written complaints. A customer assistance specialist does an initial review, sends it to the institution for a reply, and then analyzes the response. Customer assistance seeks additional information from the institution if there is a disagreement or if the initial response had insufficient detail. OCC occasionally

[73] Ibid.

has on-site examiners obtain supplementary information. OCC does not encourage in-person meetings with consumers, but it does receive about 2 walk-ins each month. In contrast, state insurance regulators report meeting with several hundred complainants a year.

All four federal regulators follow-up with the institution about referred complaints and require a written response from the institution. Additionally each regulator maintains a complaint activity database. FDIC, FRB and OCC all specifically note that they use complaint data to inform compliance exams.

Consumers can contact OCC and OTS by email, telephone or the mail. The FRB and FDIC accept complaints by those means and through their websites. FDIC also allows faxes. FDIC requires the complaint to be in writing to initiate an investigation and OTS requires a physical signature to process a complaint involving personal financial information. OTS will accept complaints via email if a signed version arrives later.

All the banking agencies send a final letter to consumers about the resolution of their complaints. FDIC only transmits such letters to those who have written to them. FDIC and FRB send out consumer satisfaction surveys. All the bank regulators except the OTS report making complaint data available to the public. The FRB and OCC specifically refer to the Freedom of Information Act (FOIA). While OTS does not publish complaint data, they may provide some aggregate data if requested in accordance with FOIA.

Percent of Complaints by Company Asset Size

	> 100 billion	**$50-100 billion**	**$20-50 billion**	**$1-20 billion**	**<$1billion**
OCC	85%	10%	3%	1%	1%
OTS	61% (for >$20 billion)			29%	10%

The FDIC and FRB do not track complaints by the asset size of the financial institutions.

OCC believes it has the premier complaint handling process and tracking system. OCC reports regularly meeting with the largest national banks each year to review complaint volumes and trends and to provide peer data.

Dual Charters

OCC reports that the percentage of charter conversions (from federal to state and vice versa) is less than 1% per year for the number of banks supervised. OTS reported an average of 0.8% of thrifts transfer per year from a state OTS-thrift charter to a federal OTS-thrift charter. An average of 0.9% charter conversions per year were to an OTS-thrift charter (federal or state), while 1.8% were from an OTS thrift charter (federal or state). Transfers from an OTS federal charter to a state, non-OTS, charter averaged 0.9%.

OTS reported two thrifts had switched charters more than once. In 1995 an institution changed from a federal mutual savings institution to a state stock savings bank and then

back to a federal stock institution. In 1998 a different institution switched from a state mutual savings bank to a federal stock saving bank and then back to a state stock savings bank. Neither FRB nor FDIC track institutions that have switched charters more than once. OCC does not know of any institutions switching charters more than once.

The OCC and FDIC do not believe that the ability of a bank to opt for either a federal or state charter inhibits effective enforcement of consumer protection laws. FDIC points out that federal consumer protection laws are enforced against institutions that hold both federal and state charters by the appropriate federal financial institution regulators. Unless pre-empted, state consumer protection laws also apply to all institutions that fall within the appropriate state's jurisdiction. Furthermore OCC notes that both the state banking regulators and the OCC enforce consumer protection laws.

OTS believes in charter choice and that institutions should have the right to choose the best charter that fits their particular niche or business strategy. OTS reports that it works closely with state and other federal banking regulators. OTS finds that these good working relationships help enhance rather than inhibit the effective enforcement of consumer protection laws.

The FDIC, OCC, and OTS all are unaware of any instance in which an institution has changed charters in order to avoid consumer protection requirements.

VI. IMPACT ON CONSUMERS OF OPTIONAL FEDERAL CHARTERING

A. Uniformity

It seems clear that consumers could benefit from uniform national regulation in a number of ways.

Company and producer licensing would be streamlined with uniform standards and a single point of filing. This would enhance the quality of review, reduce costs and inefficiencies, and promote competition by making it easier for smaller companies to expand nationwide. A federal insurance regulator could also expedite the creation of a uniform system for background checks of producers that is integrated with both state and federal regulatory and law enforcement databases. [74] The lack of such a system has been a key impediment to achieving uniform producer licensing standards, and has hindered state regulatory efforts to address so-called "rogue" agents who move from one jurisdiction to another.

Consistent with the bank regulatory approach, a federal regulator would be in a position to develop a single set of common standards for market regulation that would include all states. Market conduct examinations could be conducted on a routine, company-wide basis in contrast to the current hodge-podge of multiple exams by individual states. Uniform regulatory standards could assure consumers that they would enjoy the same regulatory protections regardless of where they might live during the years they hold their policies.

Uniform product standards would enable consumers to better understand and compare policies. The Medigap experience is one example of how national product standards can help consumers.[75] In 1990, Congress mandated that new Medigap policies conform to one of ten standardized packages, and most studies have shown that this reform has achieved highly favorable results. Though Medigap standards are more prescriptive than standards likely to be adopted by a federal regulator, the Medigap experience illustrates how uniformity can improve customer understanding of products and thus promote competition.

A federal regulator could enhance the quality of product review, given the fact that a federal regulator would have a level of national prominences and greater resources to attract staff. A number of individuals interviewed for this report expressed concerns about the uneven quality of review under the current system, and the ability of regulatory staff, particularly in smaller states, to understand the intricacies of insurance product

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[74] We acknowledge the efforts NAIC has made to persuade Congress to address this issue, but believe this underscores that insurance issues are not always given the priority attention they deserve because of a lack of a federal role and expertise in insurance regulation.

[75] See., e.g., Rice, Graham and Fox. (1997) "Impact of Policy Standardization on the Medigap Market." *Inquiry.* Vol 34, Summer. ; Health Care Financing Review. *Medigap Reform Legislation of 1990: A 10 year Review.* Spring.

filings. Centralized review of filings under uniform standards could make for better utilization of staff resources and more in-depth review.

Insurers would also have greater ability to modify policies, and innovate new products in response to customer demand. Regulatory costs and delays associated with new products in areas such as long-term care would be reduced. A "one-stop" approval process would allow insurers to more immediately obtain national experience with a new product, and reduce the costs of making adjustments. On the other hand, a national regulator would have resources to hire expert specialists to assure expeditious, but at the same time, in-depth and high quality review.

Not only would a federal regulator achieve uniformity in the regulation of nationally chartered insurers, it would also likely contribute to greater uniformity in state regulation. State bank regulation has achieved a high degree of uniformity in many areas. The reason: state legislatures and bank regulators have found that for their charters to be attractive to large, multi-state institutions, they must provide some level of uniformity to make it cost-efficient for those banks to operate under a state charter. Presumably, this dynamic would also be at work under dual chartering for insurers.

B. Greater Emphasis on "Back-End" Regulation

Federal bank regulators place great emphasis on ongoing examinations and supervision, and less emphasis on "front-end" regulation, particularly in the area of product approval. Federal bank statutes and regulations generally prefer strong disclosure requirements in lieu of merit review of individual financial products. This is based on the philosophy that informed consumers, not regulators, are in a better position to determine a product's merits, and that the market will reward products that offer true benefits to consumers and punish those that do not. This philosophical approach, however, rests on the assumption that consumers are in position to understand and meaningfully compare products, as well as determine the ongoing ability and willingness of the company to make good on its commitments. Because of imperfect information that may be available to consumers in this regard, federally regulated banks are required to make specific disclosures regarding the cost structure of their products, and are also subject to frequent, rigorous examinations, and ongoing supervision.

A federal insurance regulator patterned after a federal bank regulator would likely conduct much more frequent and comprehensive examinations. This could entail annual solvency examinations for all but the smallest institutions, as well as market conduct examinations on a 1 to 3 year cycle, depending on the size of the institution and its record on consumer protection. A federal regulatory regime could also be expected to emphasize clear disclosures, particularly with regard to pricing, just as bank regulation emphasizes pricing disclosures under the Truth in Lending Act and other federal consumer laws.

Some might argue that annual examinations are not necessary for insurers because they do not have the same liquidity demands as banks. However, it could just as easily be argued that *because* policyholders place less frequent demands on a life insurer's liquidity, they are in a worse position to evaluate their insurer's ongoing ability to fulfill its commitments than are bank customers. Consumers will typically have multiple transactions with their banks in a given year. If a bank has insufficient resources to meet its commitments, or if its customer service deteriorates, those facts will become quickly apparent. In contrast, insurance customers presumably investigate their life insurers before purchasing their policies. However, it may be many years before the insurer is called upon to fulfill its obligations and during that time, the company's management and investment policies could radically change. Reserves might be dissipated. A company's previous practice of treating consumers fairly might shift. The difficulty of life insurance policyholders to know about such changes before they actually make a claim – when it is too late -- argues just as easily for more rigorous, ongoing oversight.

Survey data indicated that the bulk of complaints received by life insurers arose from producer misconduct or claims disputes. These are the types of abuses most likely to be revealed through on-site inspection of an insurer, review of customer complaint records, and interviews with insurer personnel. Insurance commissions responding to our survey consistently ranked product approval behind market conduct supervision in regulatory importance. Thus, concentrating greater resources on examinations and ongoing oversight should enhance regulatory quality by placing more focus on those areas more likely to ferret out customer abuse.

A central issue is whether a federal regulator would do away with prior product approval requirements in favor of a system of "file and use." Though industry-backed proposals clearly contemplate such a shift, they are controversial with traditional consumer groups. Industry advocates, along with market based citizens groups, assert that a "file and use" approach is necessary to achieve true parity with banks and securities firms, and that "file and use" is more consistent with modern financial regulatory theory which allows consumers to decide for themselves the merits of particular products. Traditional consumer advocates counter that the pricing and terms of insurance policies are more difficult to understand than banking products, and that unlike banking customers, insurance customers might not be able to understand the full ramifications of "bad" products until years after purchase when they make a claim. "Some bad products are coming to market too quickly," says CFA's Hunter.

It should be noted that even under a "file and use" regime, a regulator would be able to block the sale of a new product (or implementation of a product change) that is deemed to violate regulatory requirements. "File and use" allows the insurance company to take the product to market upon filing, though the regulator may take action to block the product at any time upon a finding that it violates regulatory requirements. The advantage to the insurer is that it can bring the product to market quickly. The disadvantage is that the insurer runs the risk the regulator might subsequently find that the product does not comply with regulatory requirements. Prior approval requires the regulator to affirmatively take action to approve the product before it is brought to market. It can

result in delays in marketing the product, but once approved, the product enjoys a regulatory imprimatur. Advocates of "file and use" argue that it encourages greater due diligence on the part of insurers to design products in full compliance with regulations, given the legal risks in selling a product regulators might later find harmful to consumers. Critics of "file and use" argue that it allows abusive products to be sold until regulators take action.

Survey data indicated that the current prior approval regime is causing significant delays in bringing new products or product changes to market. Interviews with industry officials also suggest that the current cumbersome process has a chilling effect on making product changes and enhancements in response to consumer demand. However, *it is unclear how much of this is attributable to lack of uniformity and centralization, versus the need for prior approval.* If prior product approval requirements were retained under the federal system, the risk that a federal regulator would arbitrarily refuse to approve a product, or subject it to extended delays, seems low. Federal regulators generally operate under a much brighter spotlight than their state counterparts. Arbitrary regulatory action meets with a quick response from Congress and/or the media. In addition, given its expected interaction with federal bank and securities regulators, a federal insurance regulator would presumably be highly cognizant of the opportunity of banks and securities firms to exploit its regulatory delays, which should augur against arbitrary action. On the other hand, if a federal regulator did arbitrarily refuse to approve a product, the consequences would be much more severe than regulatory inaction by individual state insurance regulators, insofar as the product would be blocked nationwide not just in an individual state.

On balance, given the greater complexity of insurance products, it would seem prudent to retain prior approval requirements for most products unless and until federal standards are developed to improve disclosure and simplify policies.[76] Though not perfect, bank and credit products are subject to an extensive disclosure regime that is lacking in the regulation of insurance products. Conversion to a "file and use" system could perhaps be justified for term policies, or whole life products of minimal complexity and clear pricing that are marketed to a "high-end" clientele, or variable products that must already go through a registration process at the SEC. However, prior approval requirements should be retained for products with a history of consumer abuse, such as small face life policies, where market competition is inhibited because of the way the product is sold, e.g., credit life, or where the company making the filing has a past record of violating consumer protection rules. In addition, prior approval and rate regulation of LTC and DI products should be preserved given their complexity, and the vulnerability of the population relying upon them. A single, centralized rate and form review of such products should help insurers more efficiently adapt them to customer needs and make them more widely available, while at the same time preserving important consumer protections.

[76] As CFA's Hunter puts it, "With file and use, issues like product regulation for uniformity, suitability, disclosure, and simplification take on more importance. If you are going to put more responsibility on the consumer, you need to give them the tools to understand and compare the products."

C. The Potential for Regulatory Arbitrage

A key objection to dual chartering for insurers is that the ability of insurers to shift back and forth between state and federal charters would place undue pressure on regulators to accommodate industry views leading to a "race to the bottom" in regulatory standards. Traditional consumer groups have expressed strong opposition to optional federal chartering where the insurer, at its sole discretion, can "pick" its regulator, believing this structure is a "prescription for regulatory arbitrage that can only undermine needed consumer protections."[77] While acknowledging OCC's strength as a safety and soundness regulator, some consumer groups charge that the OCC has been insensitive to consumer needs, placing solvency regulation over consumer protections and, as discussed below, preempting state consumer laws to benefit nationally chartered banks. Supporters of optional chartering, and even some of its critics[78] believe that competition among state and federal regulators would improve efficiency, just as does in the private markets.

Federal bank officials interviewed for this study dispute the notion that dual chartering leads to a "race to the bottom." [79]They argue that the reputation risks inherent in lax regulation effectively preclude regulators from competing on that basis. They point out that federal financial regulators are under heavy, continual scrutiny by the media, Congress, and politically powerful national consumer advocacy groups. Any perceived efforts to relax safety and soundness or consumer protection requirements provokes swift and vigorous response from one or more of these groups. If anything, they argue, dual chartering leads to a "race to the top" because competing state regulators also keep a close eye on their federal counterparts and are quick to denounce any perceived deficiencies in federal oversight.

Given generally acknowledgement of the high quality of bank supervision – state and federal – that exists in this country today, it does not appear that regulatory competition has led to a diminution in standards. Indeed, the one clear historical example of negative competition – federal efforts to ease capital standards after the Civil War to attract banks to the national charter – failed miserably. Since that time, dual chartering has for the most part resulted in a healthy dynamic of give and take, with many examples of competitive pressures producing positive results for consumers. For instance, the Office of the Comptroller of the Currency led desegregation of the nation's banks. States today are taking the lead against predatory mortgage lending. Both OCC and OTS have taken hard lines against bank/thrift affiliations with payday lenders with the result that no nationally chartered bank or thrift affiliates with a payday lender. There are some 12 state-chartered banks that have such affiliations; however, these relationships are under intensifying

[77] Robert Hunter. (2003) "State of Insurance Regulation."
[78] Scott Harrington. (2002) "Optional Federal Chartering of Property-Casualty Insurance Companies." August.
[79] Interview with Jerry Hawke, Comptroller of the Currency (January 20, 2004).

review by the FDIC[80] and state regulators – no doubt at least partly because of competitive pressure from OCC and OTS.

In addition, it appears that in the banking area, consumer groups have been more successful in securing various consumer protections than they have at the state level in the insurance area. The Community Reinvestment Act, the Home Mortgage Disclosure Act, and the Truth in Lending Act are all central to banking regulation yet they have no ready counterpart in insurance. Moreover, because of these extensive requirements, consumer advocates tend to be more visibly represented in the banking industry on boards and advisory committees, as well as with regulators.

Critics of dual chartering point to the current controversy over OCC's recently finalized "field pre-emption" regulations as evidence that dual chartering allows industry to undermine regulators' efforts to toughen consumer protections. As discussed in more detail below, legitimate issues have been raised about the scope of OCC's recently finalized pre-emption rules and their compatibility with traditional state prerogatives. However, the suggestion that these rules were motivated by a desire to weaken consumer protections applicable to national banks does not seem supportable. Rather, the purpose of the rules appears to be, as Comptroller Hawke has stated, the protection of uniform, consistent and predictable regulatory standards applicable to national banks. It is generally acknowledged that national banks and their subsidiaries are not a significant source of predatory lending abuses. Nor does it appear that where instances of abuse have been discovered, the OCC has failed to move aggressively. It has pioneered use of Section 5 of the FTC Act to combat lending abuses, and recently strengthened its ban on loans that rely on the foreclosure value of the collateral for repayment. It has intensified its vigilance against unfair lending practices, no doubt spurred by public scrutiny and complaints from state bank regulators and attorneys general – the competitive pressure has been "up."

OCC's defense of its position would have been stronger if, in conjunction with its preemption rules, it had issued anti-predatory lending rules that were modeled more closely after those adopted in the states, or if Congress had already enacted a strong national anti-predatory lending standard. OCC's rule against asset based lending, while helpful, falls short of stronger state proscriptions in many respects. Congress has not acted because there is as yet no national consensus on what constitutes "predatory lending" – underscoring the importance, as discussed below, of letting states continue to experiment in this area before a national preemptive standard is developed. On the other hand, OCC's aggressive use of Section 5, coupled with its proscription of asset based lending, impacts national banks and their affiliates nationwide. In contrast, only 21 states have enacted predatory lending laws, and many of these are nothing more than a reiteration of HOEPA's minimal standards. Though large states such as California, Illinois and New York have among the strongest anti-predatory lending laws, residents in most states have no specific protection in this area at all.

[80] John Lane. (2003) Statement of the Deputy Director, Division of Supervision and Consumer Protection, FDIC Banking Policy Advisory Committee. November 19. 0

The low number of banks -- less than 1% per year -- that switch between federal and state charters suggests that there is not much "shopping" between regulatory venues. None of the federal bank regulators interviewed for this report were aware of any instance where a bank changed charters to avoid application of consumer protection requirements.

For their part, industry officials interviewed affirmed that their interest in optional federal chartering was to achieve uniformity and promote regulatory efficiency and quality, not to avoid regulatory requirements. In an effort to address concerns about the potential for regulatory arbitrage, one chief executive said he would be willing to support a requirement that a company would have to keep its national charter for a minimum of five years. [81]

Finally, the current system of insurance regulation provides the opportunity for regulatory arbitrage among states. Several respondents to our industry survey indicated that they had set up separate subsidiaries to achieve parity with competitors domiciled in less restrictive regulatory environments. Arbitrage among state regulatory regimes may be problematic because of the ability of insurers to domicile in a smaller, remote state, with limited regulatory resources and lacking organized consumer representation. Thus, the danger of "negative" competition under the current system may be more acute than it would be under a system of federal/state dual regulation.

The lack of a federal insurance regulator to coordinate with federal bank supervisors also creates the potential for regulatory gaps in consumer protections. For instance, bank and insurance regulators take differing approaches toward single premium credit insurance (SPCI). To address concerns about excessive premiums, the NAIC has recommended setting a minimum loss ratio of 60% on such products. The OCC's approach has been to prohibit similar bank products, generally referred to as lump sum "debt cancellation agreements" (DCAs), on residential mortgages and has imposed various disclosure requirements and consumer safeguards on other uses of this product, but has not imposed a fee cap.[82] As discussed below, SPCI abuses are ripe for strong national standards. An OFC would provide a vehicle for implementation of such a standard, which Congress could also choose to extend to DCAs.[83]

D. The Problem of Pre-emption

Background: Financial services regulation is one of many areas where Congress and the individual states have concurrent jurisdictional interests. This inevitably leads at times to conflict between federal and state law. To resolve these conflicts, the Supremacy Clause of the U.S. Constitution states that federal law is "the supreme Law of the Land" thereby

[81] Interview with Robert O'Connell, President and CEO, MassMutual (Jan. 5, 2004)
[82] In addition, the FRB recently amended its HOEPA regulations to require that premiums/fees on both SPCI and lump sum DCAs be included in calculating whether a mortgage is viewed as "high cost" under HOEPA. The FRB's action has had a significant chilling effect on the offering of such products by mortgage lenders.
[83] An excellent analysis of the SPCI/DCA issue can be found "Consumer Credit Insurance" (CRA Report to Congress, Sept. 20, 2002)

preempting state law. Over the years, a considerable body of case law has developed for determining when a federal law overturns that of a state.[84]

Preemption analysis generally divides over whether the preemption is "express" or "implied." "Express" preemption arises when Congress has clearly stated its intention that federal law is to preempt state laws. Preemption can also be "implied" by the courts from a federal statute's structure and purpose. "Field" preemption is a form of implied preemption that arises when a federal statutory scheme is so pervasive or dominant that it can be assumed Congress intended to leave no room for state regulation. "Conflict" preemption, on the other hand, is a form of implied preemption that arises when a federal statute is in irreconcilable conflict with a state law.

With regard to federal thrift regulation, the Home Owners Loan Act gives OTS authority to "provide for the organization, incorporation, examination, operation and regulation" of federally chartered thrifts. Based on this statutory authority, OTS and its predecessor have, over the years, promulgated a series of regulations and advisory opinions that consistently rely on a finding that the Congressional scheme for federal thrift regulation was to preempt the field.

In contrast, until recently, the OCC has relied on a conflict analysis in making preemption determinations, dating back to the enactment of the National Banking Act which grants national banks the authority to exercise "all such incidental powers as shall be necessary to carry on the business of banking."[85] The Supreme Court has repeatedly addressed the scope and nature of national bank regulation preemption of state laws, most often ruling in the OCC's favor. In the seminal case of Barnett Bank of Marion Count v Nelson,[86] the Court struck down a Florida law that restricted the sale of insurance by national banks because it conflicted with a federal statute that granted national banks the right to sell insurance in towns with less than 5,000 in population. In Barnett, the Supreme Court stated, "grants of both enumerated and incidental 'powers' to national banks are (interpreted as) grants of authority not normally limited by, but rather ordinarily preempting, contrary state law."[87] The Court went on to state that "normally Congress would not want States to forbid, or to impair significantly, the exercise of a power that Congress explicitly granted" but also that preemption was not intended to "deprive States of the power to regulate national banks, where (unlike here) doing so does not prevent or significantly interfere with the national bank's exercise of its powers."[88]

The National Association of Attorneys General (NAAG), the Conference of State Bank Supervisors (CSBS) and others have pointed to Barnett in challenging regulations recently finalized by the OCC which establish field preemption in the area of real estate lending and expand the list of previously enumerated state laws the OCC believes are

[84] In fact, the first Supreme Court case to uphold the supremacy of federal law, M'Cullloch v Maryland, 17 US 316 (1819) involved the Second Bank of the United States' challenge to a Maryland law taxing its activities.
[85] 12 USC Section 24
[86] 517 US 25 (1996)
[87] Id at 32
[88] Id at 33

preempted under court precedents. The OCC's rules apply not only to national banks, but to their operating subsidiaries as well. The rules appear to preempt most states laws applicable to banking, including consumer protection laws, specifically preserving only those that deal with contracts, torts, crimes, taxation, or zoning – essentially those areas where the Supreme Court has expressly held that federal preemption under the NBA does not apply. Critics have charged that instead of using the "significantly interfere" standard under Barnett, OCC has embraced a standard that preempts any state law which arguably "impairs the efficiency" of a national bank's lending operations.[89] OCC has responded that the standards articulated in its new rule are compatible with a variety of Supreme Court precedents.[90] Critics also complain that that OCC is ignoring Congressional intent as expressed in the Riegle-Neal Act which purported to preserve application of state consumer and certain other laws to the interstate branches of national banks "except if" preempted by federal laws.

Federal Preemption under an OFC for Insurers: Any establishment of a federal regulatory regime for insurance – whether optional or unitary – will necessarily involve some level of preemption, whether express or implied. It can be presumed that Congress would not go to the trouble of creating a new regulatory regime for insurance while permitting states, in the words of Barnett "to forbid, or to impair significantly" that regulatory regime through enactment or promulgation of its own laws and regulations. Thus, the question becomes not whether there should be preemption, but rather, what should the nature and extent of that federal preemption be?

The controversy over preemption in federal bank regulation has generally focused on consumer protections. Safety and soundness standards are usually viewed as the proper province of the regulator that has chartered the institution. In the consumer area, one approach is to establish federal standards as a "floor" over which states would be free to apply. In other words, federal law preempts only those state laws and regulations that can be viewed as weaker than the national standards. This was the approach taken by Congress in the Gramm-Leach-Bliley Act's treatment of the federal privacy standard for financial institutions. Specifically, the GLBA provides that the privacy standard does not preempt state law if the protection it "affords any consumer is greater than the protection provided under this subtitle, as determined by the FTC…." [91] This is the approach to preemption which traditional consumer groups would vigorously advocate in any legislation to create a federal insurance regulator.

The GLBA took a different approach regarding federal preemption of bank/insurance affiliations and insurance sales by national banks and their subsidiaries. Section 104 of the GLBA prohibits states from "preventing or restricting" these affiliations, and limits the states to actions to prevent the insolvency of one of the affiliates. Regarding insurance sales, solicitations and cross-marketing activities of national banks and their subsidiaries,

[89] National Association of Attorneys General. (2003). Letter to Office of the Comptroller of the Currency Regarding Docket No. 03-16, 12 CFR Parts 7 and 34. October 6. **CSBS letters (related to preemption)**
[90] John D. Hawke. (2003) Letter from John D. Hawke, Jr. Comptroller of the Currency to the Honorable Paul S. Sarbanes. December 9.
[91] GLBA Conference Report (1999) November 1.

GLBA codifies the Barnett standard that a state may not "prevent or significantly impair" the ability of a national banks to engage in authorized insurance sales, subject to 13 safe harbors.[92]

Whether Congress should utilize the GLBA privacy standard, the Barnett standard, or some new standard, whether it should invoke field preemption or require conflict analysis are likely to be hotly debated in any effort to create a federal insurance regulator. Preemption issues engender strong passion among consumer advocates who find some states more receptive to their concerns than the national government. It is equally important to industry advocates, who want to maximize regulatory uniformity for their multi-state operations. Industry advocates are wary of trying to distinguish between "safety and soundness" and "consumer protection" requirements. They are also wary of trying to distinguish laws that provide the "strongest" consumer protections.

The problem with such delineations lies in their imprecision. Are state requirements specific to bank affiliated insurance sales designed to protect consumers or to impede competition, which would hurt consumers? Do "countersignature" requirements for out-of-state producers protect consumers from rogue foreign agents, or protect the state's domestic producer community? Because of the uncertainty and unpredictability of trying to make such delineations, dual chartering advocates generally favor a broad approach to federal preemption. Preemption may take on added importance in the insurance area, where states have shown hostility toward the creation of a federal regulator and may be motivated to pass laws interfering with its powers and oversight. Moreover, if preemption were too limited, the consensus reason for creating a federal regulator – uniform regulatory standards – would be undermined.

Though the scope of preemption should be sufficient to achieve the needed level of uniformity and protect against potential hostile state action, it should also tolerate bona fide efforts by states to protect consumers within their borders. States can serve as laboratories for experimentation with consumer protection initiatives – testing grounds that can inform the development of national policy. For instance, North Carolina's 1999 anti-predatory lending law was decried as radical by some lenders when it was first adopted. However, most major subprime lenders have now adopted its key provisions voluntarily. Far from discouraging subprime lending, the North Carolina standards have helped create "bright line" standards, which have facilitated the extension of subprime credit. One of the advantages of dual chartering is that it leaves a state regulatory structure in place to provide this kind of experimentation.

Moreover, Congress has shown, as it should, reluctance to preempt state law in the area of consumer financial services. The OCC's new preemption rules have provoked considerable controversy.[93] Industry was successful in last year securing extension of the

[92] GLBA, Sec. 104(d)(2)(B)

[93] In addition to opposition from the NAAG, CSBS, and a host of consumer groups, NY AG Eliot Spitzer has initiated litigation challenging the rules. Cong. Sue Kelly (R NY), Chairman of the Oversight and Investigations Subcommittee of the House Financial Services Committee has initiated hearings. In February 2004, the Committee voted 34-28 to censure the OCC for issuing the rules without Congressional

Fair Credit Reporting Acts preemption provisions, but efforts to also secure a preemptive national privacy standard gained little momentum. Congress may be loath to preempt state consumer laws in the area of insurance regulation without also establishing strong federal standards in their place. Below is a partial list of initiatives consumer groups would likely want addressed as part of any effort to establish federal regulation of life insurance and which should be addressed to maximize consumer benefit from federal regulation[94]:

1) Form regulation to promote uniformity and comparison shopping of policies.
2) Rules for internet marketing of life products, including guides that cover price and solvency service.
3) Abuses in the small face life market. There have been a number of reported abuses in the small face value life market, particularly in the marketing of these products to low income and minority groups. Consumer complaints generally focus on excessive premiums (in some instances, many multiples of the face amount) and insufficient value to cover funeral expenses.
2) The lack of an insurance suitability standard. Variable annuity and variable life products are already subject to federal suitability standards under the securities laws. Consumer groups believe all life products should be subject to suitability standards, and that rate of return disclosures should be required for whole life policies. According to CFA's Hunter "It is at times impossible to discern the rate of return on a whole life policy. If a product has advertised investment features, rate of return disclosures should be required."
3) Collection of market performance data by zip code, similar to requirements imposed on banks under the Home Mortgage Disclosure Act, and strong prohibitions on race-based premiums.
4) Credit Scoring and other criteria many consider to be discriminatory and arbitrary in evaluating risk, including human genome rating. Birny Birnbaum, the head of the Center for Economic Justice, points out that credit scoring frequently penalizes victims of economic or medical catastrophes and has a disparate impact on poor and minority consumers.
5) Single premium credit insurance (SPCI). Most major banks and their affiliates have dropped SPCI in mortgage lending as a result of a number of state laws banning or restricting the product, and action by the Federal Reserve Board including SCPI in the test used to determine whether a mortgage is classified as a high cost "HOEPA" loan. However, SPCI is still widely used in other types of consumer lending, particularly auto loans. In addressing SPCI, Congress should also address the use of comparable debt cancellation agreements (DCA) offered by banks.

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authorization and without increasing the agency's consumer law enforcement budget. See, American Banker, "Mixed View on Impact of Panel's Preemption Vote" (Feb. 27, 2004)

[94] Birnbaum (2003) Interview.; Birny Birnbaum. (2003) "Insurance Credit Scoring." Testimony of Birny Birnbaum, Center for Economic Justice, Before the New York Assembly Committee on Insurance. October 22.; Hunter (2003) Interview.; Hunter (2003) Testimony.; Lavada LaSalle. (2003) Written Statement of Lavada e. Desalles, Member, AARP Board of Directors, Before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises of the Committee on Financial Services, U.S. House of Representatives. May 15.

6) Community Investment. A number of states already have voluntary community investment programs for insurers which are supported by both industry and community groups.

E. Impact on the State Regulatory Structure

Critics of dual chartering also argue that the creation of a federal regulator would overwhelm state insurance commissions and ultimately lead to their demise. They argue that a national regulator would have unfair competitive advantage in terms of stature and resources, thus making it impossible to maintain the attractiveness of a state charter. Thus, eventually, there would be no meaningful dual system, but a de facto monolithic national regime.

This argument does not find support in the experience of dual bank chartering. Indeed, Congress created the federal banking system to supplant the state banking system, but in this effort, it was singularly unsuccessful. Competition from a federal charter had the reverse effect of strengthening the state banking system, creating a "dynamic and interactive regulatory structure."[95] Historical analysis of bank charter conversions indicates that throughout the dual banking system's history, neither regime has been able to dominate. Even the rapid rate of conversions to national bank charters during the 1960's eventually slackened and then reversed. [96] Recent trends continue to reflect a healthy dynamic between the two systems. In fact, the percentage of FDIC-insured institutions that are state chartered has grown from 66.2% in 1984 to 73.9% in 2003. The percentage of domestic deposits held in state chartered institutions has grown from 42.6% to 46.0%.[97]

State banks had no difficulty staying in business during the many decades that passed between enactment of the NBA and the creation of the Federal Reserve Board and later, the Federal Deposit Insurance Corporation. At the same time, it must be acknowledged that the involvement of these two powerful federal agencies in regulating state-chartered banks has enhanced the competitiveness of the state charter. Proposals for optional federal insurance chartering do not contemplate the creation of a single federal guarantor agency for all insurers. Thus state regulators and their chartered insurers would not have their "own FDIC" to enhance state regulation and serve as an advocate in federal policy debates.

Nonetheless, state regulation of insurance is well entrenched, and it is unlikely to be "done in" easily. Survey responses suggest that while support for creation of a federal insurance *option* is widespread, a significant 25% were unlikely to choose that regulatory venue. It appears much of the desire for optional federal chartering is to create a

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[95] Ken Scott article, fn 52.

[96] From 1962 to 1966, under the liberal chartering policies of Comptroller James Saxon, the ratio of national/state charter conversions was 3 to 1. However, during the period 1967 to 1974, the trend reversed itself, with 50% more conversions to state charters than a federal charter. Id.

[97] CSBS, from data supplied by the FDIC.

competitive environment that will improve efficiency in the system. If that can be achieved, it seems likely that a number of insurers would be content to remain with their state regulators.

In fact, one positive outcome from the consumers' standpoint would be to increase regulatory resources available to state insurance commissions, while reducing the number of institutions for which they are responsible. All OFC chartering proposals provide that nationally chartered insurers would continue paying premium taxes to the states. Premium taxes – which represent 88% of all state insurance generated revenues --are a significant source of regulatory funding in many states. As has been proposed, this revenue stream would continue to be available, even though the number of institutions regulated by the states would shrink.

F. Complaint Processing

Most individuals interviewed for this study felt that states insurance commissions play an important role in complaint handling, and that a national regulator would not be as accessible to consumers in helping to resolve disputes. Some consumer groups also criticized the OCC's complaint handling processes as weak, a concern underscored by survey data, which show high caseload volumes for OCC complaint handling staff.

Regulator survey data indicate that complaint volume is significantly higher in insurance that it is in banking: 54,851 complaints were reported by all bank regulators, as compared to 496,272[98] for all insurers. State insurance commissions also devote more resources to complaint processing than do bank regulators. The 20 insurance commissions responding to our survey alone employed a total of 331 FTEs for complaint handling functions, as compared to a total of 136 for the four bank regulators.

Both the insurance commission survey and the industry survey indicated that complaint volume is highly concentrated in small companies. Thus complaint volume for a national insurance regulator may be reduced if one assumes that large companies will predominantly opt for the federal charter, but small companies will remain with the states.

Given the advantages of having a more localized agency handle consumer complaints, some thought should be given to providing for coordination between a federal insurance regulator and state insurance commissions in their handling. The FDIC partners with state banking supervisors in processing complaints with great success. The OCC has also recently moved toward greater coordination and cooperation with states. It has entered into an information sharing agreement with the Office of Consumer Credit Regulation in Maine to coordinate complaint-handling efforts [99] and in March, 2004, directed its

[98] NAIC. (2003) 2002 Insurance Department Resources Report.
[99] Julie L. Williams. (2003) Remarks by Julie L. Williams, Chief Counsel and Senior Deputy Comptroller, Office of the Comptroller of the Currency, Before the Consumer Federation of America. December 5.

national banks to work directly with state regulators on consumer complaints referred by them.[100]

G. Costs Associated with the Creation of a New Regulator

A potentially strong argument against optional federal chartering for insurers is that it would require the creation of a new federal regulatory bureaucracy, when the federal government already has too many financial services regulators. It would also entail duplication of the national regulatory infrastructure that the NAIC has built for company and producer licensing, product filings, and financial regulation. To avoid these costs, it would be better to support NAIC's efforts to achieve modernization than to create a whole new federal regime.[101] As NY State Insurance Superintendent Greg Serio puts it, "the OFC would be costly and wasteful by requiring the federal government to create a de novo infrastructure for the review of filings and regulatory functions. The Compact is a more efficient approach to address shortcomings in the lack of a uniform structure for multi-state insurers."[102]

This would be a powerful argument if it appeared likely that the NAIC would be able to achieve uniform standards in key areas such as company and producer licensing, product approval standards, and market conduct reviews. Unfortunately, because NAIC has no independent legal authority to impose uniform standards, it is unlikely that uniformity will be achieved in the near term in any of these areas. In fact, the centerpiece of NAIC's modernization efforts, the Interstate Compact, has already been delayed until 2008. NAIC is a highly professional organization, with expert, dedicated staff. It has long recognized the benefits to consumers for achieving uniformity, as do many if not most of its members. The problem is that structurally it must achieve broad consensus among its 55 members to move ahead with model laws and other initiatives – a problem which is exacerbated by the high turnover rate among state insurance commissioners. Even once it has garnered that consensus, the individual legislatures of its member jurisdictions must be persuaded to act. Though NAIC models are usually eventually adopted, state legislatures frequently add their own variations to those model laws. Limited acceptance of the Compact – which would circumvent much of the bureaucracy by empowering a separate commission to set standards – underscores how unwilling individual states can be to give up their prerogative to tailor insurance laws and regulations as they deem fit.

H. Regulatory Risks

Another issue associated with optional federal chartering of insurers is the concentration of regulatory risk. Advocates of the state based regime argue that regulatory failures are confined to individual states under the current system, but with a federal system

[100] OCC Advisory Letter (March 1, 2004)
[101] It should be noted that all OFC proposals require that the new federal insurance regulator be fully funded through assessments on nationally chartered insurers.
[102] Interview with Greg Serio (Nov. 24, 2003)

regulatory failures are felt nationwide. They point to the S&L crisis as an example of the disastrous consequences that can ensue as a result of national regulatory mistakes.

This argument could be made essentially against any form of national regulation. The question is whether the relatively low risk of a systemic national regulatory failure outweighs the benefits to be achieved from uniformity. No regulatory system is perfect, and it should be pointed out that the S&L debacle stemmed from mistakes by both federal and state regulators. Indeed, the lack of clear delineation of responsibilities between state and federal regulators may have contributed to the disaster. The S&L debacle is not an argument against federal regulation. It is an argument against flawed regulation.

The system of thrift regulation had been poorly constructed. Congress gave a relatively obscure independent federal agency authority over both the FHLB System that extended credit to thrifts for mortgage loans, as well as the thrifts themselves. Moreover, the FHLB system had oversight responsibility over both federal and state members. Regulatory responsibilities were confused and the interests of the "regulator" and the regulated were too closely aligned. It also operated outside the financial regulatory mainstream and away from the scrutiny of other bank regulators. In FIRREA, Congress corrected its mistake and created a separate agency, the Office of Thrift Supervision, to oversee federally chartered thrifts, making it a bureau of the U.S. Treasury Department, and providing it with strong regulatory powers patterned after the OCC, which has a highly successful regulatory track record. Most current proposals for an optional federal insurance regulator are also patterned after the OCC.

The Congress and the federal financial community learned powerful lessons from the S&L debacle. As a result, modern bank regulation is characterized by stringent financial regulation, including mandatory annual safety and soundness examinations and strict prompt corrective action (PCA) measures. These are lessons that can and presumably would be applied to federal insurance regulation.

Moreover, as was seen in the 1990's with the failure of First Executive Life and other insurers, deficiencies in state oversight *do* have national impact. To be sure, under the NAIC's leadership, state solvency regulation has improved dramatically. However, the resources of any individual state to oversee insurers will be more limited than that of a federal regulator. Thus, it can just as easily be argued that the lack of centralized federal oversight of large, complex life insurers heightens the risk of their failure and the resulting systemic implications.

I. Repeal of McCarran Ferguson

Most individuals interviewed for this report saw positive pro-competitive benefits from the repeal of McCarran-Ferguson's antitrust exemption, as is contemplated under OFC proposals. However, because court cases have slowly eroded the exemption over the years, the benefits from eliminating it are unlikely to be major. Some expressed the concern that small companies might be disadvantaged, insofar as they benefit from

information sharing facilitated by McCarran-Ferguson. Others felt that small companies should not be disadvantaged because historical data is already made publicly available and can be used freely by small insurers.

VII. FEDERAL INSURANCE REGULATION AND NATIONAL POLICY

Background: Recent research by the Employee Benefits Research Institute (EBRI) indicates that retirement plan participation by American workers declined in 2002 – from 44.4% to 41.8%, and has shown only a minor increase from 1987 to 2002.[103] It has been projected that at current rates, America's elderly face an income shortfall between 2020 and 2030 of at least $400 billion in their ability to cover basic living expenses and expenses associated with nursing home or home health care.[104] At the same time, with projected deficits in the Social Security System, increasing health costs for the elderly, and a shrinking working population, government resources will be strained to make up this shortfall.

Declining retirement plan participation has been particularly acute for workers participating in defined benefit plans. There are two basic types of employer provided retirement vehicles: defined contribution (DC) and defined benefit (DB) plans. With a DC plan, employee contributions are placed in an individual account, and may or may not be supplemented with employer contributions. The employee assumes all the investment risk in the account. In contrast, DB plans are typically funded by the employer and are held in trust on behalf of all participants. Employers guarantee a certain level of benefit and assume the investment risk of plan asset performance. In addition, DB plans must offer life annuities which, when chosen, eliminate the need for the retiree to manage those assets in retirement. In contrast, a DC plan usually pays out benefits in a lump sum, requiring retirees to manage their money and assume the risk that they may outlive the assets.

The decline in DB plans in relation to DC plans has been well documented and pronounced. One study shows that the number of private sector employees with a DB plan decreased from 27 million in 1975 to 23 million in 1998. At the same time, DC plan participants increased from 4 million in 1975 to 29 million in 1998.[105] During the bull market of the 1990's, 401(k)s and similar type DC plans were highly popular with employees. Volatility in the stock market, combined with 401(k) losses associated with corporate governance abuses, have raised questions about the desirability of employees placing exclusive reliance on DC plans. Most experts agree that retirees should have some portion of their private retirement income in a fixed, guaranteed annuity. With the

[103] See EBRI. (2003) "Employment Based Retirement and Pension Plan Participation: Declining Levels and Geographic Differences." *Issue Brief Number 262.* October.
[104] EBRI. (2003) "Can Americans Afford Tomorrow's Retirees: Results from the EBRI-ERF Retirement Security Projection Model." *Issue Brief Number 263.* November.
[105] David Rajnes as cited in EBRI (2002) "An Evolving Pension System: Trends in Defined Benefit and Defined Contribution Plans." *Issue Brief Number 249.* September.

decline in employer-sponsored DB plans, life insurers may be uniquely situated to fulfill that need.

The Pension Benefit Guarantee Cooperation (PBGC), the federally chartered entity that insures defined benefit pension plans, estimates that U.S. pension plans were underfunded by $350 billion as of September 15, 2003. The cause of the underfunding is attributable, in large part, to a mismatch in pension fund assets, which are heavily invested in the stock market, and liabilities, which are long term fixed obligations that tend to more closely track bond returns[106]. Life insures may be able to play a role in addressing this problem through expanded use of group annuity contracts, because their assets are overwhelmingly invested in long term fixed instruments.

Also related to retirement security are the high costs associated with nursing home and home health care. Here again, life insurers through innovations in long-term care products, and the ability to package LTC benefits with other retirement products, may be well positioned to meet this growing need.

Interviews with industry officials revealed widespread concerns about their lack of a government agency advocate in important policy discussion surrounding retirement and tax policy and in international negotiations. In particular, they pointed to the disadvantages of annuity products currently inherent in the tax code as compared to competing securities products. [107] They argue that annuities – with their guarantee features and opportunity for withdrawal in fixed, monthly payments – may be more suitable for many investors, but that federal policy officials lack confidence in such products because they are not federally regulated.

Analysis: We interviewed a number of federal officials on the role of life insurance products in retirement income policy, and whether the industry was disadvantaged because of it lacks federal regulation. Most federal officials gave the life insurance industry high marks for its lobbying prowess, particularly on tax matters. Most also thought it would be helpful to hear from a "neutral" expert on insurance issues and that this kind of expertise could be provided through a federal insurance regulator. Most pointed out that other financial bank and securities regulators do not "lobby" for their industries. However, they do provide helpful expertise, as needed, from time to time.

All interviewees thought very favorably of the NAIC, and gave that group kudos for being responsive to federal requests for technical expertise and information. However, interaction with NAIC was generally intermittent, on an "as needed" basis. NAIC's lack of legal authority over its membership created questions about whether it could "deliver" all state insurance commissions on important policy questions, make good on its agreements, and how long it would take states to implement changes once agreement was reached. A few officials thought that the cumbersome process of securing nation-wide

[106] Steven Kandarian. (2003) Testimony before the Special Committee on Aging, United States Senate. Executive Director, Pension Benefit Guarantee Corporation. October 14.
[107] Variable annuity withdrawals are taxed at ordinary income tax rates, whereas the capital gain and dividend portion of tax-deferred securities investments are taxed at maximum rate of 15%.

conforming changes in state insurance laws and regulations intensified industry resistance to tax and ERISA changes, complicating policy development in the tax treatment of life insurance products.

Several felt that fixed annuity products could play an important role in federal retirement income policy, while acknowledging that concerns about uneven regulatory quality impeded their consideration. On this point, there was consensus that life insurers needed to do more to make annuities attractive to the middle class, and that annuities currently were too expensive to be competitive and too complicated to understand. There was uncertainty about whether federal insurance regulation could improve those products transparency and competitive pricing, but general agreement that regulatory action to make fixed annuity options more accessible to the middle class would be a welcome development.

There was general acknowledgment that the private pension system was in trouble and that life insurers could play an important role in making defined benefit plans more widely available. One possibility would be to convert to a system whereby employers provide DB benefits through third party insurers, as they typically do now with health and other benefits. Life insurers could achieve a better alignment of assets and liabilities, since they are heavily invested in the bond markets and pension liabilities more closely track bond returns. Providing a DB plan through a third party insurer would also have the advantage of getting pension assets – with their attendant volatility – off the balance sheets of employers.

Such a system would have to be supported by stringent financial regulation, given the long-term nature of pension liabilities and the growing longevity of American workers. Officials interviewed felt that a federal regulator patterned after the OCC would provide the needed level of confidence in solvency oversight. While acknowledging improvements in state solvency oversight, federal officials expressed concerns about uneven state regulation for companies domiciled in small states, and in holding company oversight.

Regarding international trade discussions, the NAIC received high marks for helping to represent US interests in the insurance sector. However, the NAIC's lack of authority to bind its membership was viewed as an impediment to discussions. Some officials noted that the lack of a federal insurance regulator contributed to inconsistency in who represented the insurance sector in international organizations. For instance, USTR represents insurance in the WTO, using the NAIC as a consultant. In the OECD, however, the US Commerce Department represents insurance. The NAIC alone belongs to the International Association of Insurance Supervisors.

At present, there is no official representative for US insurance in the International Accounting Standards Board (IASB), though there is a strong need for an insurance representative given the unique accounting rules that apply to the US insurance industry.

The NAIC, through its International Accounting Standards Working Group (IASWG), has been a regular observer at IASB meetings dealing with insurance related accounting issues. NAIC representatives are regular participants at Board meetings. As a member of the International Association of Insurance Supervisors' (IAIS) Accounting Subcommittee, NAIC is involved in coordinating international regulatory responses to the IASB. Both the IASWG and the IAIS Accounting Subcommittees have submitted comment letters to the IASB on matters of interest to insurance regulators. Additionally, NAIC recently met with the Chairman and Vice-Chairman of the IASB, and intends to continue a regular dialog as the IASB begins work on Phase II of its International Financial Reporting Standard for Insurance Contracts.

VIII. OTHER SUGGESTED OPTIONS FOR REFORM

During the course of our research, several other options were suggested as possible solutions to the current lack of uniformity in the regulation of insurance.

Federal Standards Commission: One suggestion was to empower a federal commission to create uniform regulatory standards, but preserve authority with the states to supervise and enforce compliance with those standards. In designing the Commission, Congress could draw from the work already done by the NAIC on the Interstate Compact, perhaps drawing from sitting insurance commissioners to make up part of the Commission's membership, and utilizing NAIC systems and personnel for centralized processing of filings. The advantage of this approach is that it would build upon the infrastructure NAIC has already developed, while preserving state prerogatives regarding supervision, complaint handling and enforcement.

Such a Commission would be less costly than setting up a completely new federal regulatory agency. Congress could also require that the Commission adhere to the administrative safeguards and procedural requirements typically applied to federal rulemakings, such as the opportunity for public comment and required cost/benefit analysis. The lack of such procedural requirements has been a source of contention with advocacy groups regarding the NAIC's work, and has also been a controversial aspect of the Interstate Compact.

Constitutional issues associated with the Congress' ability to create an entity that would have the power to impose national standards on state licensed insurers and producers, using state insurance commissions to enforce such standards, would have to be carefully analyzed. However, in the banking area, the Federal Reserve Board had been authorized by Congress to set certain lending standards that, for state regulated entities, are enforced by state bank supervisors. In addition, state attorneys general are authorized to enforce parts of the Federal Trade Commission Act.

To be effective, the Commission should be empowered to develop standards not only with regard to form filings, but company and producer licensing, market conduct regulation and examinations as well. In this regard, its powers would be significantly greater than that contemplated by the Interstate Compact. However, all these areas should be addressed for consumers to receive maximum benefit. As previously discussed, "modernization" initiatives such as conversion to "file and use" should not occur without enhanced examinations, improved disclosure and form simplification. To accomplish this, the federal standards commission would need to have authority to address the full range of regulatory issues.

One disadvantage of this approach is that it would allow for inconsistencies resulting from interpretations of individual state commissions. Another major disadvantage is the potential confusion of regulatory responsibilities between state and federal regulators, a factor that some feel contributed to weaknesses in S&L oversight. This problem could be

exacerbated by potential hostility of individual state commissions to enforcing the standards set by another entity. However, cooperative federal/state working relationships might be promoted by requiring that a certain number of the Commission's membership be drawn from sitting insurance commissioners. This would also allow the agency setting federal standards to draw from the tremendous expertise offered by state regulators.

Grant Legal Authority to the NAIC to Set Standards: A variation of the above suggestion was for Congress to simply grant the NAIC authority to develop optional national standards, while preserving supervision and enforcement authority with the states. Such legal authority would need to be combined with procedural safeguards ordinarily applicable to federal rulemakings. On at least one previous occasion, Congress has granted the NAIC standard setting authority: the 1990 Medigap reform legislation delegated to the NAIC the task of creating the 10 standardized Medicare supplement insurance policies. No constitutional issues were raised in association with this delegation, though this was a highly limited delegation of authority.

Reciprocity: As previously discussed, compliance with NARAB has to a great extent been achieved through reciprocity arrangements, as opposed to development of uniform standards. At least one commentator has suggested that Congress should simply mandate inter-state reciprocity for licensing and form approval, to maximize regulatory competition and preservation of state autonomy, and not try to dictate uniformity either directly or through the NAIC.[108] Such a structure would seem to lend itself to a good deal of regulatory arbitrage, without the safeguards against "negative competition" inherent in a federal regulatory system. And it would lack consumer benefits to be gained through uniformity in terms of consistent consumer protections regardless of state of residence. This appears to be the least desirable of all options from a consumer standpoint.

Incremental Reforms: Absent consensus regarding creation of a federal regulator, Congress could continue to undertake incremental reforms, as it did with producer licensing and NARAB. At least one trade group has suggested that Congress mandate single-state company and producer licensing; 30 day file and use for policy forms; and interstate compacts to coordinate market conduct exams.[109] However, to protect consumers, a holistic approach is needed. A new regulatory authority with broad authority and subject to procedural safeguards is needed. It is impractical for Congress to incrementally address every issue that arises. These are the kinds of decisions best made by an independent regulatory body, not the Congress.

Unitary Regulation: As is mentioned throughout this report, some major consumer groups have favorably viewed a unitary approach sponsored by Senator Hollings (D SC) that provides for federal regulation of all interstate insurers, leaving oversight of intrastate insurers to the states. This approach would achieve uniformity and its benefits,

[108] Michael Greve. (2001) "Federalism and Insurance Regulation." Remarks presented to the Federalist Society. November 15.
[109] Tom Ahart. (2003) Statement of the Independent Insurance Agents and Brokers of America, Before Committee on Commerce, Science and Transportation, United States Senate. October 22.

but would lose the benefits to be derived from healthy federal/state regulatory competition. Leaving states with jurisdiction only over intrastate insurers would eviscerate the state based system.

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Exhibit 1: Industry Survey Response Description

	Actual Responses	Population	%
Stand Alone Co:	19	135	14.07%
Fleets:	30	67	44.78%
Total Individual Companies:	129	383	33.68%

Asset Size Distribution as a Percentage of the Population

	Actual Responses		Population	%
	Stand-Alone Companies	Fleets	Stand-Alone and Fleets	Actual Responses/ Population
Less than 1 billion:	13	6	102	18.63%
1 billion - 18 billion:	6	12	70	25.71%
18 billion - 55 billion:	0	4	15	26.67%
More that 55 billion:	0	8	15	53.33%
Total Companies:	**19**	**30**	**202**	**24.26%**

Asset Size Distribution of Individual Companies

	Actual Responses
	Individual Companies
Less than 1 billion:	64
1 billion - 18 billion:	52
18 billion - 55 billion:	8
More that 55 billion:	5
Total Companies:	**129**

Geographical Distribution of Individual Companies

	Actual Responses
	Individual Companies
Atlantic	21
North Central	36
North Eastern	30
South Central	17
Western	24
Canada	1
Total Companies:	**129**

Exhibit 2a: Direct, Indirect and Total Costs: Breakdown by Components

Total Direct Cost: Breakdown by Components

	Total Direct	% Distribution	Average per company	Per 1,000 Policyholders	Per $100,000 Premium Income
Company Licensing	31,419,706	31.1%	257,539	275	21.78
Producer Licensing	22,829,913	22.6%	228,299	200	15.83
Product Approval	6,059,061	6.0%	56,102	53	4.20
Financial Exams & Regulation	30,794,998	30.5%	267,783	270	21.35
Market Exams & Regulation	5,905,393	5.8%	53,685	52	4.09
Total Direct Cost	**$100,964,619**	**100.0%**	**$877,953**	**$823**	**$70**

Total Indirect Cost: Breakdown by Components

	Total Indirect	% Distribution	Average per company	Per 1,000 Policyholders	Per $100,000 Premium Income
Company Licensing	29,662,414	14.7%	264,843	260	20.57
Producer Licensing	59,158,920	29.3%	579,989	518	41.02
Product Approval	42,501,046	21.1%	429,303	372	29.47
Financial Exams & Regulation	21,365,981	10.6%	196,018	187	14.81
Market Exams & Regulation	45,283,460	22.4%	404,317	397	31.40
Total Indirect Cost	**$201,801,529**	**100.0%**	**$1,851,390**	**$1,736**	**$140**

Total Cost: Breakdown by Components

	Total Cost	% Distribution	Average per company	Per 1,000 Policyholders	Per $100,000 Premium Income
Company Licensing	61,082,120	20.2%	500,673	535	42.35
Producer Licensing	81,988,833	27.1%	732,043	719	56.84
Product Approval	48,560,107	16.0%	433,572	426	33.67
Financial Exams & Regulation	52,160,979	17.2%	438,328	457	36.16
Market Exams & Regulation	51,188,853	16.9%	412,813	449	35.49
Total Cost	**$302,766,148**	**100.0%**	**$2,729,343**	**$2,559**	**$210**

Notes:

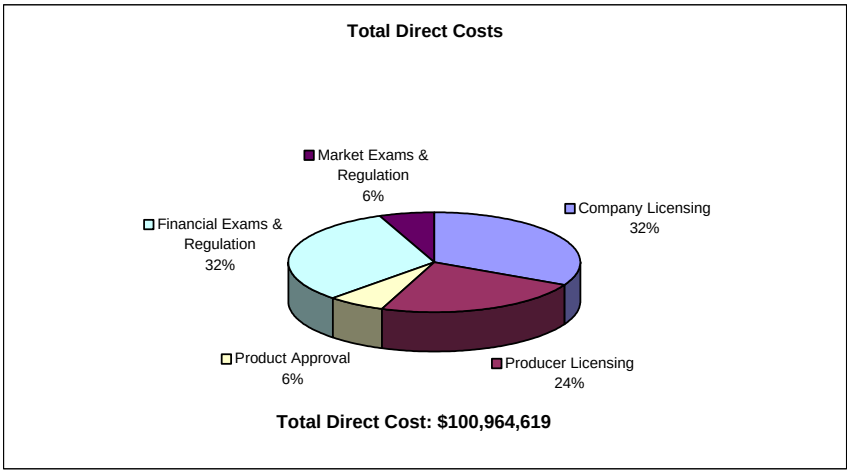
1. Total costs are not equal to the sum of their cost components.
Total direct reported cost exceeds the sum of component costs by $3,955,548 since some companies believed that there are other direct costs that cannot be included in one of the five components. Similarly, total indirect reported cost exceeds the sum of component costs by $3,829,708.

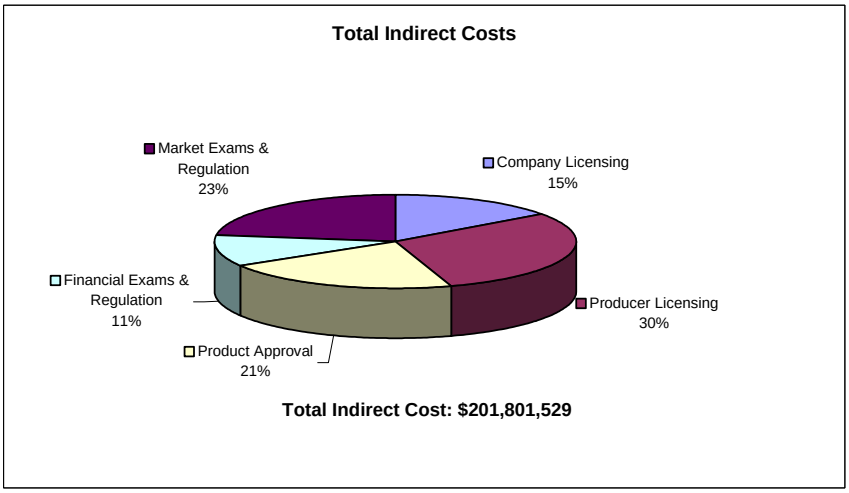
2. The total number of individual companies that responded to the survey is 129.

3. The total number of policyholders of the companies that responded to the survey is 113,861,056.

4. The total premium income of the companies that responded to the survey is $144.2 billion.

Exhibit 2b: Direct, Indirect and Total Costs: Breakdown by Components





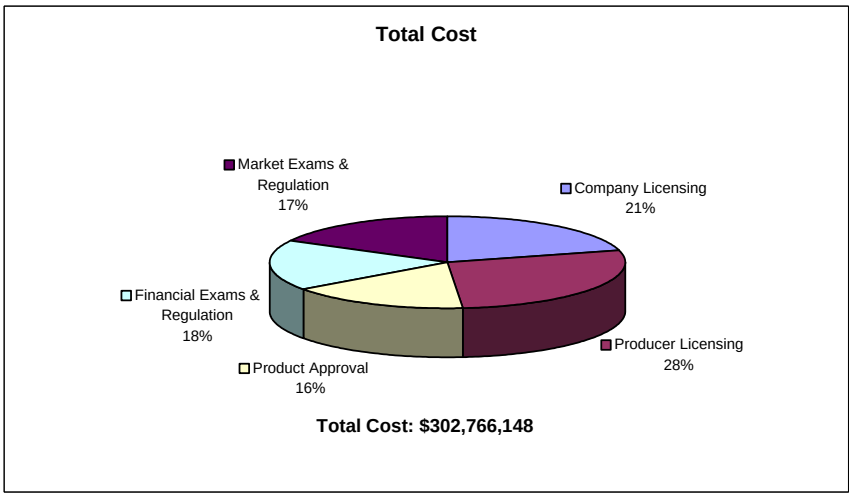


Exhibit 3: Average Assets, Premiums, Policyholders and Costs by Asset Size and Per Company

Assets, Premiums, Policyholders, and Costs per Company by Asset Size Groups						
Asset Size Group	**Average Assets**	**Average Premiums**	**Average Policyholders**	**Average Direct Cost**	**Average Indirect Cost**	**Average Total Cost**
Less than 1 billion	231,531,448	64,154,302	107,443	275,080	239,550	514,630
1 billion - 18 billion	5,379,159,441	837,853,797	1,227,056	746,443	1,323,843	2,070,286
18 billion - 55 billion	34,299,970,786	4,882,213,731	2,293,101	2,990,434	4,311,887	7,302,321
More than 55 billion	101,937,455,059	11,577,268,212	7,939,863	6,285,949	21,382,797	27,668,746
Average per Company	**8,757,985,012**	**1,172,629,251**	**1,066,369**	**877,953**	**1,851,390**	**2,729,343**

Note:

1. Cost were reported on per fleet basis. Cost per company were allocated based on the premium weight of each company in the fleet.

Exhibit 4: Company Costs by Asset Size as a Percentage of Assets, Premiums and Per Policyholder

Company Cost as a Percentage of Assets

Asset Size Group	Average Direct Cost	Average Indirect Cost	Average Total Cost
	As a Percentage of Assets		
Less than 1 billion	0.1188%	0.1035%	0.2223%
1 billion - 18 billion	0.0139%	0.0246%	0.0385%
18 billion - 55 billion	0.0087%	0.0126%	0.0213%
More than 55 billion	0.0062%	0.0210%	0.0271%
Average per Company as a Percentage of Assets	0.0100%	0.0211%	0.0312%

Company Cost as a Percentage of Premium

Asset Size Group	Average Direct Cost	Average Indirect Cost	Average Total Cost
	As a Percentage of Premium		
Less than 1 billion	0.4288%	0.3734%	0.8022%
1 billion - 18 billion	0.0891%	0.1580%	0.2471%
18 billion - 55 billion	0.0613%	0.0883%	0.1496%
More than 55 billion	0.0543%	0.1847%	0.2390%
Average per Company as a Percentage of Premiums	0.0749%	0.1579%	0.2328%

Company Costs per Policyholder

Asset Size Group	Average Direct Cost	Average Indirect Cost	Average Total Cost
	Per Policyholder		
Less than 1 billion	$2.56	$2.23	$4.79
1 billion - 18 billion	$0.61	$1.08	$1.69
18 billion - 55 billion	$1.30	$1.88	$3.18
More than 55 billion	$0.79	$2.69	$3.48
Average per Company per Policyholder	$0.82	$1.74	$2.56

Exhibit 5a: Average Direct, Indirect and Total Costs by Asset Size and by Components

Direct Costs per Company by Components		Average Cost				
	Average Total Direct Cost	Company Licensing	Producer Licensing	Product Approval	Financial Exam & Regul	Market Exam & Regul
Less than 1 billion	275,080	85,093	79,809	9,596	44,675	17,640
1 billion - 18 billion	746,443	275,598	143,384	55,578	184,018	40,807
18 billion - 55 billion	2,990,434	1,102,659	517,013	370,503	698,514	250,179
More than 55 billion	6,285,949	873,909	1,954,351	122,618	3,053,854	281,217
Average per Company	**877,953**	**257,539**	**228,299**	**56,102**	**267,783**	**53,685**

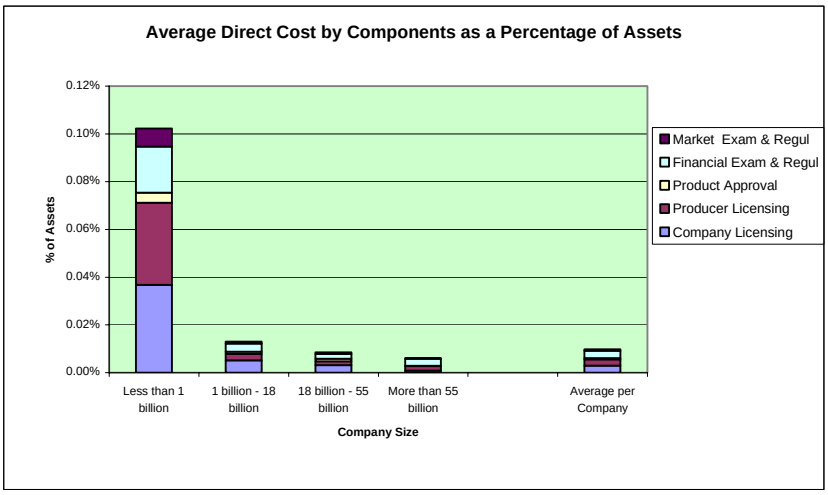
Indirect Costs per Company by Components		Average Cost				
	Average Total Indirect Cost	Company Licensing	Producer Licensing	Product Approval	Financial Exam & Regul	Market Exam & Regul
Less than 1 billion	239,550	61,477	55,789	43,870	35,054	14,377
1 billion - 18 billion	1,323,843	330,067	266,284	345,489	137,924	201,782
18 billion - 55 billion	4,311,887	839,905	507,209	1,582,096	201,663	479,813
More than 55 billion	21,382,797	1,217,203	8,475,633	2,928,012	2,426,139	6,335,811
Average per Company	**1,851,390**	**264,843**	**579,989**	**429,303**	**196,018**	**404,317**

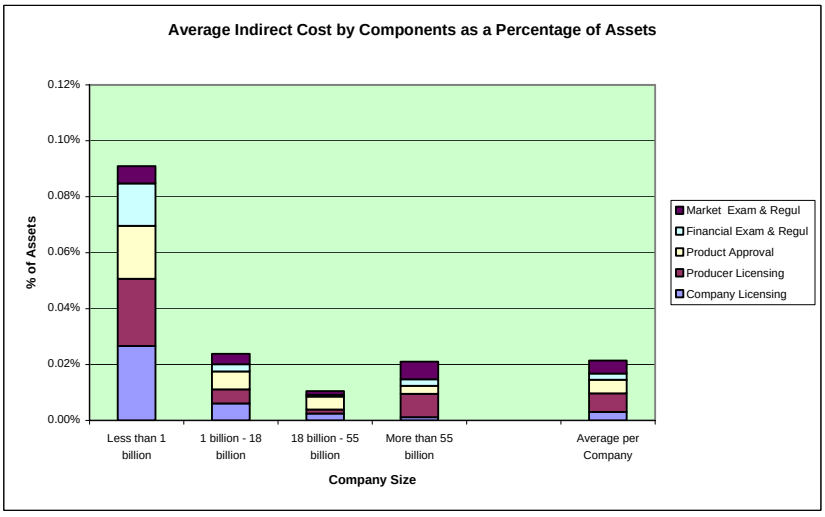
Total Costs per Company by Components		Average Cost				
	Average Total Cost	Company Licensing	Producer Licensing	Product Approval	Financial Exam & Regul	Market Exam & Regul
Less than 1 billion	514,630	141,613	122,066	43,723	74,486	28,575
1 billion - 18 billion	2,070,286	577,574	368,225	390,688	307,575	221,162
18 billion - 55 billion	7,302,321	1,837,576	896,194	1,952,600	800,389	638,743
More than 55 billion	27,668,746	2,091,112	10,429,984	3,050,629	5,479,993	6,617,028
	-					
Average per Company	**2,729,343**	**500,673**	**732,043**	**433,572**	**438,328**	**412,813**

Notes:

1. Average total costs are greater than the sum of their cost components because some companies believed that there are costs that could not be classified in one of the five categories.

Exhibit 5b: Average Direct, Indirect and Total Costs as a Percentage of Average Assets





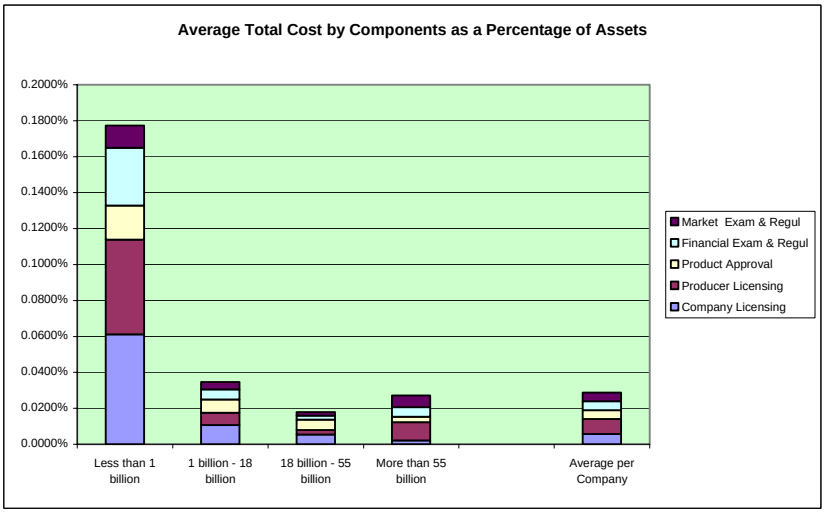
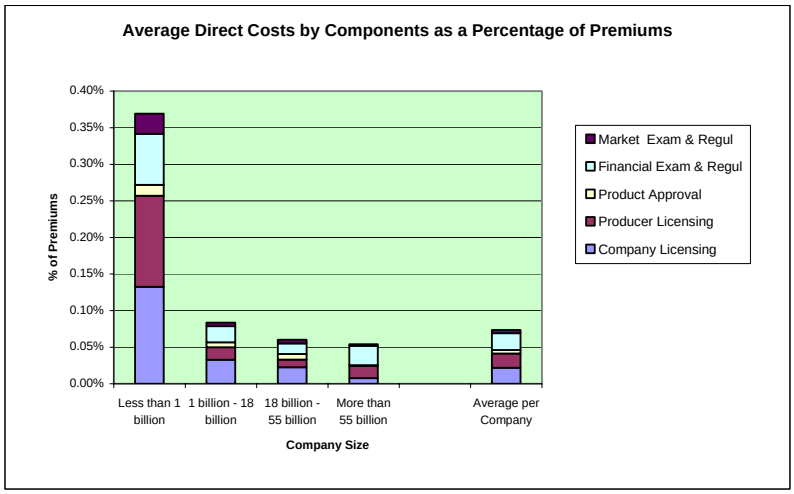
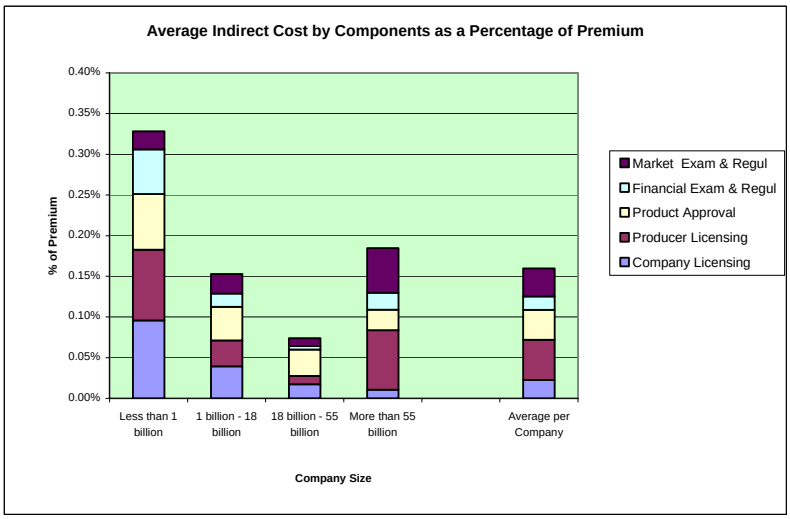


Exhibit 5c: Average Direct, Indirect and Total Costs as a Percentage of Average Premium





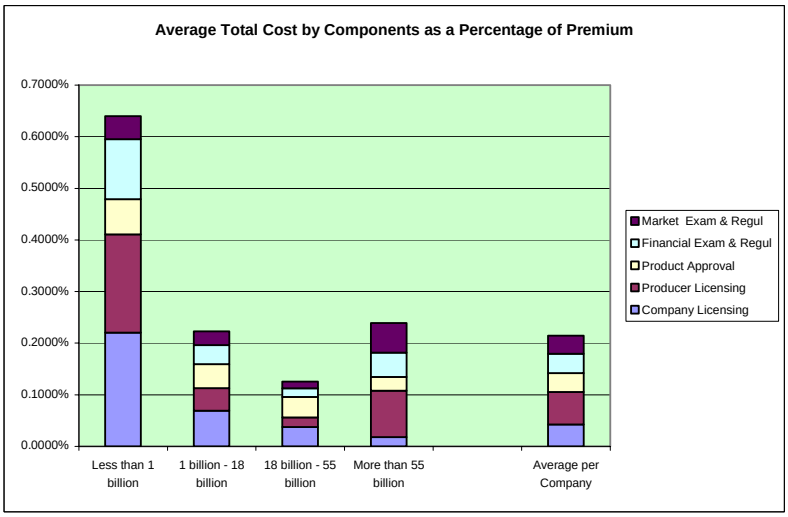


Exhibit 6a: Direct and Indirect Costs of Front and Back-End Regulation

Total Direct Costs by Asset Size Categories

				% of Total Direct Cost	
	Total Direct Cost	Front-End Regulation Cost	Back-End Regulation Cost	Front-End Regulation Cost	Back-End Regulation Cost
Less than 1 billion	16,504,793	9,784,445	3,454,316	73.9%	26.1%
1 billion - 18 billion	32,097,043	20,735,963	10,628,382	66.1%	33.9%
18 billion - 55 billion	20,933,039	15,033,885	5,942,334	71.7%	28.3%
More than 55 billion	31,429,744	14,754,386	16,675,358	46.9%	53.1%
Total	**100,964,619**	**60,308,680**	**36,700,391**	**62.2%**	**37.8%**

Total Indirect Costs by Asset Size Categories

				% of Total Indirect Cost	
	Total Indirect Cost	Front-End Regulation Cost	Back-End Regulation Cost	Front-End Regulation Cost	Back-End Regulation Cost
Less than 1 billion	13,414,820	8,279,711	2,654,878	75.7%	24.3%
1 billion - 18 billion	55,601,401	39,433,958	15,414,482	71.9%	28.1%
18 billion - 55 billion	25,871,321	20,504,471	4,770,334	81.1%	18.9%
More than 55 billion	106,913,987	63,104,240	43,809,747	59.0%	41.0%
Total	**201,801,529**	**131,322,380**	**66,649,441**	**66.3%**	**33.7%**

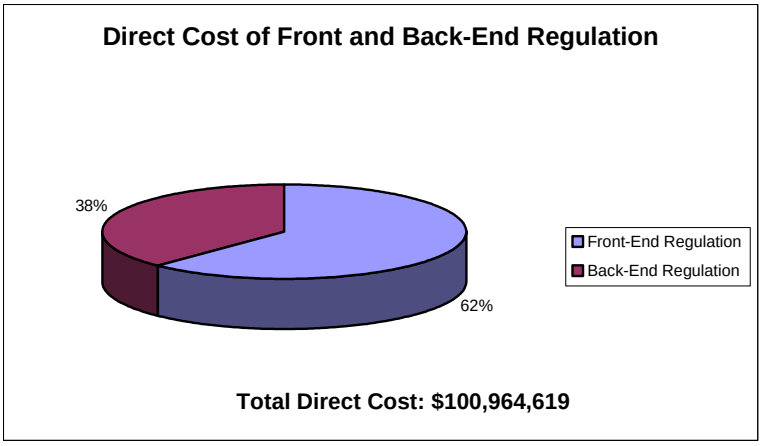
Total Costs by Asset Size Categories

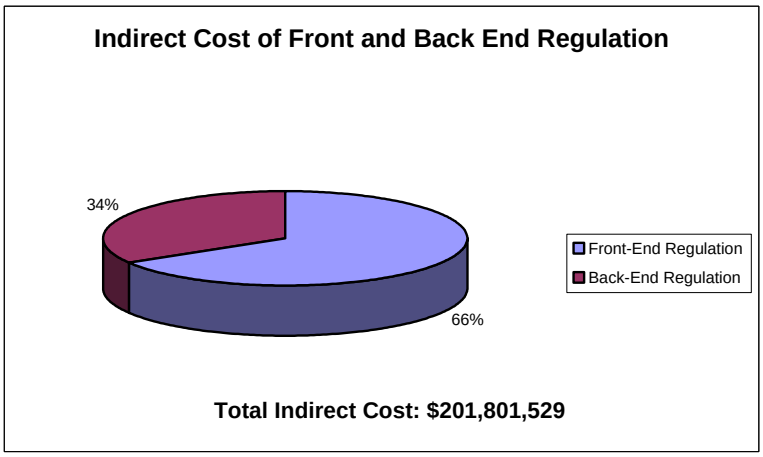
				% of Total Cost	
	Total Cost	Front-End Regulation Cost	Back-End Regulation Cost	Front-End Regulation Cost	Back-End Regulation Cost
Less than 1 billion	29,919,612	18,064,156	6,109,194	74.7%	25.3%
1 billion - 18 billion	87,698,444	60,169,921	26,042,865	69.8%	30.2%
18 billion - 55 billion	46,804,361	35,538,356	10,712,668	76.8%	23.2%
More than 55 billion	138,343,731	77,858,626	60,485,105	56.3%	43.7%
Total	**302,766,148**	**191,631,060**	**103,349,832**	**65.0%**	**35.0%**

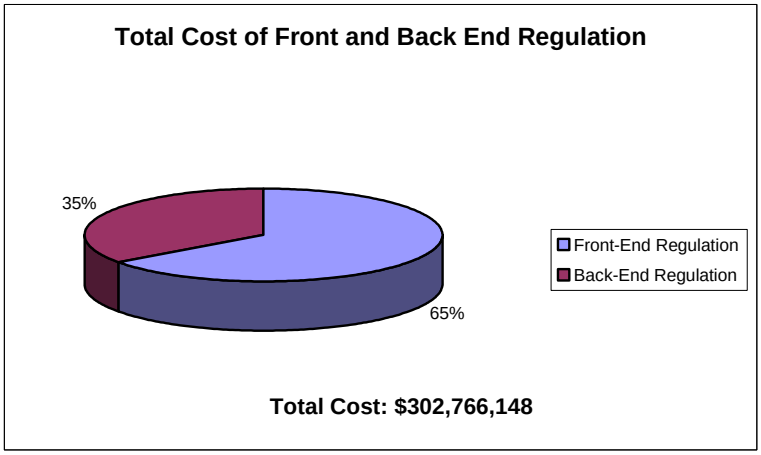
Notes:

1. Front-end regulation includes: company licensing, producer licensing and product approval.
   Back-end regulation includes: financial and market conduct examinations and regulation.
2. Total cost are higher than the sum of front and back-end regulation costs because some companies believed that there are costs that could not be classified in one of the five categories.

Exhibit 6b: Direct and Indirect Costs of Front and Back-End Regulation







Notes:

1. Front-end regulation includes: company licensing, producer licensing and product approval.
   Back-end regulation includes: financial and market conduct examinations and regulation.

Exhibit 7: Potential Savings from Single Regulator: Comparison of Nationwide Cost vs. Cost of Domiciliary Regulator

Total Cost Savings

	State Regulation	Home State Regulation	Potential Savings
Direct Costs	100,964,619		
Indirect Costs	201,801,529		
Total Costs	302,766,148	77,616,385	225,149,763
Total Assets	1,077,232,156,475		
Total Premium	144,233,397,916		
Total Policyholders	114,101,456		

Notes:
1. Costs of compliance with home regulator used as a proxy for single regulator costs.
   Cost of federal regulation is likely to exceed cost of domiciliary regulator.

Cost Savings as a Percentage of Assets, Premium and per Policyholder

Percentage of Assets	State Regulation	Home State Regulation	Potential Savings
Direct Costs	0.0094%		
Indirect Costs	0.0187%		
Total Costs	0.0281%	0.0072%	0.0209%

Percentage of Premium	State Regulation	Home State Regulation	Potential Savings
Direct Costs	0.0700%		
Indirect Costs	0.1399%		
Total Costs	0.2099%	0.0538%	0.1561%

Per Policyholder	State Regulation	Home State Regulation	Potential Savings
Direct Costs	$0.82		
Indirect Costs	$1.74		
Total Costs	$2.56	$0.80	$1.76

Exhibit 8a: Potential Cost Savings by Asset Size

Costs and Cost Savings: Breakdown by Asset Size Groups			
Asset Size Group	**Average Total Cost**	**Average Domestic Cost**	**Potential Savings**
Less than 1 billion	514,630	126,734	387,896
1 billion - 18 billion	2,070,286	789,790	1,280,496
18 billion - 55 billion	7,302,321	406,950	6,895,371
More than 55 billion	27,668,746	8,156,620	19,512,126
Average per Company	**2,729,343**	**852,927**	**1,876,416**

Costs and Cost Savings by Asset Size Groups and as a Percentage of Assets, Premiums and per Policyholder

Costs and Cost Savings per Company as a Percentage of Assets			
Asset Size Group	**Average Total Cost**	**Average Domestic Cost**	**Potential Savings**
Less than 1 billion	0.2223%	0.0547%	0.1675%
1 billion - 18 billion	0.0385%	0.0147%	0.0238%
18 billion - 55 billion	0.0213%	0.0012%	0.0201%
More than 55 billion	0.0271%	0.0080%	0.0191%
Average per Company as a Percentage of Assets	**0.0312%**	**0.0097%**	**0.0214%**

Costs and Cost Savings per Company as a Percentage of Premiums			
Asset Size Group	**Average Total Cost**	**Average Domestic Cost**	**Potential Savings**
Less than 1 billion	0.8022%	0.1975%	0.6046%
1 billion - 18 billion	0.2471%	0.0943%	0.1528%
18 billion - 55 billion	0.1496%	0.0083%	0.1412%
More than 55 billion	0.2390%	0.0705%	0.1685%
Average per Company as a Percentage of Premium	**0.2328%**	**0.0727%**	**0.1600%**

Costs and Cost Savings per Company per Policyholder			
Asset Size Group	**Average Total Cost**	**Average Domestic Cost**	**Potential Savings**
Less than 1 billion	$4.79	$1.18	$3.61
1 billion - 18 billion	$1.69	$0.64	$1.04
18 billion - 55 billion	$3.18	$0.18	$3.01
More than 55 billion	$3.48	$1.03	$2.46
Average per Company per Policyholder	$2.56	$0.80	$1.76

Exhibit 8b: Potential Cost Savings by Asset Size

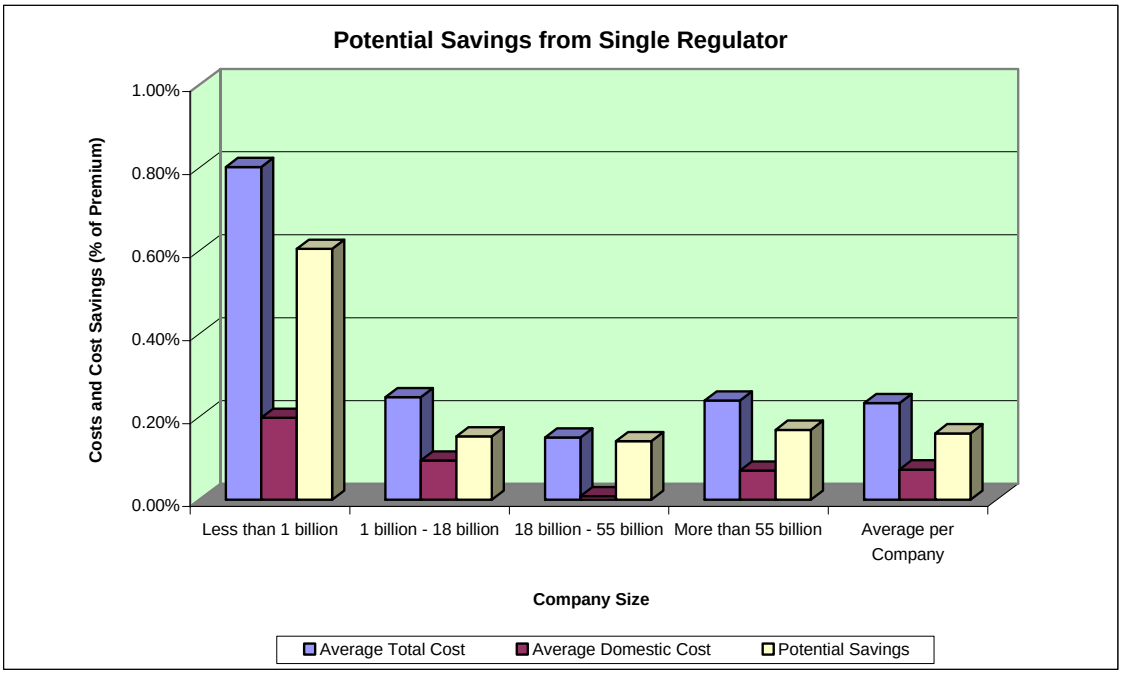
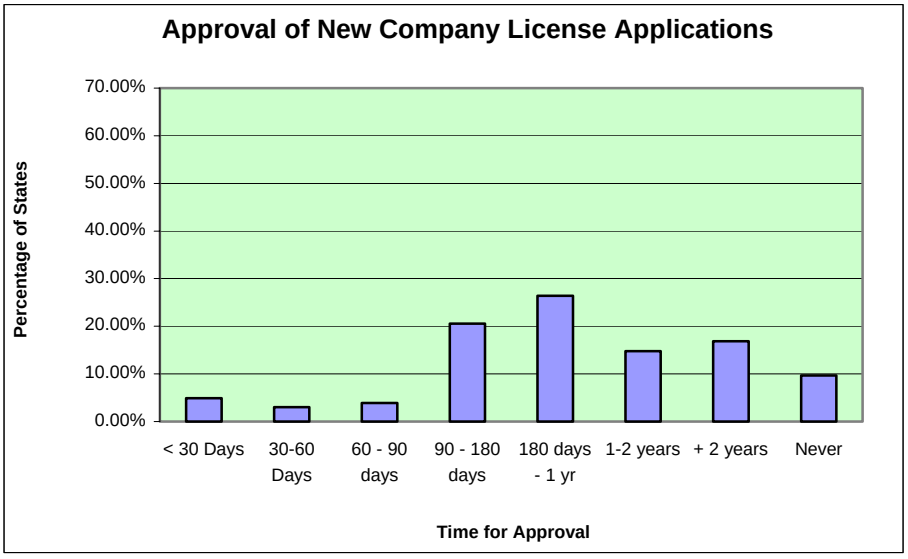


Exhibit 9: Comparison of Insurance Regulation Direct Costs and OCC Assessments and Fees

In thousand USD Per Company	Insurance Regulation Direct Cost	OCC Assessment & Fees	% OCC/ Direct Cost
A: Less than 1 billion	275,080	**148,351**	53.93%
B: 1 billion - 18 billion	746,443	**1,795,957**	240.60%
C: 18 billion - 55 billion	2,990,434	**4,611,395**	154.20%
D: More than 55 billion	6,285,949	**11,715,106**	186.37%

Exhibit 10: States by Approval Time of New Company License and New Business Line Applications



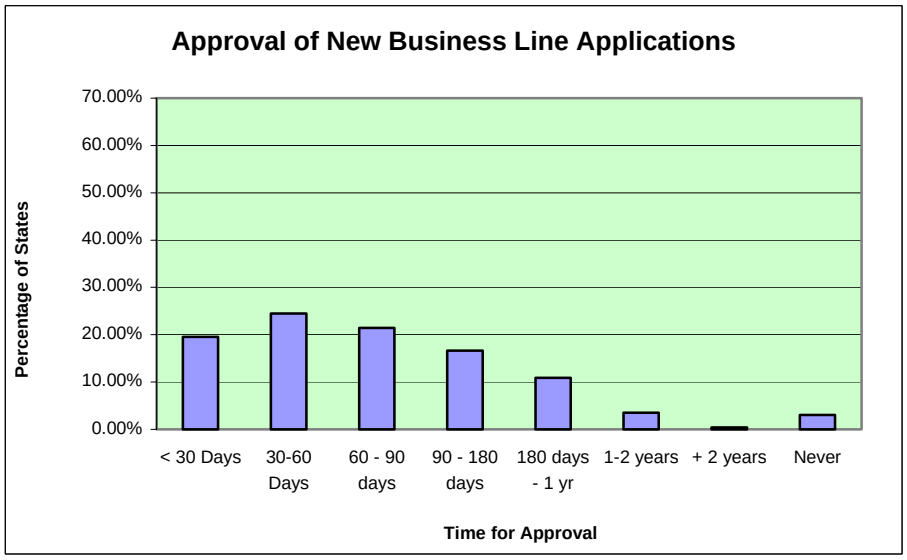


Exhibit 11. States by Approval Time of New Producer License Applications

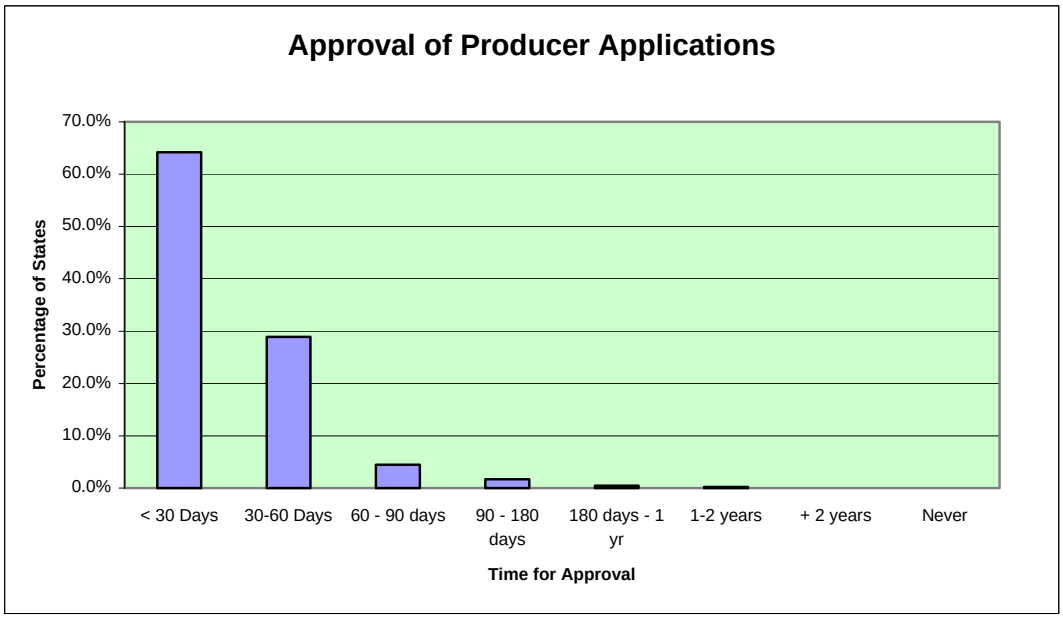


Exhibit 12. States by Approval Time of New Company, Producer and Product Applications

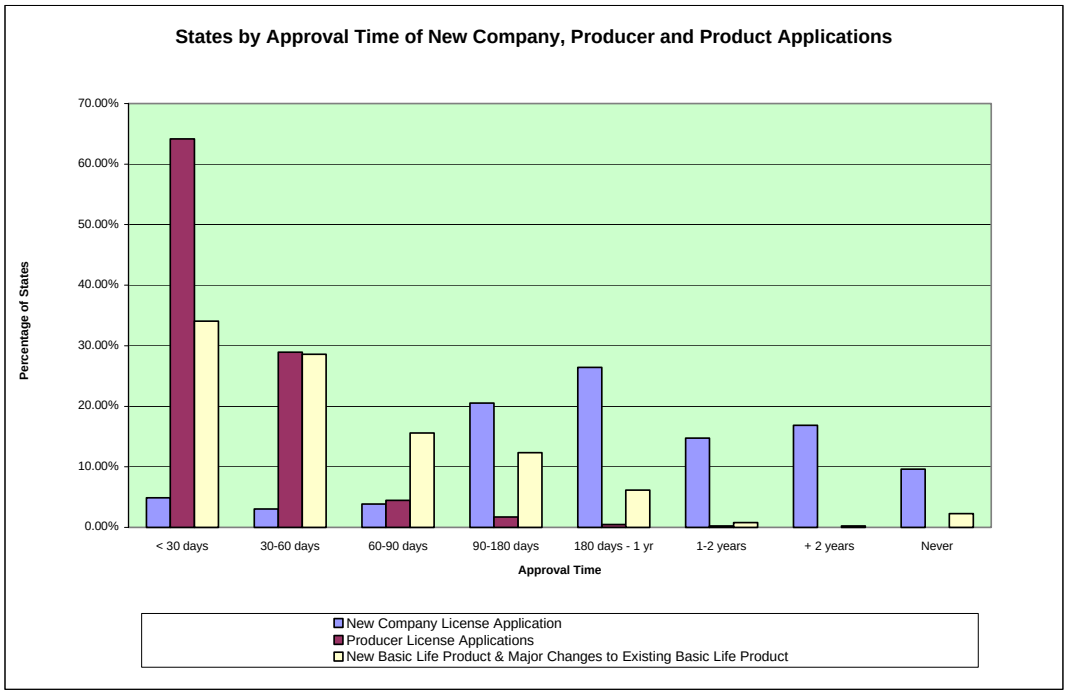
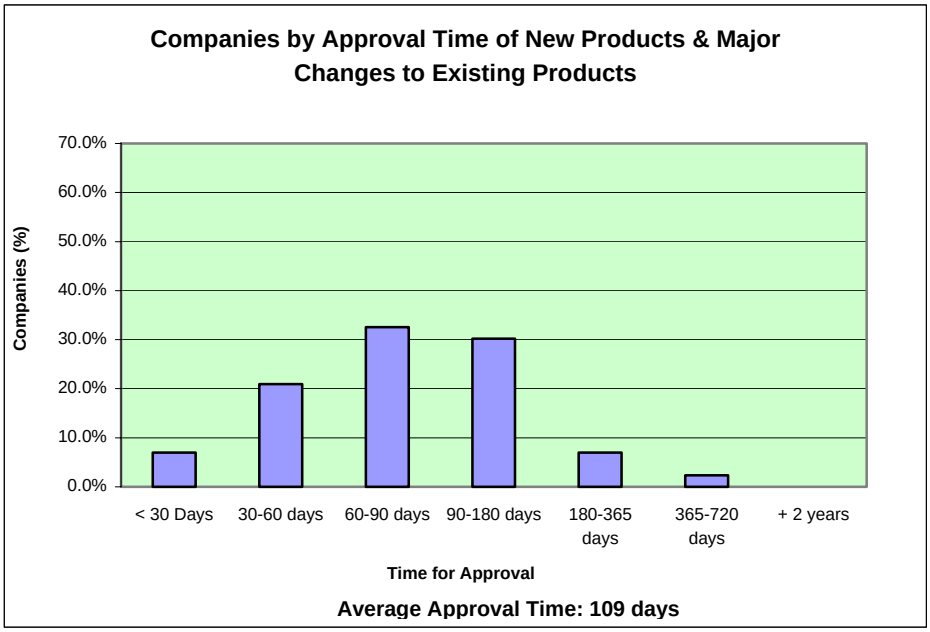
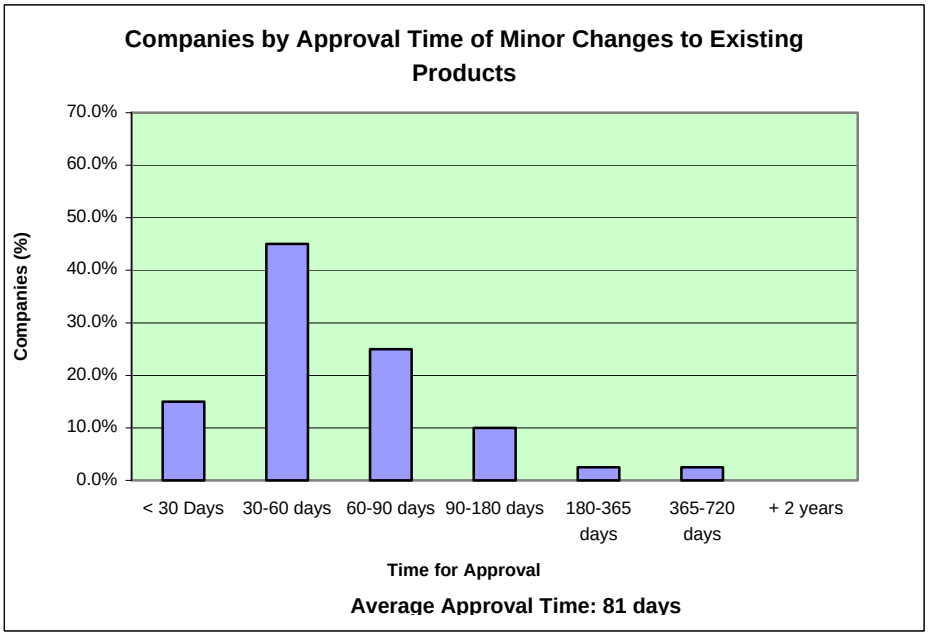


Exhibit 13: Companies by Approval Time of Their Products

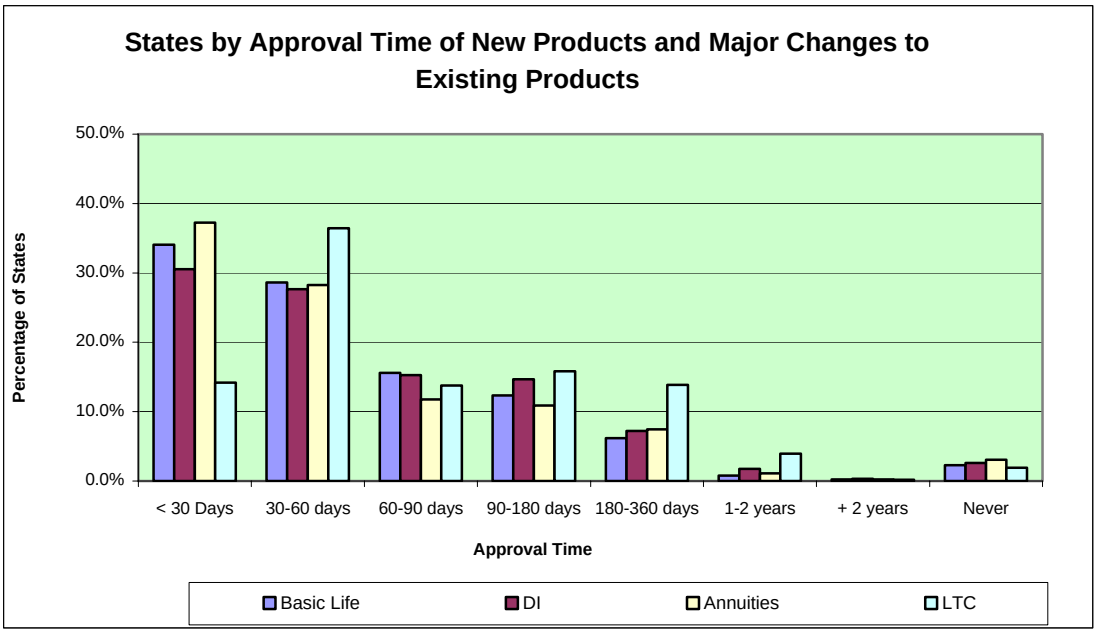




Note:

1. Approval time is the time that it takes a company to secure approval of new products, and major/ minor modifications to existing products to reach 75% of its target customer base.

Exhibit 14: States by Approval Time of Basic Life, DI, Annuities and LTC Products



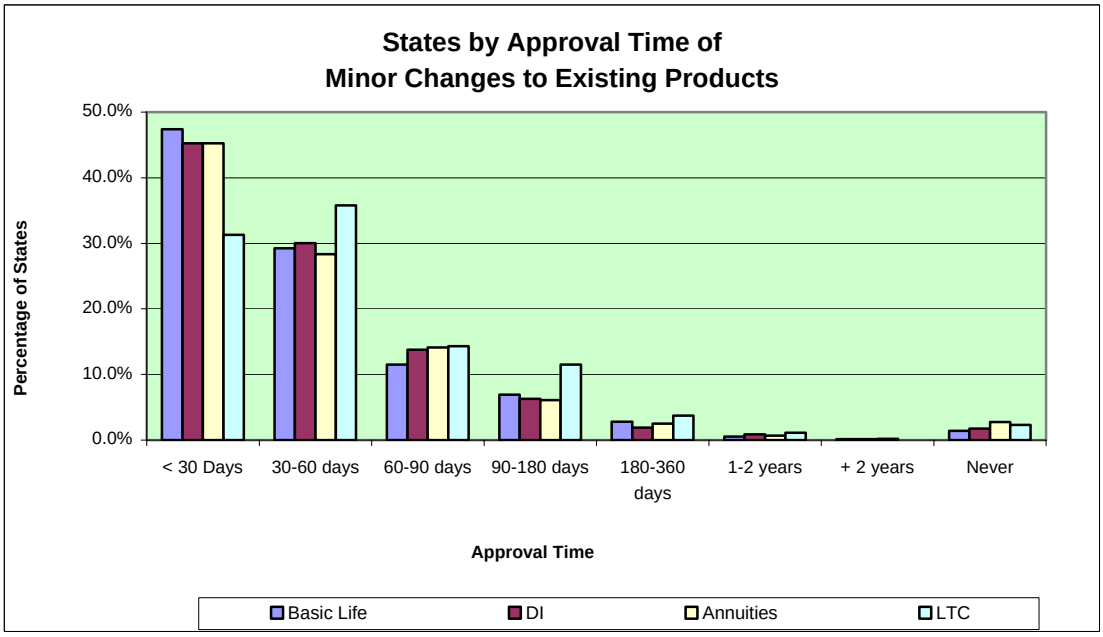
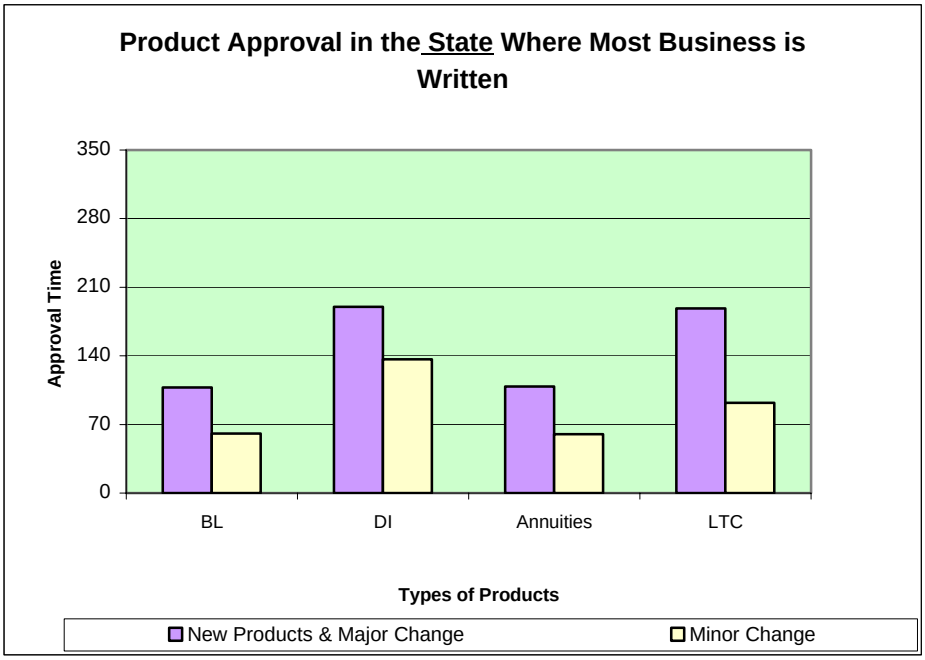


Exhibit 15: Time for Approval of New Products, and Major/ Minor Changes to Existing Products in the Top State and in the Top Five States Where Most Business is Written



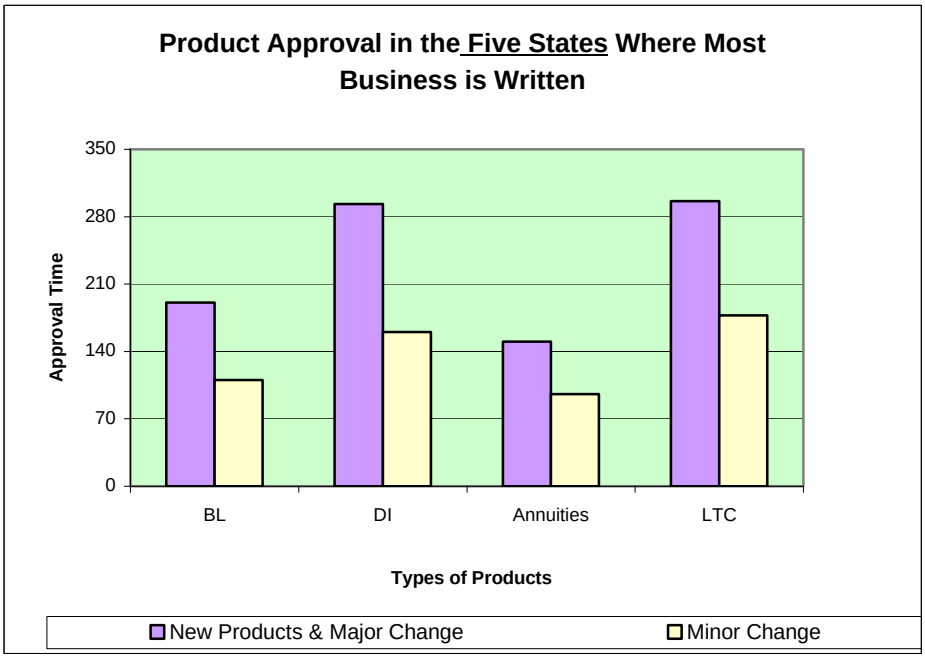
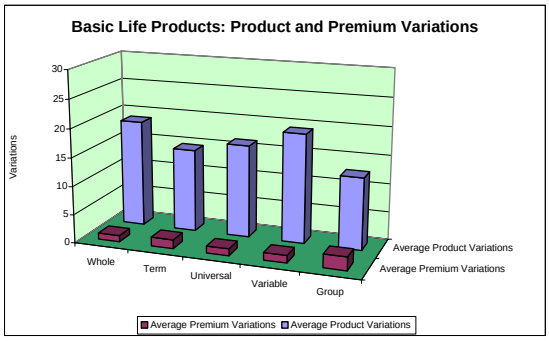
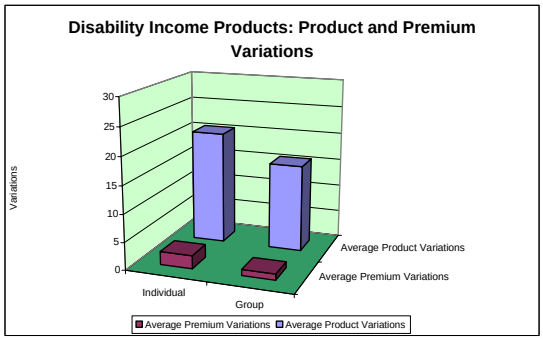
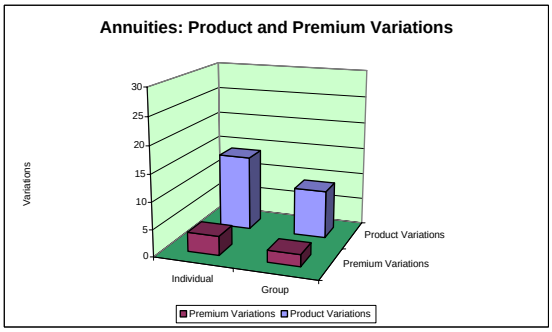


Exhibit 16: Product and Premium Variations by Product Types







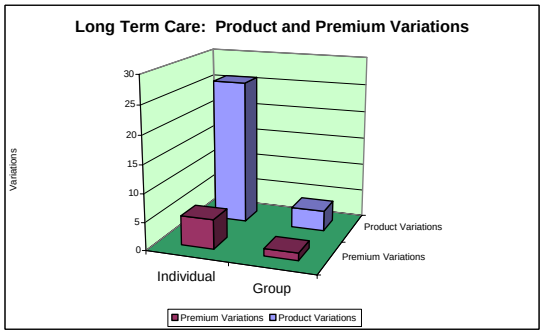


Exhibit 17: Companies by Percentage of Variations Due to Staff Interpretations

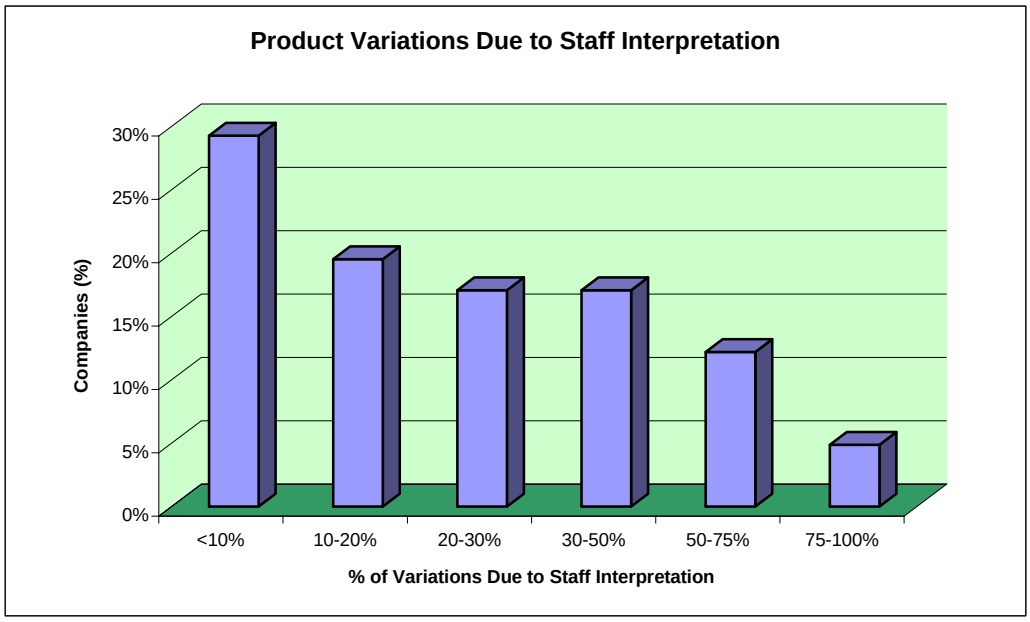


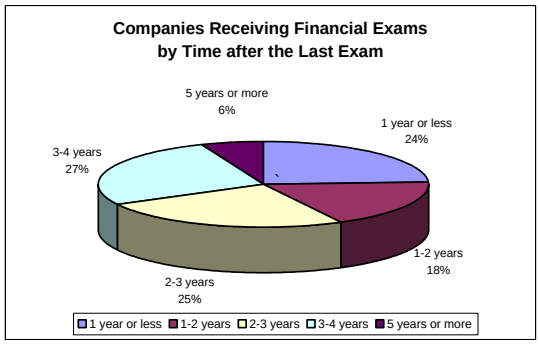
Exhibit 18: Average Cost of Financial Integrity and Market Conduct Examinations

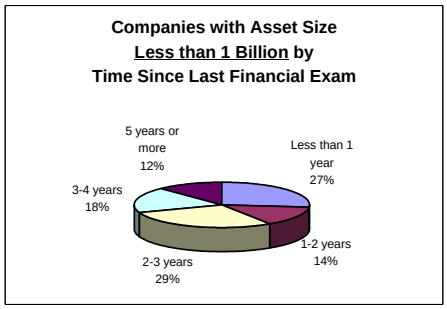
Average Exam Costs			
	Average	**Max**	**Min**
Financial Exams	$388,537	$2,500,000	$2,000
Market Conduct Exams	$107,148	$1,400,000	$392

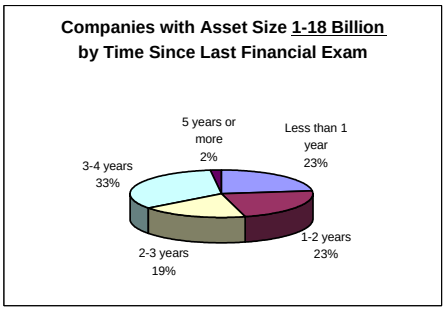
Average Cost of Financial Integrity and Market Conduct Examination by Asset Size of the Company

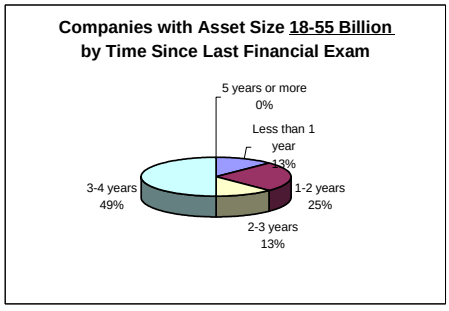
Average Exam Costs			
	Average	**Max**	**Min**
Financial Exams			
Less than 1 billion	117,754	$500,000	$2,000
1 billion - 18 billion	265,538	$760,687	$37,000
18 billion - 55 billion	1,049,498	$1,974,604	$151,000
More than 55 billion	3,026,881	$2,500,000	$863,000
Per Company	$388,537	$2,500,000	$2,000
Market Conduct Exams			
Less than 1 billion	$63,234	$280,230	$5,000
1 billion - 18 billion	$97,098	$413,789	$392
18 billion - 55 billion	$179,642	$1,400,000	$80,987
More than 55 billion	$206,286	$1,000,000	$8,100
Per Company	$107,148	$1,400,000	$392

Exhibit 19a: Companies by Time Since Last Financial Examinations









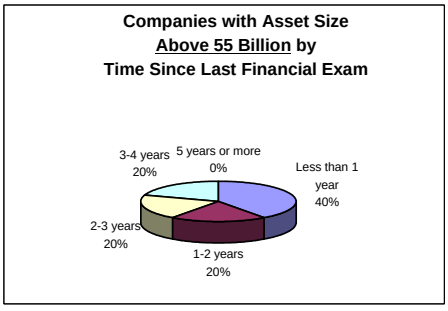
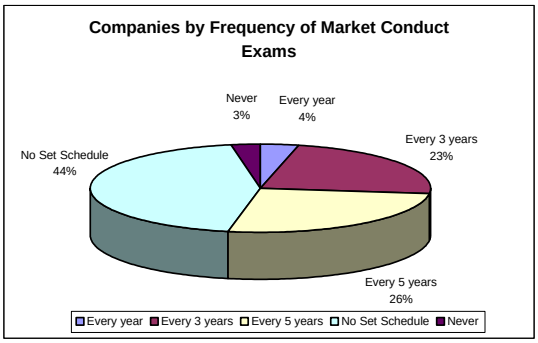
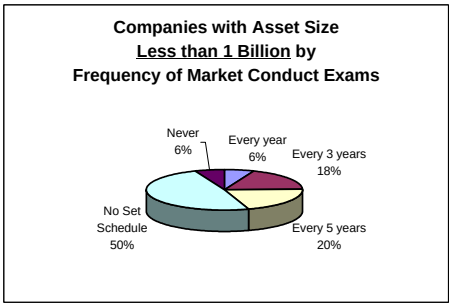
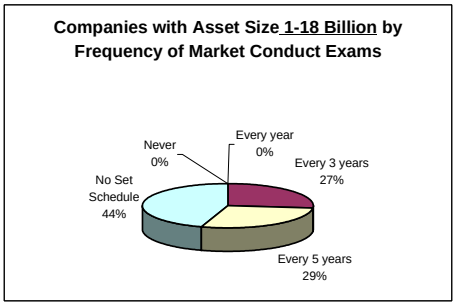
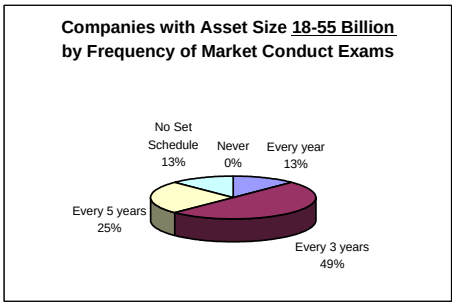


Exhibit 19b: Companies by Frequency of Market Conduct Examinations









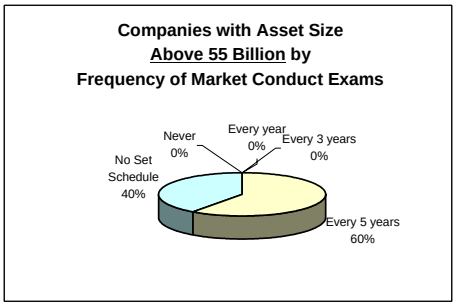
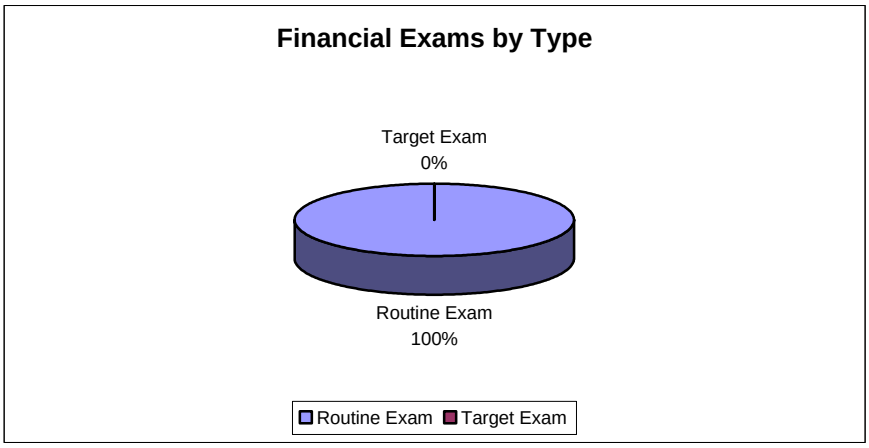
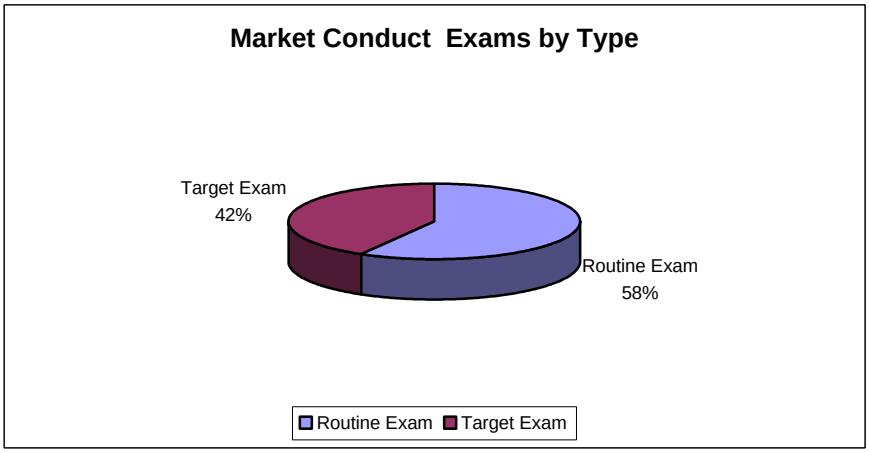


Exhibit 20: Companies that Have Received Financial and Market Conduct Exams by Exam Type: Routine vs. Target Exams





Notes:

1. Routine examinations are performed at regular intervals and generally involve a review of all of a company's business practices.
2. Target examinations are focused examinations reviewing either a specific line of business or a specific business practice.

Exhibit 21: Companies that Have Received Market Conduct Exams by Type of the Market Conduct Exam: Combined vs. Separate Exams

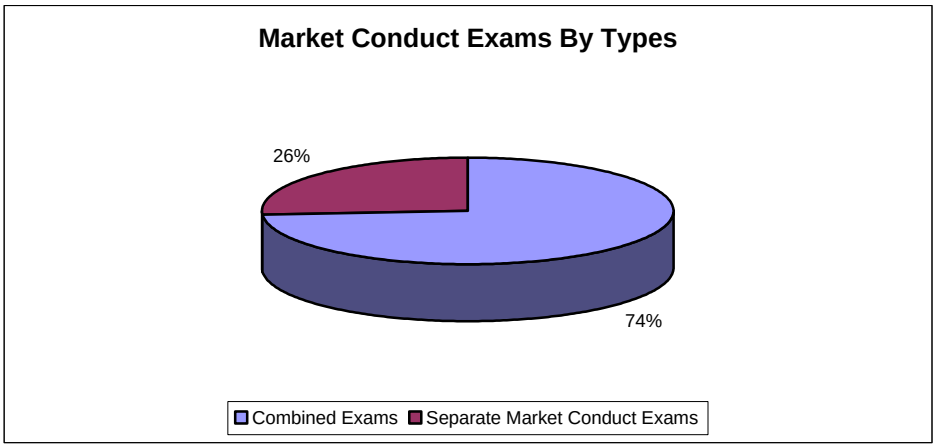


Exhibit 22: Duration of Financial and Market Conduct Exams

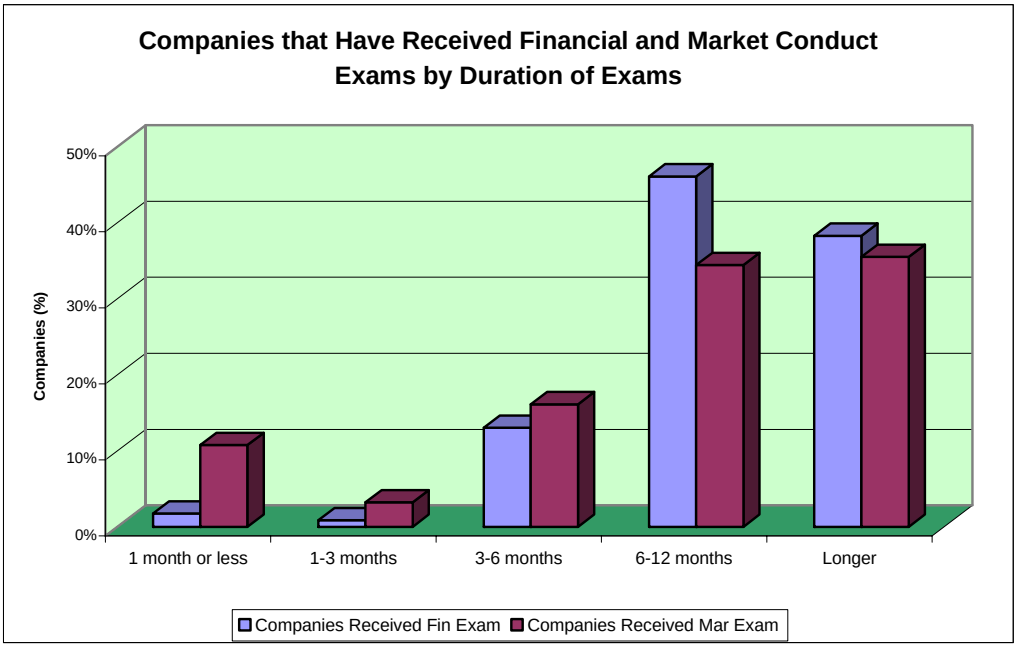
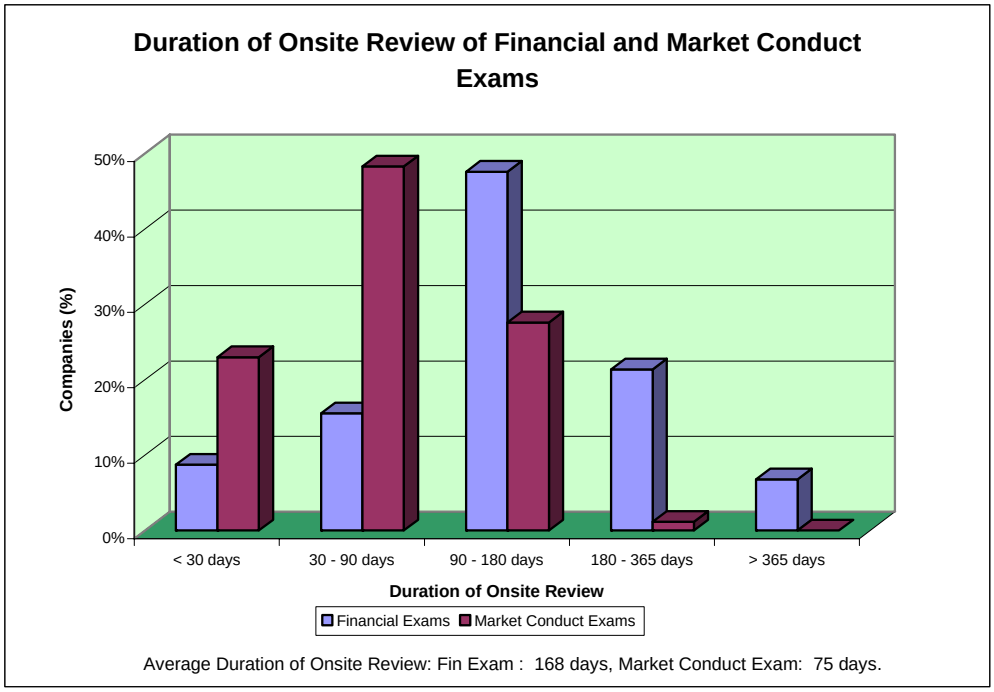
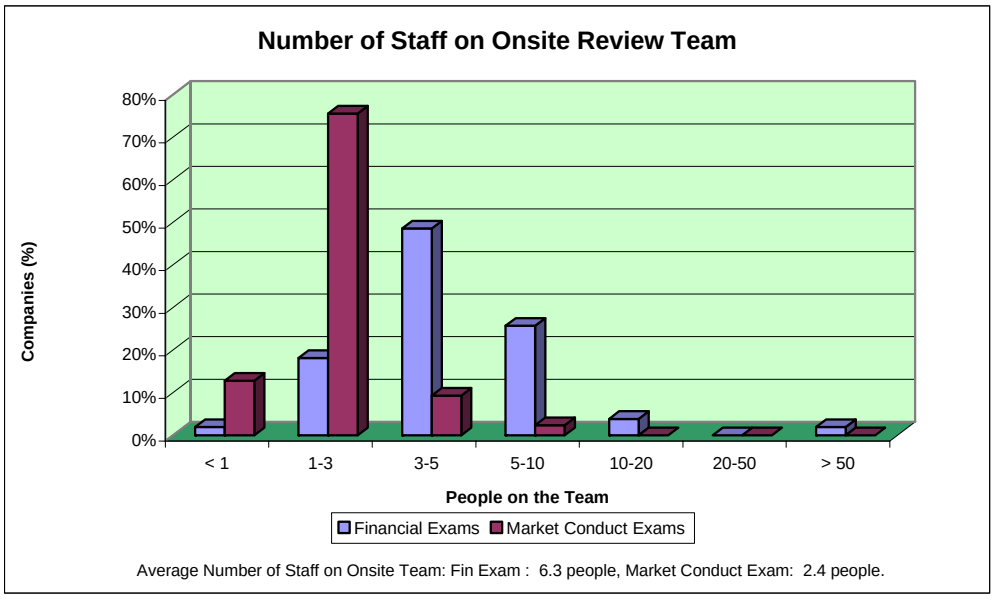


Exhibit 23: Duration of the Onsite Reviews of Financial and Market Conduct Exams



Average Duration of Onsite Review: Fin Exam : 168 days, Market Conduct Exam: 75 days.

Exhibit 24: Number of Staff on the Onsite Review Team of Financial and Market Conduct Exams



Average Number of Staff on Onsite Team: Fin Exam : 6.3 people, Market Conduct Exam: 2.4 people.

Exhibit 25: Financial and Market Conduct Exam Violations

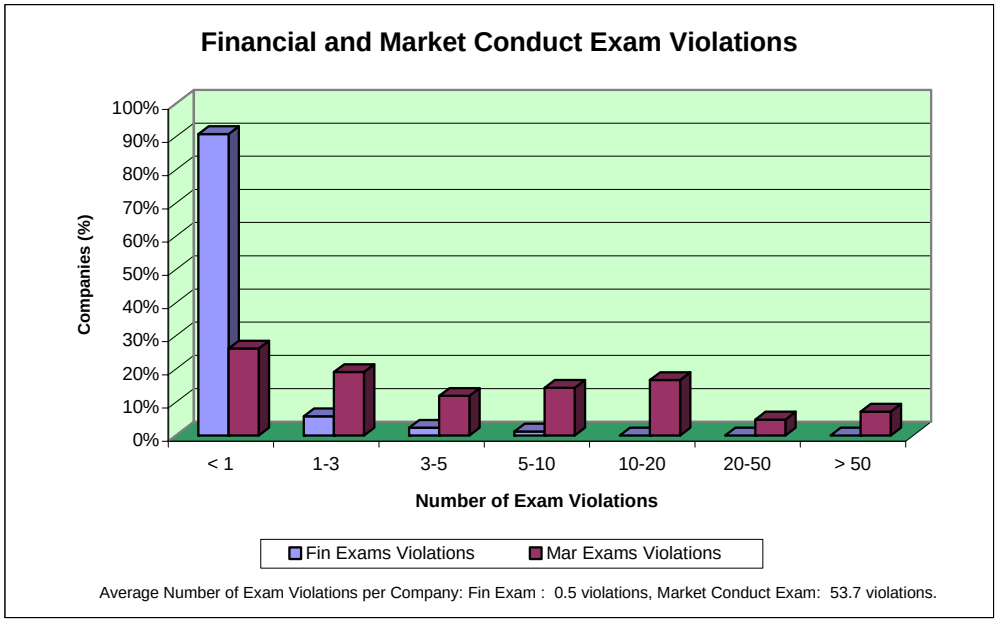


Exhibit 26a: Number of Market Conduct Exams Each State Conducted During Last 5 years

State	Number of Market Exams Performed by Each State in Last 5 Years
AK	0
AL	0
AR	1
AZ	15
CA	73
CO	6
CT	19
DC	9
DE	4
FL	8
GA	3
HI	0
IA	4
ID	0
IL	21
IN	4
KS	2
KY	11
LA	2
MA	4
MD	15
ME	0
MI	0
MN	3
MO	17
MS	2
MT	0
NC	9
ND	1
NE	10
NH	1
NJ	4
NM	0
NV	4
NY	18
OH	6
OK	4
OR	5
PA	11
RI	0
SC	1
SD	2
TN	0
TX	5
UT	0
VA	10
VT	9
WA	8
WI	6
WV	0
WY	0
WS	1
TOTAL	**338**

Exhibit 26b: Number of Market Conduct Exams Each State Conducted During Last 5 years

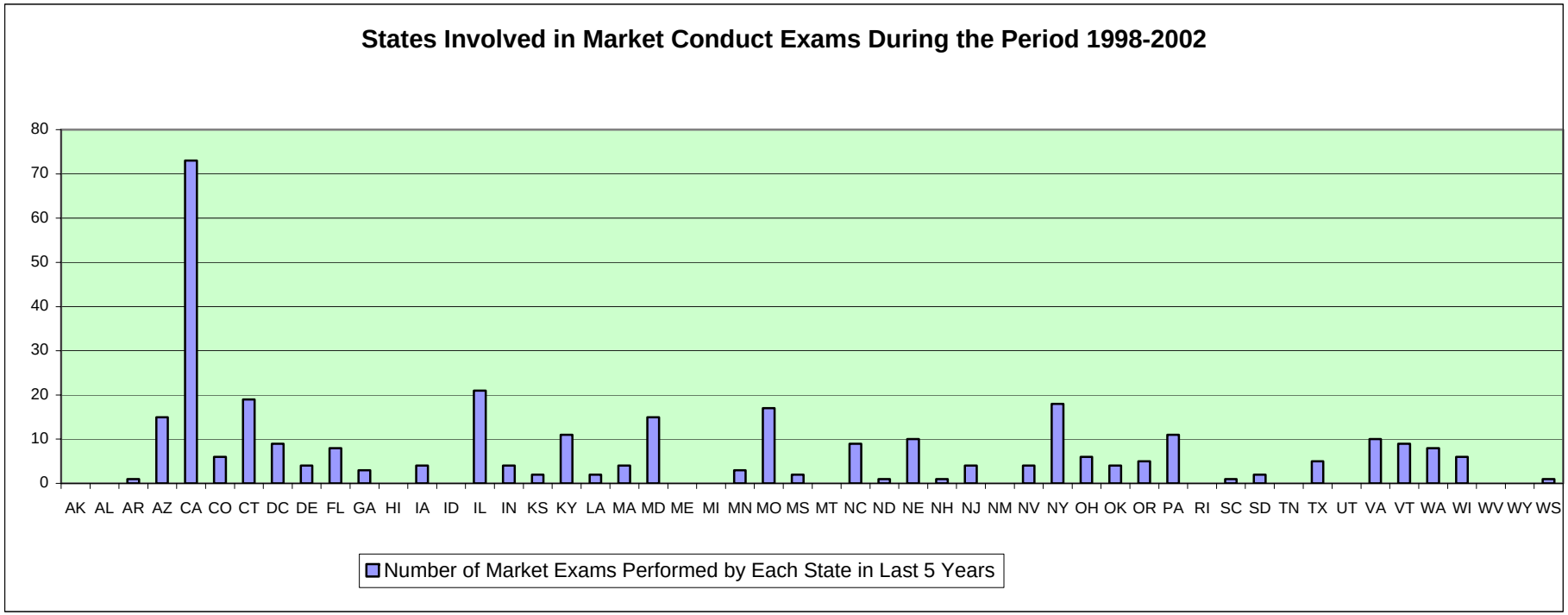


Exhibit 27

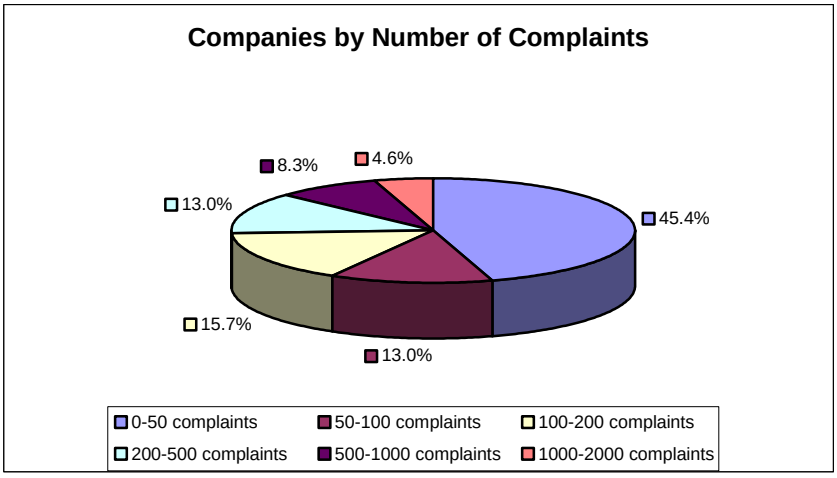

Companies by Number of Complaints
8.3%
4.6%
13.0%
45.4%
15.7%
13.0%
0-50 complaints
50-100 complaints
100-200 complaints
200-500 complaints
500-1000 complaints
1000-2000 complaints

Exhibit 28

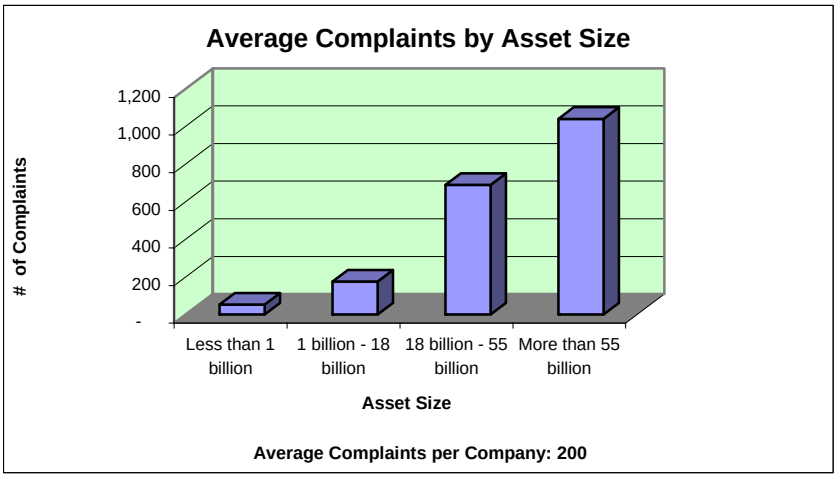

Average Complaints by Asset Size
# of Complaints
1,200
1,000
800
600
400
200
-
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion
Asset Size
Average Complaints per Company: 200

Exhibit 29

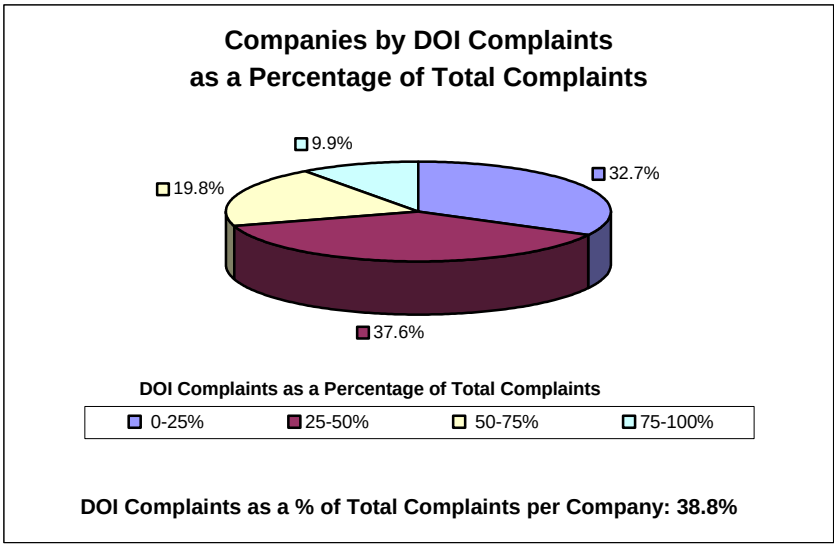
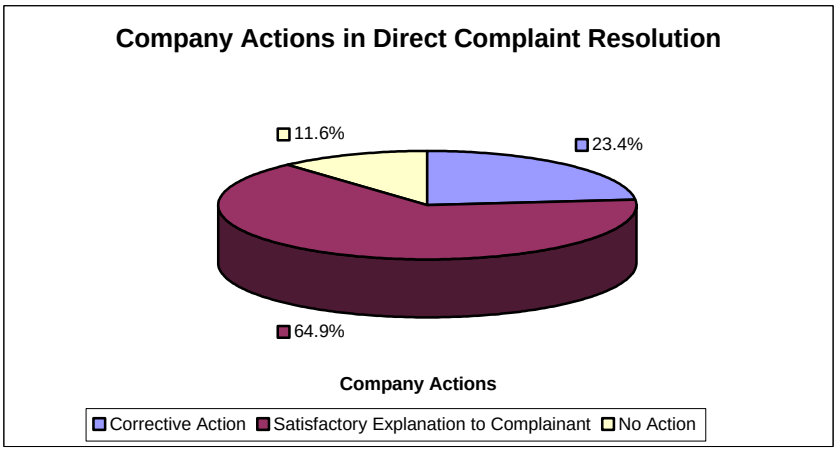

Companies by DOI Complaints
as a Percentage of Total Complaints
9.9%
32.7%
19.8%
37.6%
DOI Complaints as a Percentage of Total Complaints
0-25%
25-50%
50-75%
75-100%
DOI Complaints as a % of Total Complaints per Company: 38.8%

Exhibit 30: Complaint Resolution: Company and DOI Actions



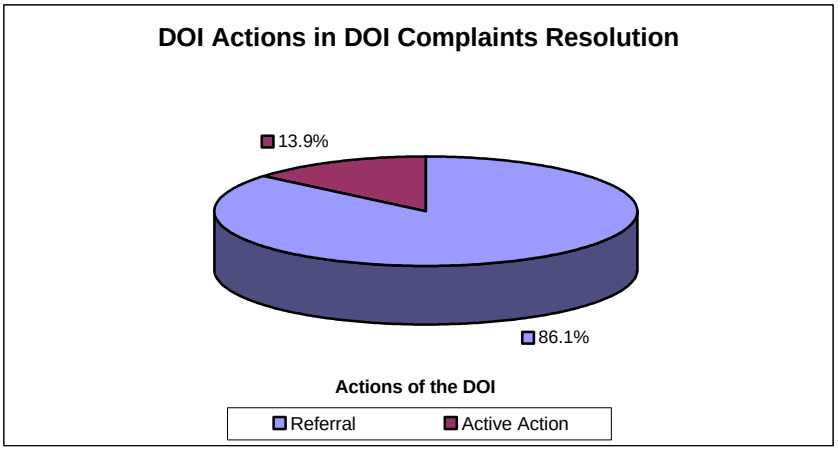


Exhibit 31

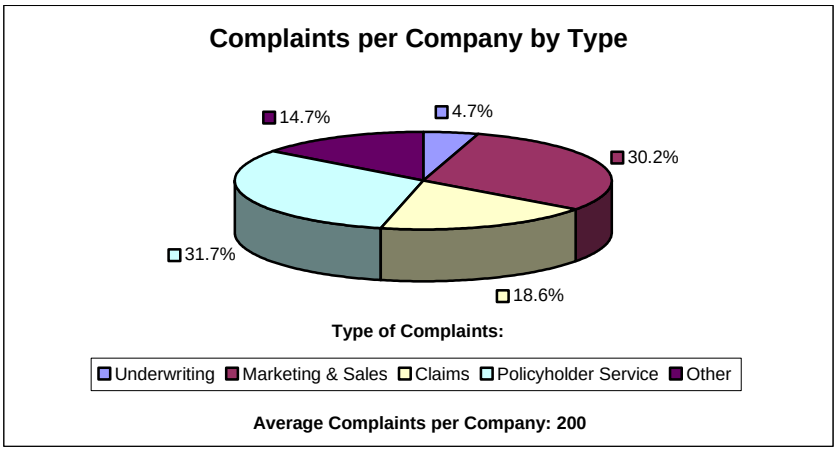
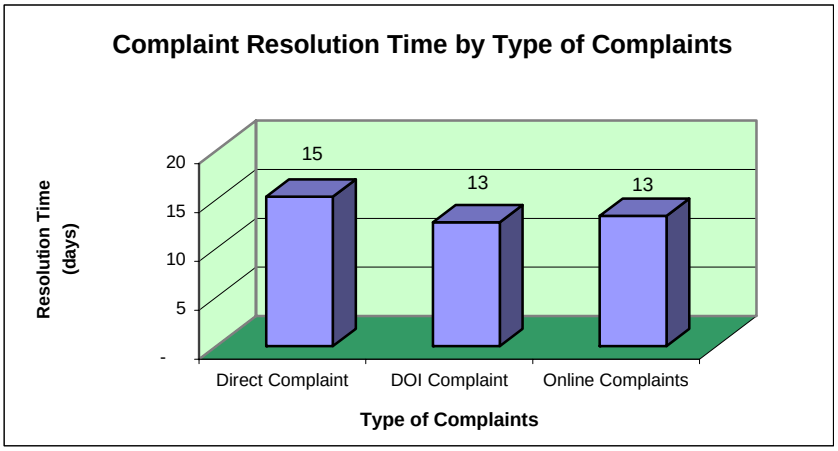

Complaints per Company by Type
14.7%
4.7%
30.2%
31.7%
18.6%
Type of Complaints:
Underwriting
Marketing & Sales
Claims
Policyholder Service
Other
Average Complaints per Company: 200

Exhibit 32


Complaint Resolution Time by Type of Complaints
Resolution Time (days)
20
15
10
5
-
15
13
13
Direct Complaint
DOI Complaint
Online Complaints
Type of Complaints

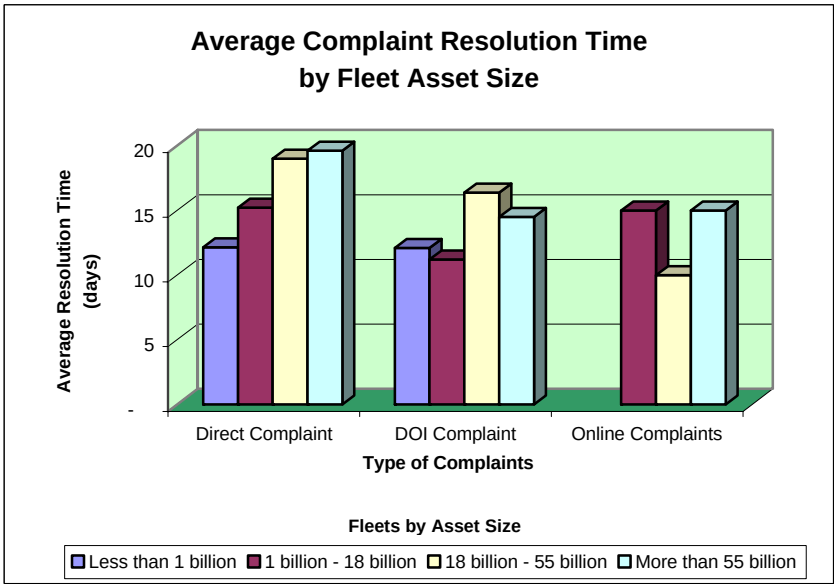
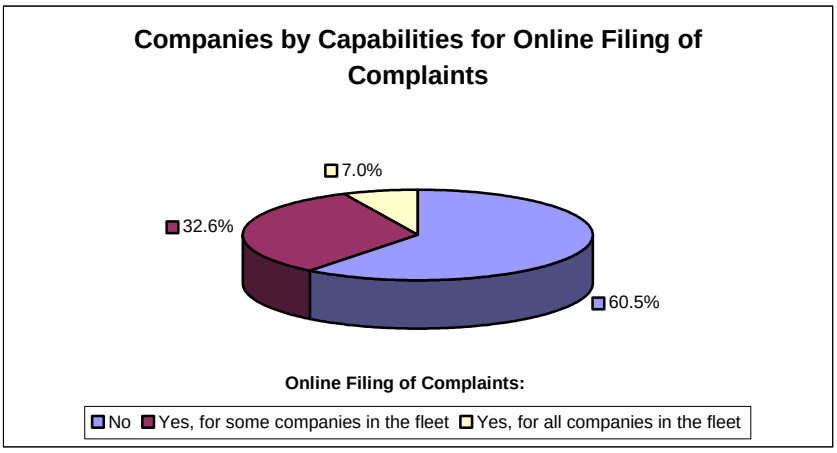
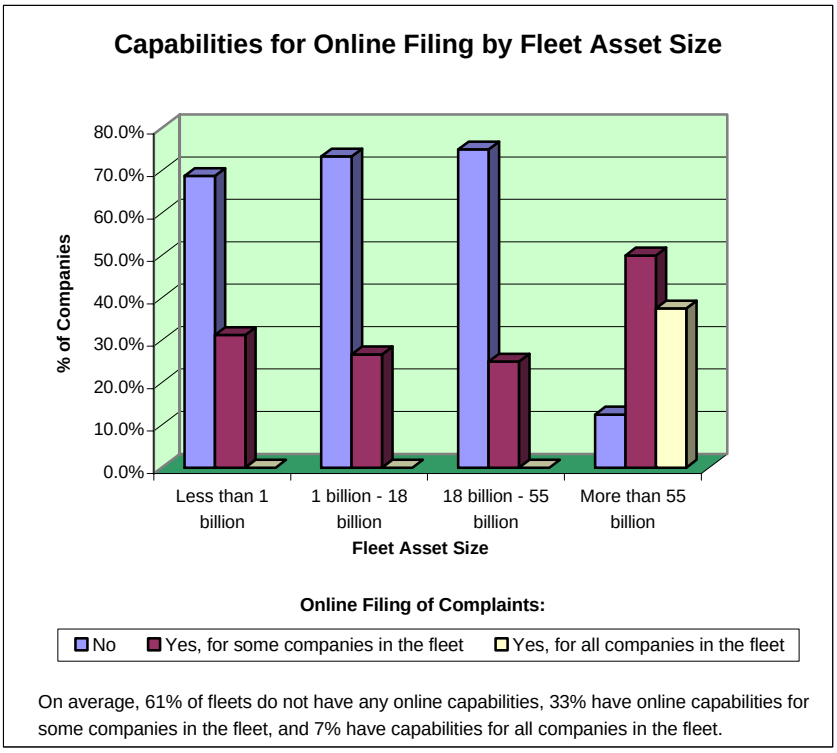

Average Complaint Resolution Time by Fleet Asset Size
Average Resolution Time (days)
20
15
10
5
-
Direct Complaint
DOI Complaint
Online Complaints
Type of Complaints
Fleets by Asset Size
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion

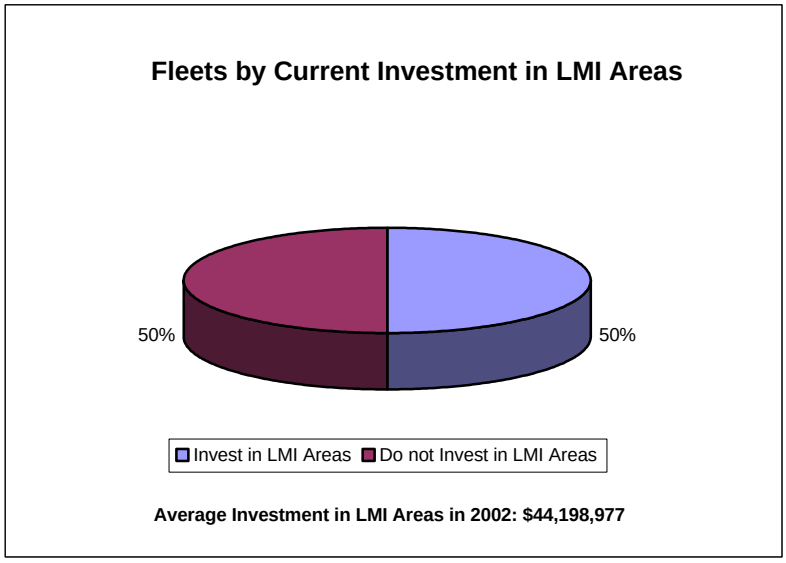
Exhibit 33





On average, 61% of fleets do not have any online capabilities, 33% have online capabilities for some companies in the fleet, and 7% have capabilities for all companies in the fleet.

Exhibit 34


Fleets by Current Investment in LMI Areas
50%
50%
Invest in LMI Areas
Do not Invest in LMI Areas
Average Investment in LMI Areas in 2002: $44,198,977

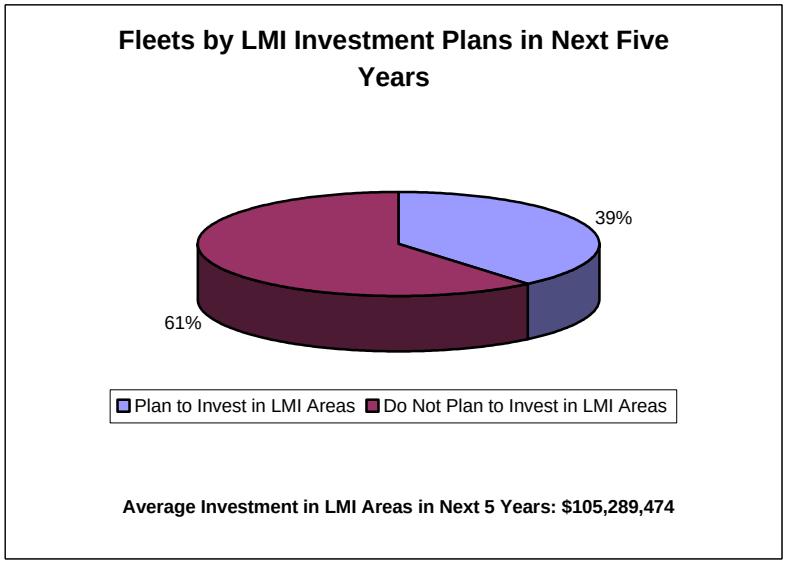

Fleets by LMI Investment Plans in Next Five Years
39%
61%
Plan to Invest in LMI Areas
Do Not Plan to Invest in LMI Areas
Average Investment in LMI Areas in Next 5 Years: $105,289,474

Exhibit 35

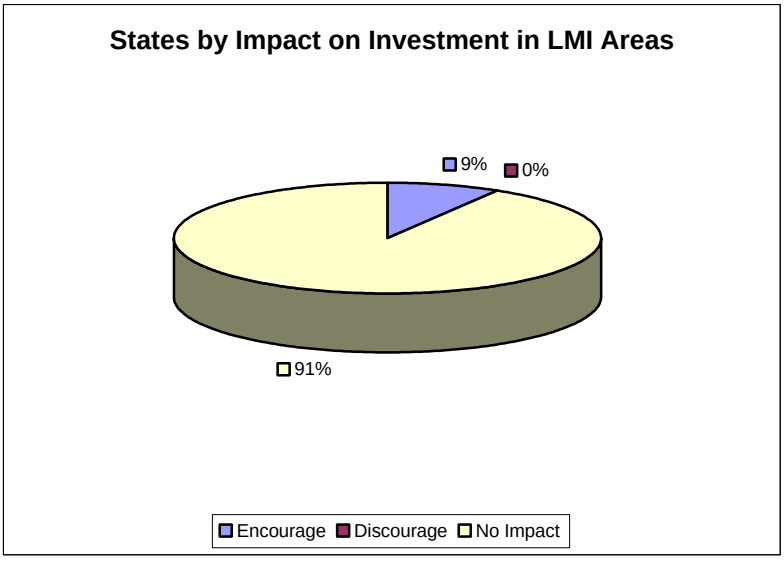
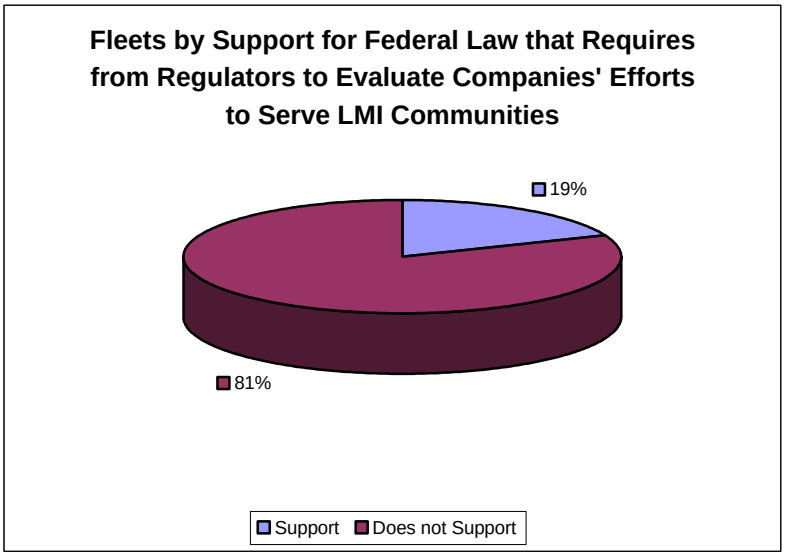

States by Impact on Investment in LMI Areas
9%
0%
91%
Encourage
Discourage
No Impact

Exhibit 36


Fleets by Support for Federal Law that Requires from Regulators to Evaluate Companies' Efforts to Serve LMI Communities
19%
81%
Support
Does not Support

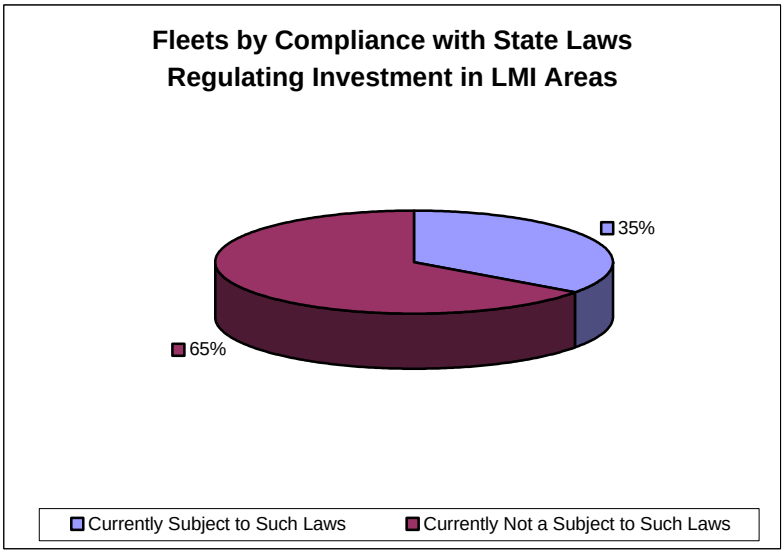

Fleets by Compliance with State Laws Regulating Investment in LMI Areas
35%
65%
Currently Subject to Such Laws
Currently Not a Subject to Such Laws

Exhibit 37

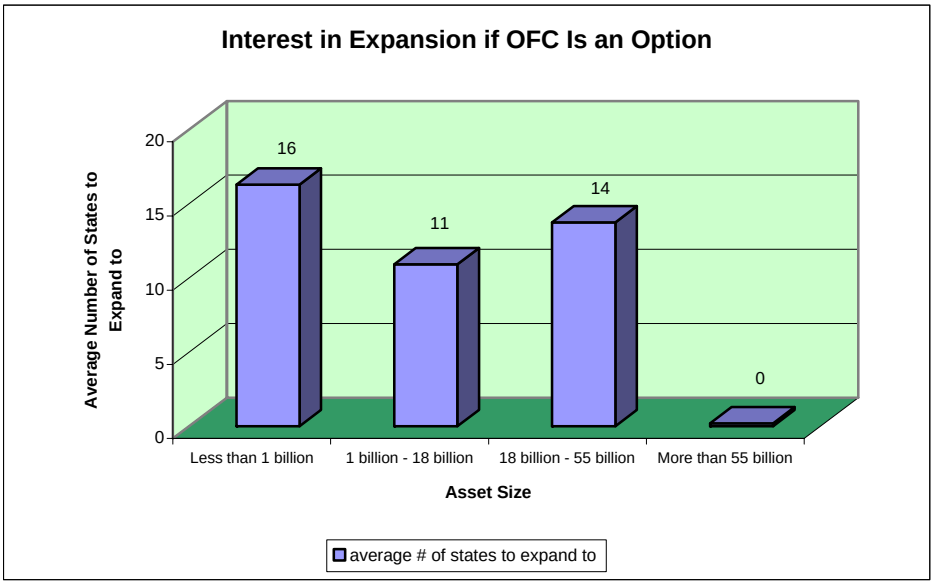
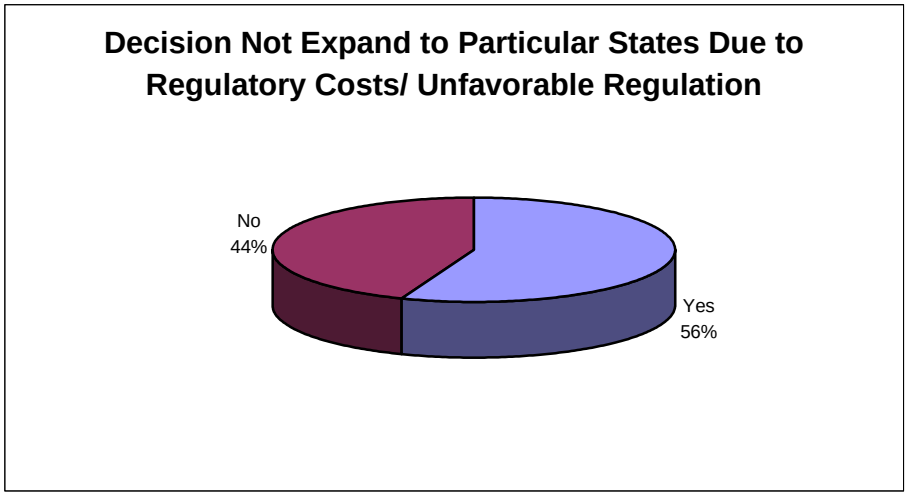

Interest in Expansion if OFC Is an Option
Average Number of States to Expand to
20
15
10
5
0
16
11
14
0
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion
Asset Size
average # of states to expand to

Exhibit 38


Decision Not Expand to Particular States Due to Regulatory Costs/ Unfavorable Regulation
No
44%
Yes
56%

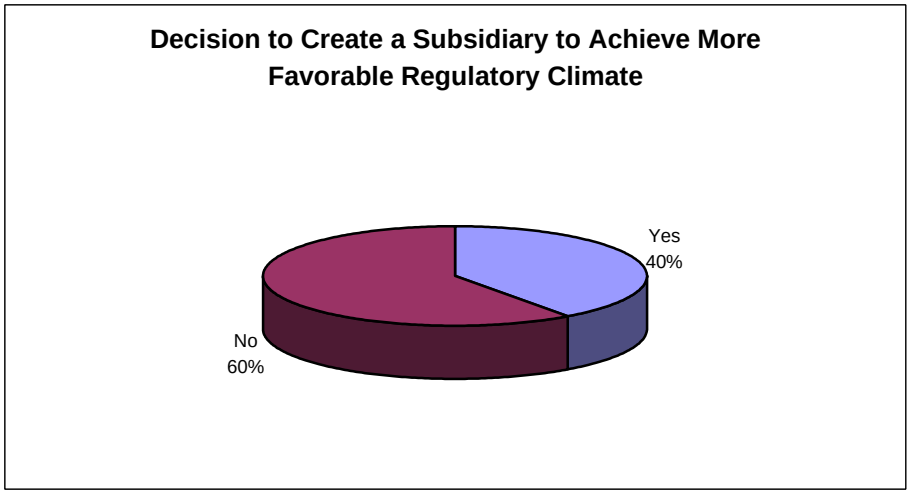
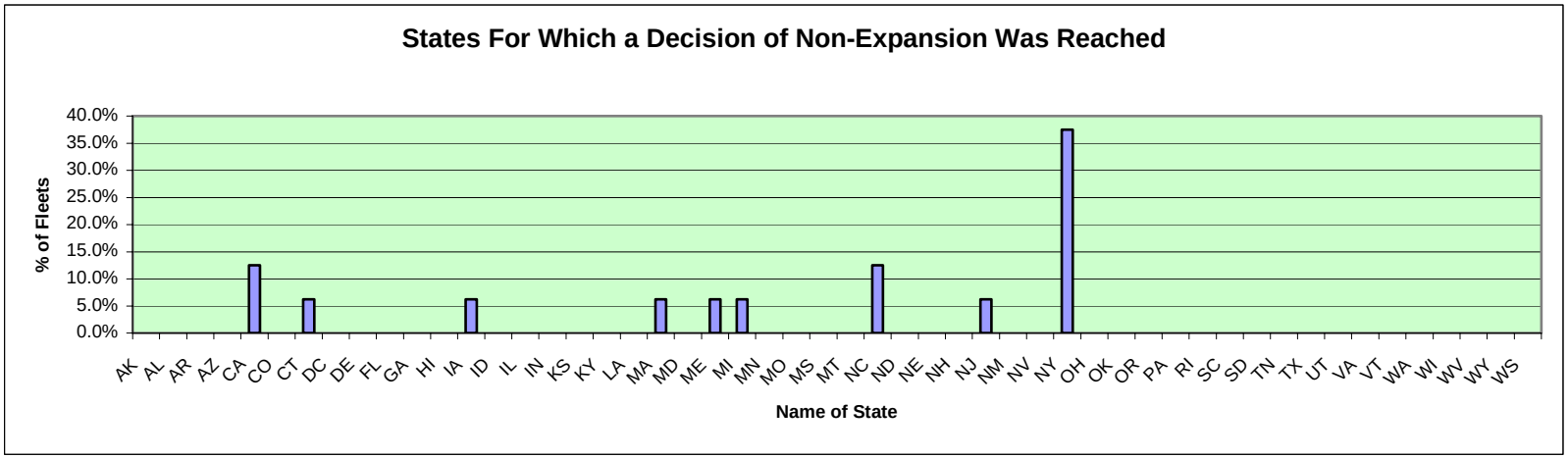

Decision to Create a Subsidiary to Achieve More Favorable Regulatory Climate
Yes
40%
No
60%

Exhibit 39


States For Which a Decision of Non-Expansion Was Reached
% of Fleets
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
AK AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS MT NC ND NE NH NJ NM NV NY OH OK OR PA RI SC SD TN TX UT VA VT WA WI WV WY WS
Name of State

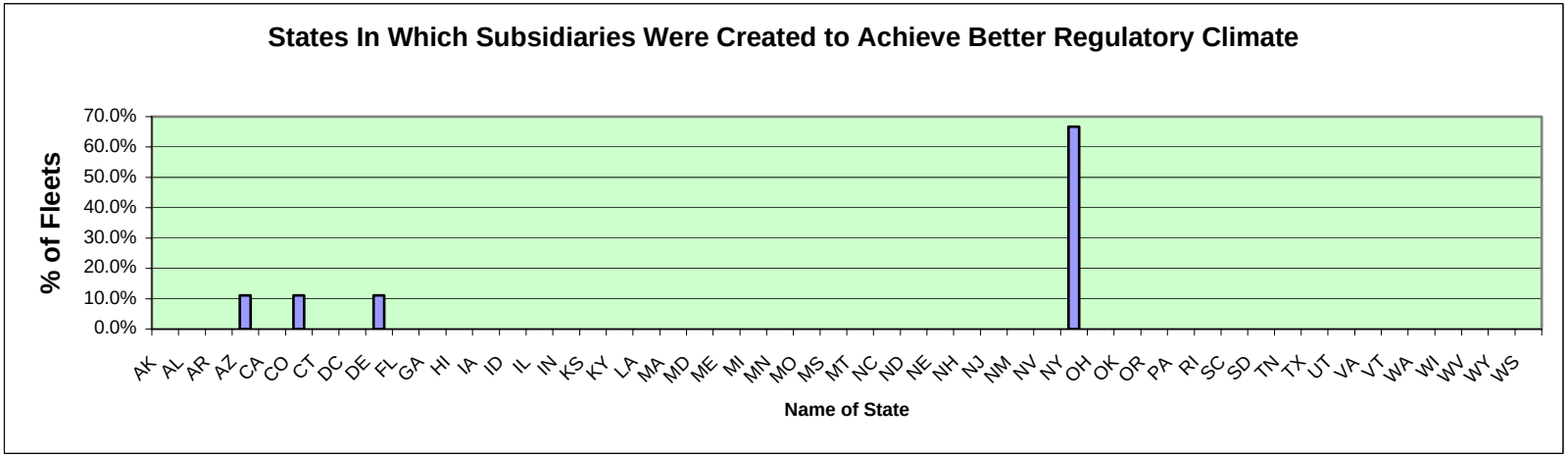
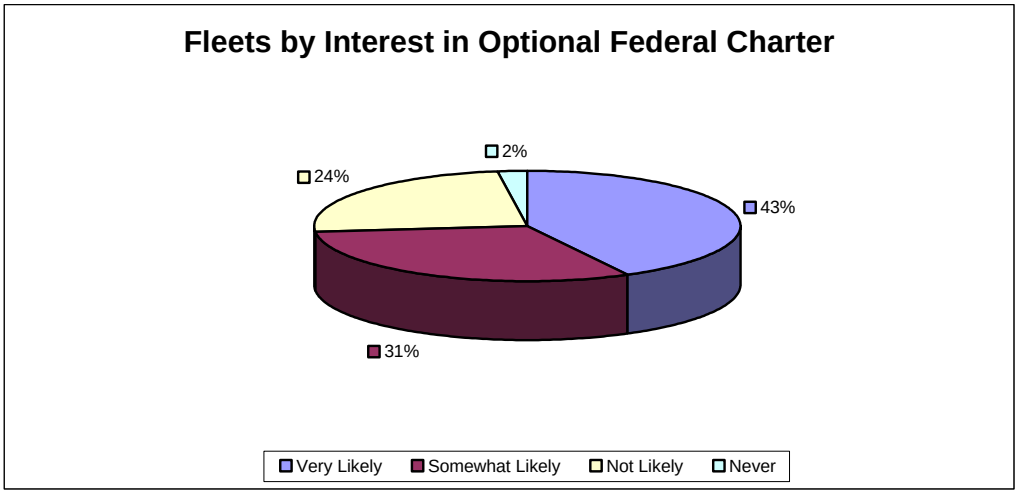

States In Which Subsidiaries Were Created to Achieve Better Regulatory Climate
% of Fleets
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
AK AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS MT NC ND NE NH NJ NM NV NY OH OK OR PA RI SC SD TN TX UT VA VT WA WI WV WY WS
Name of State

Exhibit 40


Fleets by Interest in Optional Federal Charter
2%
24%
43%
31%
Very Likely
Somewhat Likely
Not Likely
Never

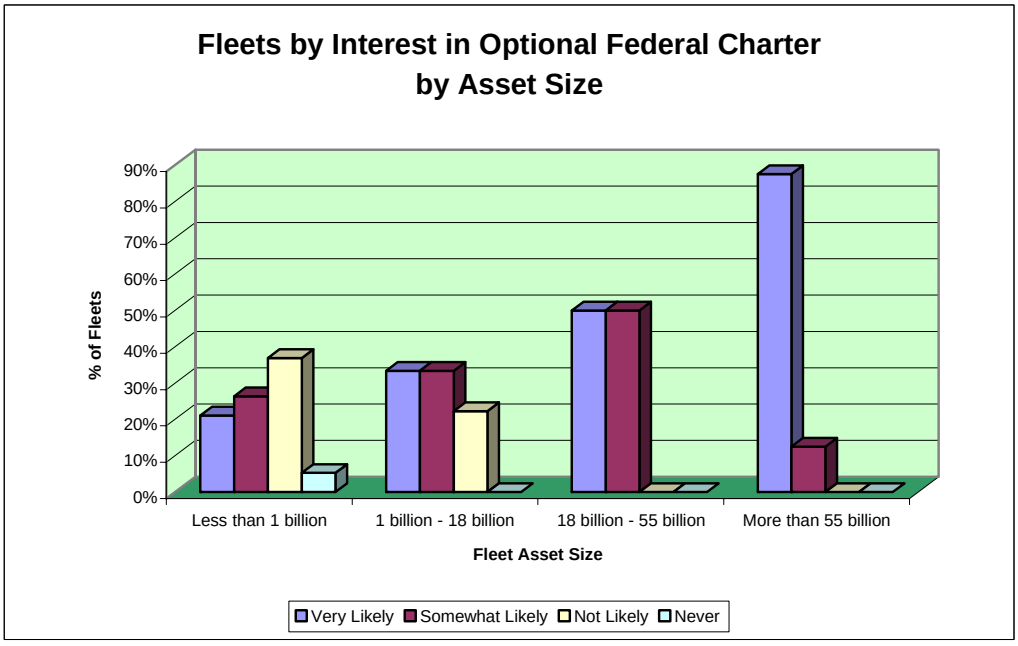

Fleets by Interest in Optional Federal Charter
by Asset Size
% of Fleets
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion
Fleet Asset Size
Very Likely
Somewhat Likely
Not Likely
Never

Exhibit 41

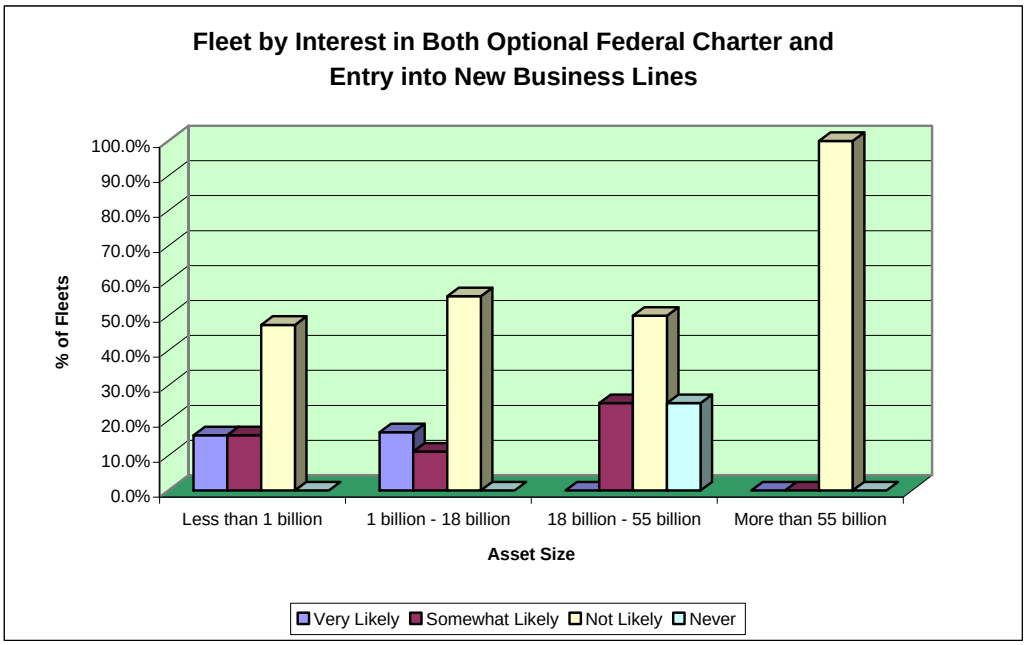

Fleet by Interest in Both Optional Federal Charter and Entry into New Business Lines
% of Fleets
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Less than 1 billion
1 billion - 18 billion
18 billion - 55 billion
More than 55 billion
Asset Size
Very Likely
Somewhat Likely
Not Likely
Never

Exhibit 42. Response Description of State Insurance Department Survey

Geographic Distribution of the Insurance Departments

	Actual Responses	Population	%
Atlantic	5	11	45.5%
North Central	2	7	28.6%
North Eastern	3	7	42.9%
South Central	3	9	33.3%
Western	7	17	41.2%
Total	**20**	**51**	**39.2%**

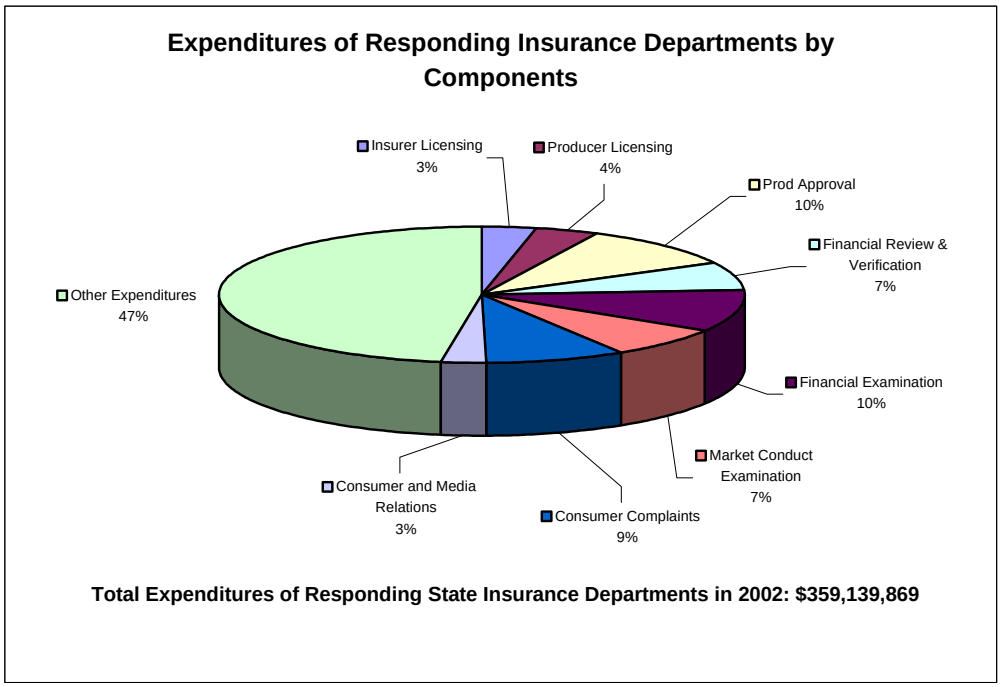
Budget Distribution of the State Insurance Departments

	Actual Responses	Population[(1)]	%
Budget			
$1-5 million	2	6	33.3%
$5-10 million	9	22	40.9%
$10-25 million	6	14	42.9%
$25-50 million	1	5	20.0%
$50-200 million	2	4	50.0%
Total	**20**	**51**	**39.2%**

Note:

1. Information about the insurance departments' budgets in 2002 comes from the 2002 NAIC Insurance Department resources Report.

Exhibit 43a. Expenditures of Responding Insurance Departments by Components



Notes:

1. Six states were not able to break down their expenditures by components because they did not capture expenditures at this detailed level. Exhibit 43a is based on Reponses provided by the other 14 states that were able to break down their expenditure

2. A new category *Other Expenditures* was created to capture the expenditures of the states that reported that there were other expenditures that could not be allocated in any one of the eight categories, i.e. expenditures related to various administrative activities such as: salaries of senior staff, regulatory coordination, legislative liaison, accounting, procurement, market enforcement responsibilities for insurance agents, consultant and actuaries, information system support, etc.

3. One state reported total expenditures and allocation of expenditures for FY2003 since for that state the accounting of expenditures in 2002 was on an insurance department level only. The state reported that in general the expenditures do not change much from year to year, and in FY2003 the expenditures were slightly lower than in FY2002.

Exhibit 43b. Full Time Equivalent of Insurance Departments' Staff by Components

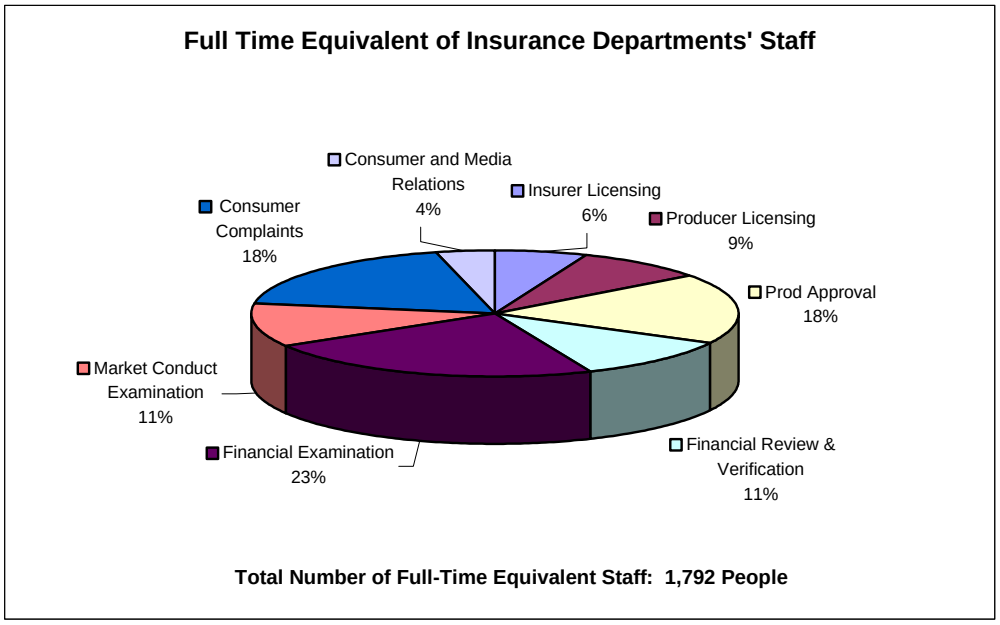
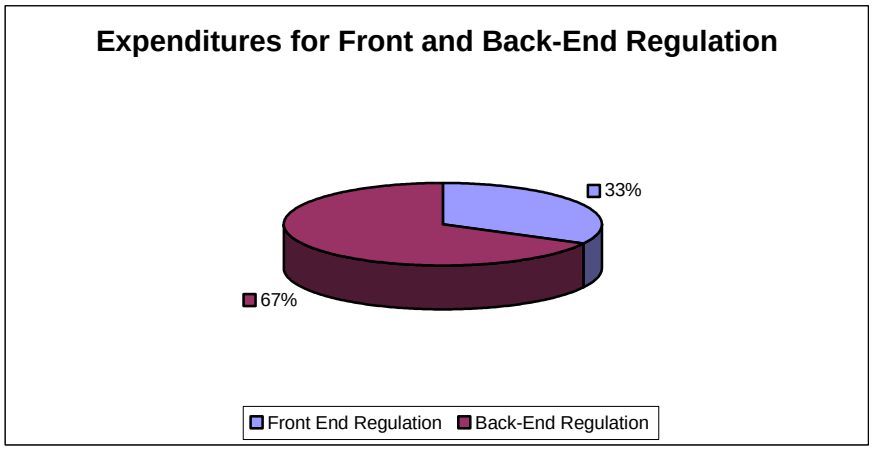
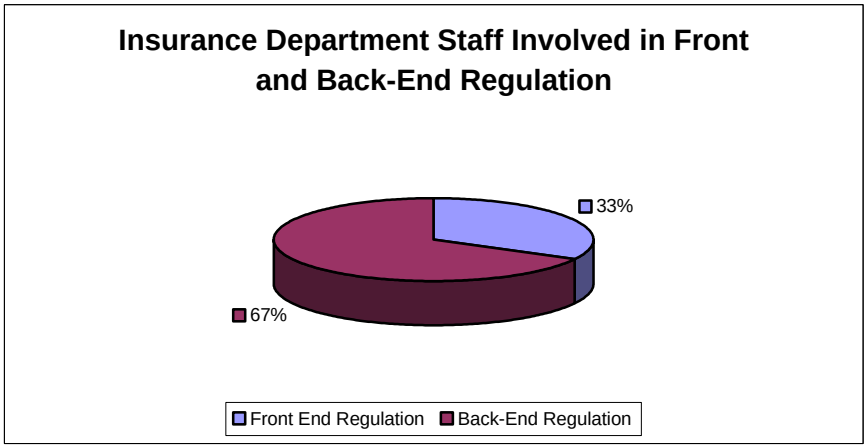


Exhibit 44. Insurance Department Staffing and Expenditures for Front and Back-End Regulation



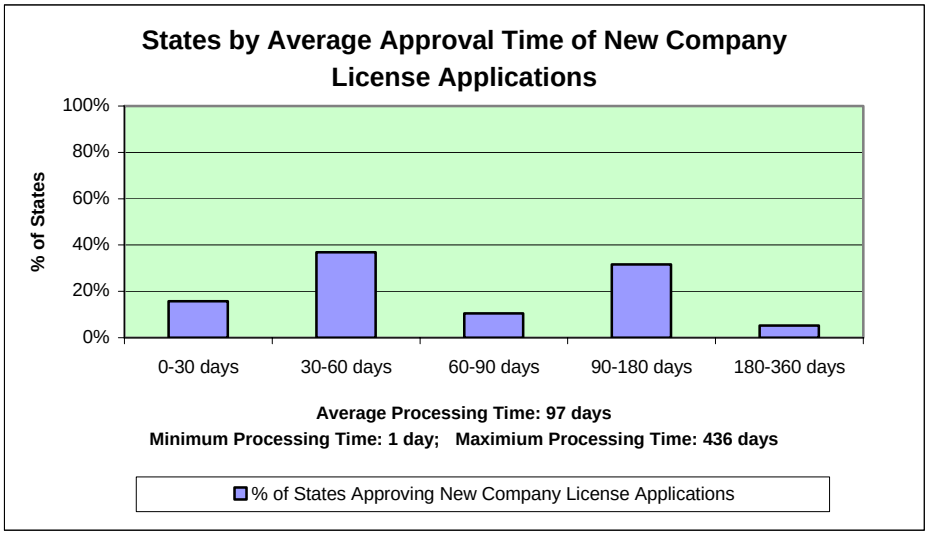


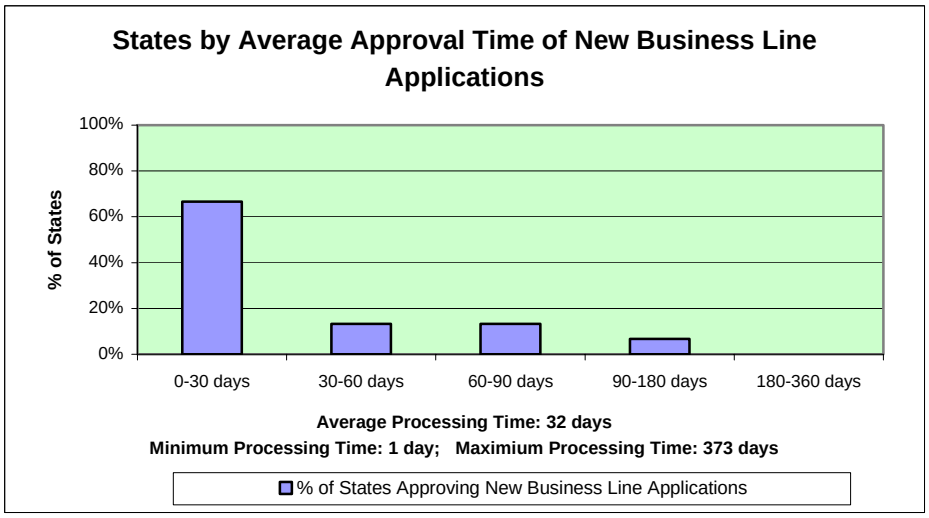
Notes:

1. Front-end regulation includes: insurer licensing, producer licensing and product approval.

2. Back-end regulation includes: financial review and verification, financial examinations, market conduct examinations, consumer complaints, and consumer and media relations.

Exhibit 45: States by Average Approval Time of New Company and New Business Line Applications

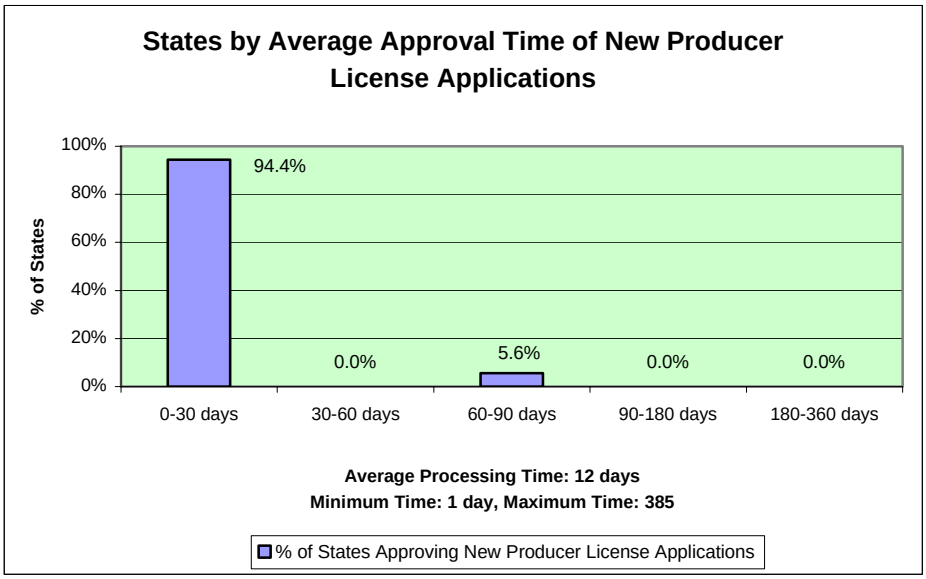




Note:

1.Average processing time is weighted based on the number of applications received by each state

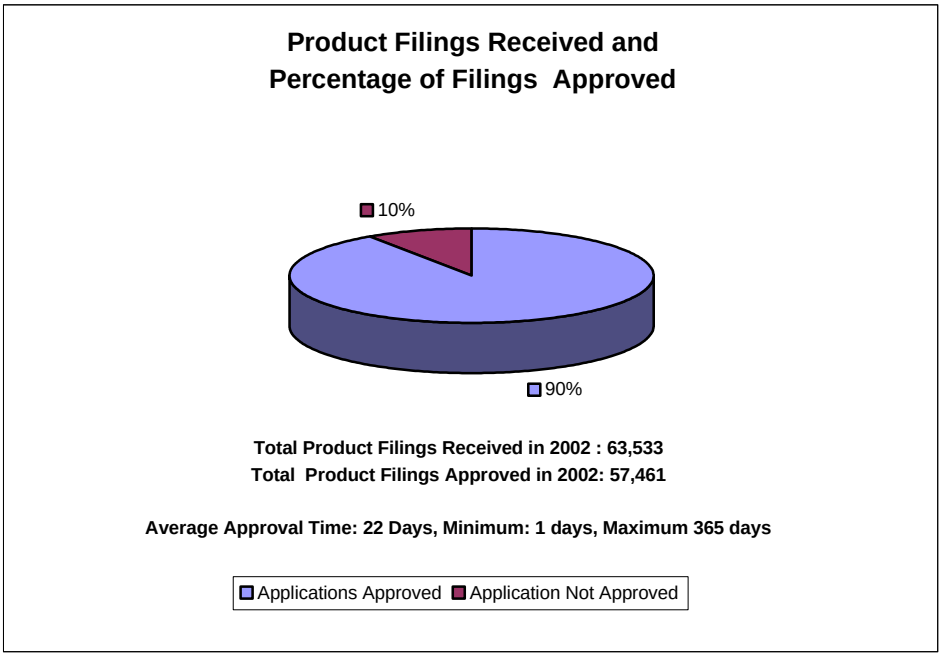
Exhibit 46: States by Average Approval Time of New Producer Applications



Note:

1.Average processing time is weighted based on the number of applications received by each state.

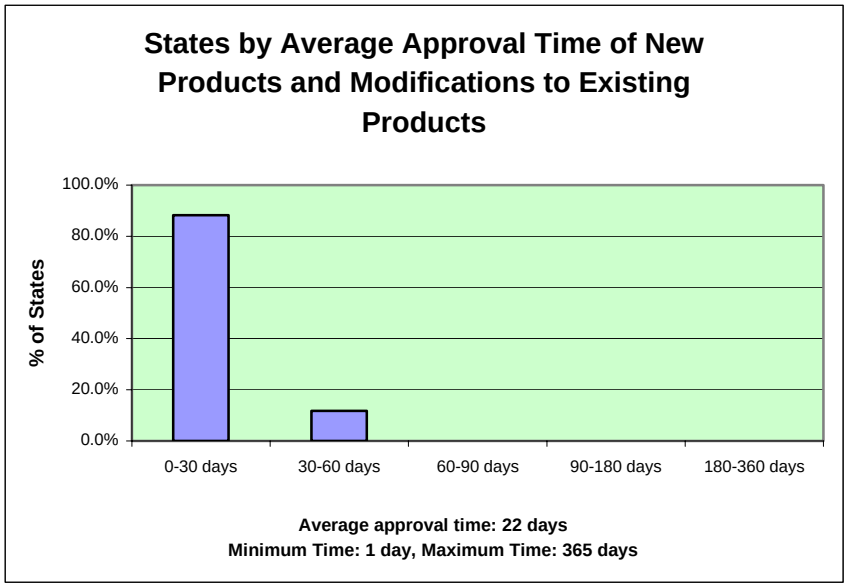
Exhibit 47: Product Filings Received and Approved by State Insurance Departments in 2002



Note:

1.Average approval time is weighted based on the number of product filings received by each state.

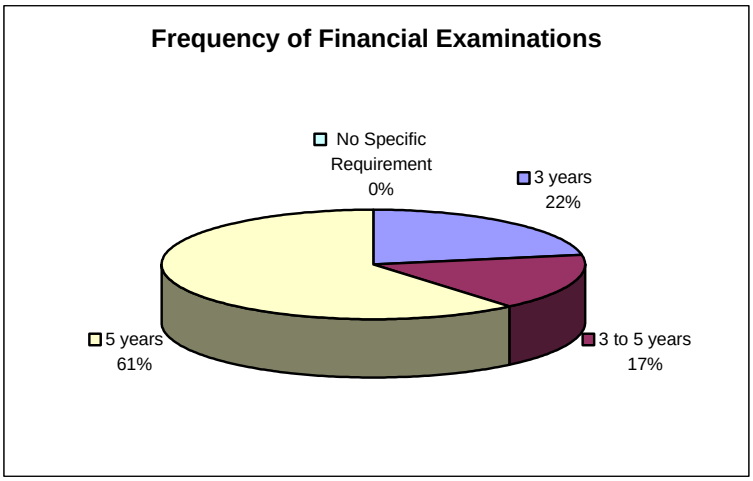
Exhibit 48. States by Average Approval Times of Product Filings

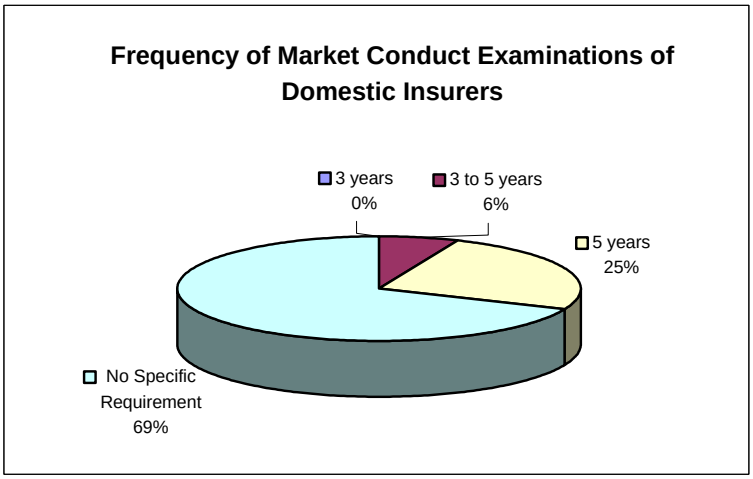


Note:

1.Average approval time is weighted based on the number of product filings received by each state

Exhibit 49. Frequency of Financial and Market Conduct Exams





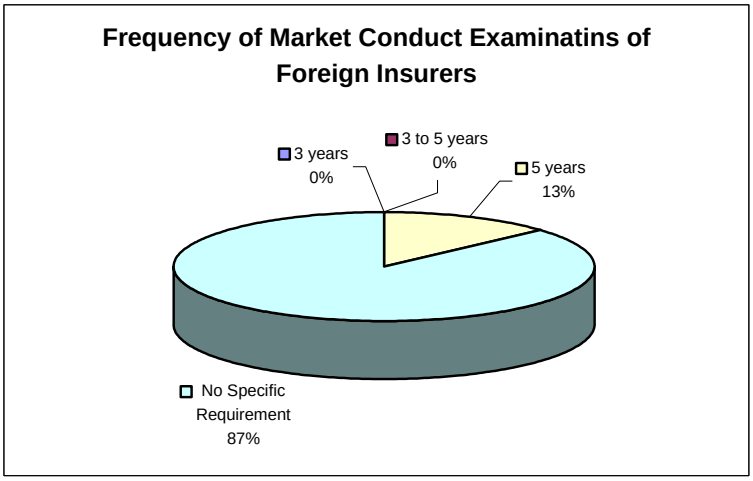
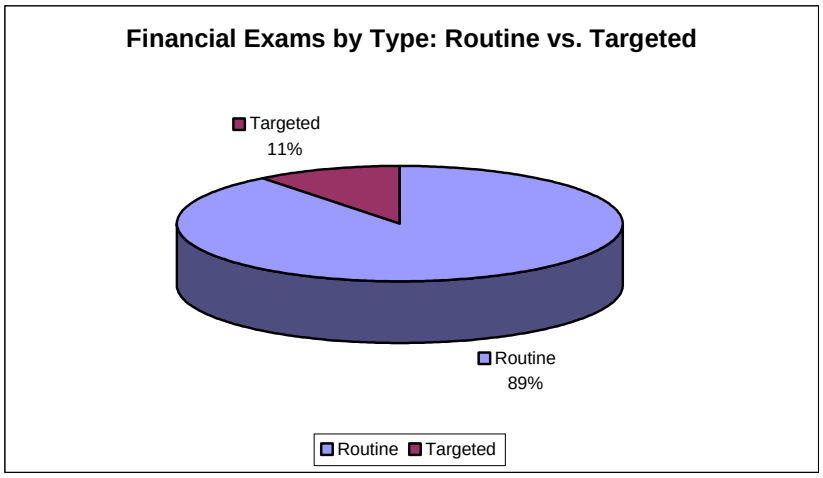
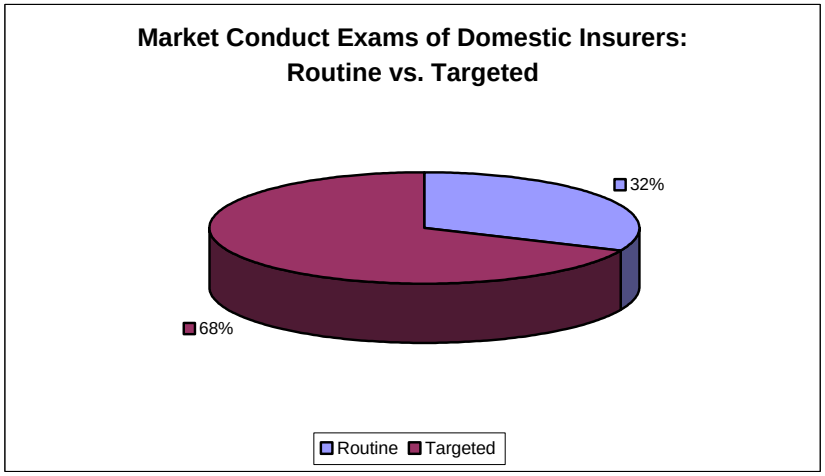


Exhibit 50. Financial and Market Conduct Exams by Type: Routine vs. Targeted





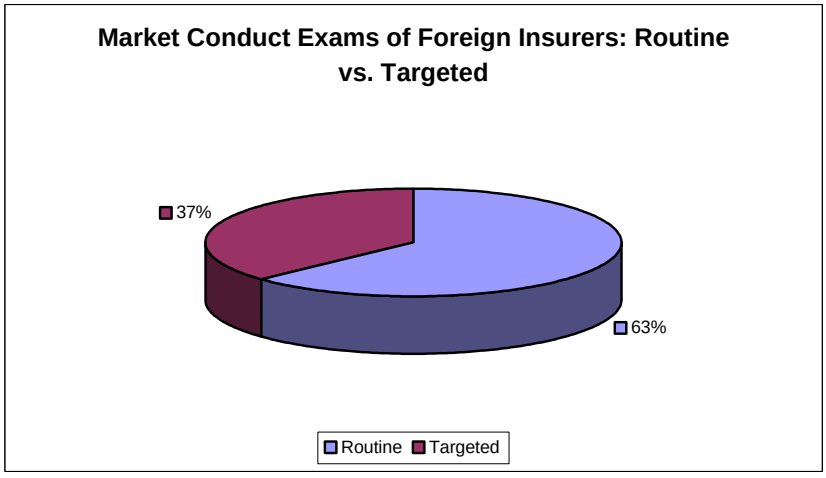


Exhibit 51: Multi-State Market Conduct Exams

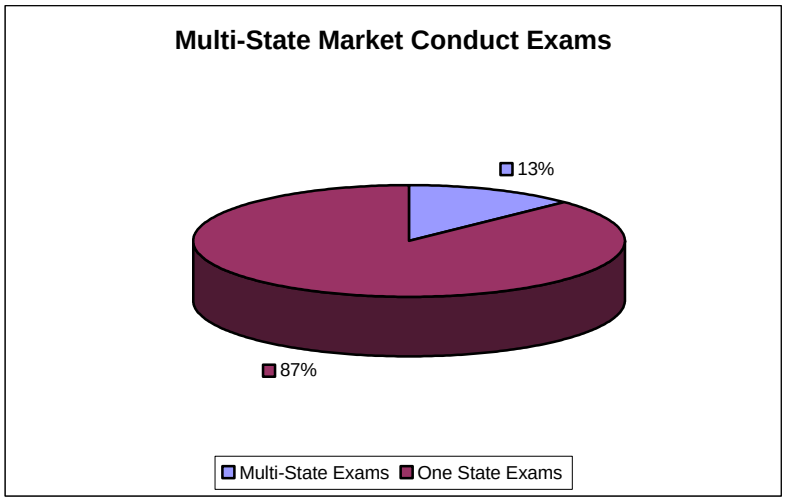
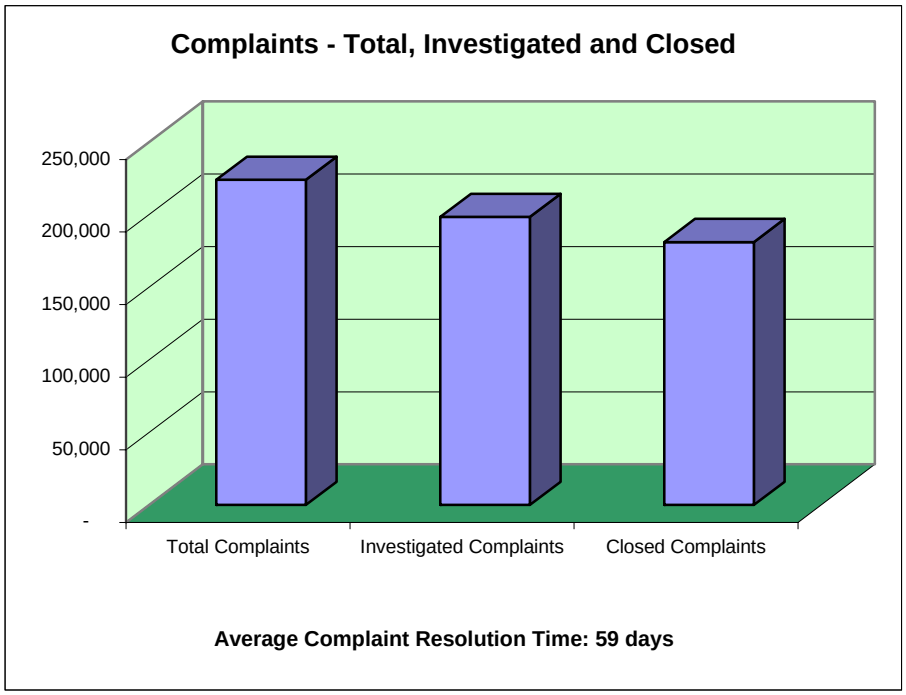


Exhibit 52



Note:

1.Average complaint resolution time is weighted based on the number of complaints closed by each state.

Exhibit 53

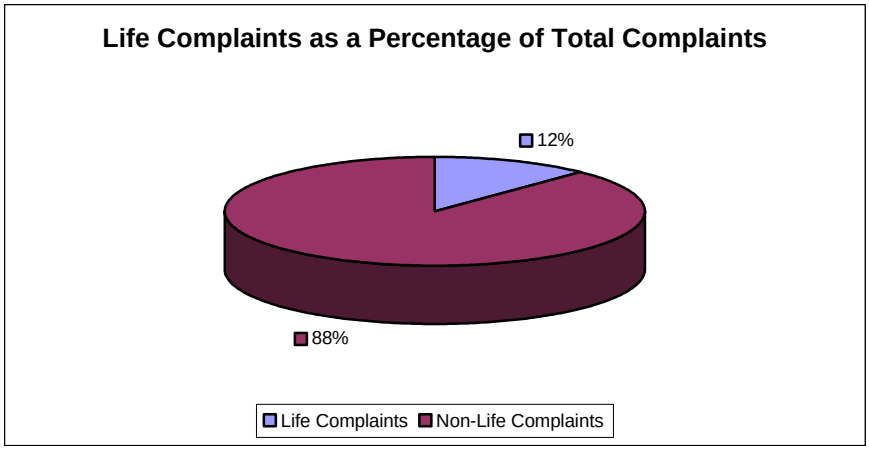

Life Complaints as a Percentage of Total Complaints
12%
88%
Life Complaints
Non-Life Complaints

Exhibit 54. Complaints by Asset Size of Insurer

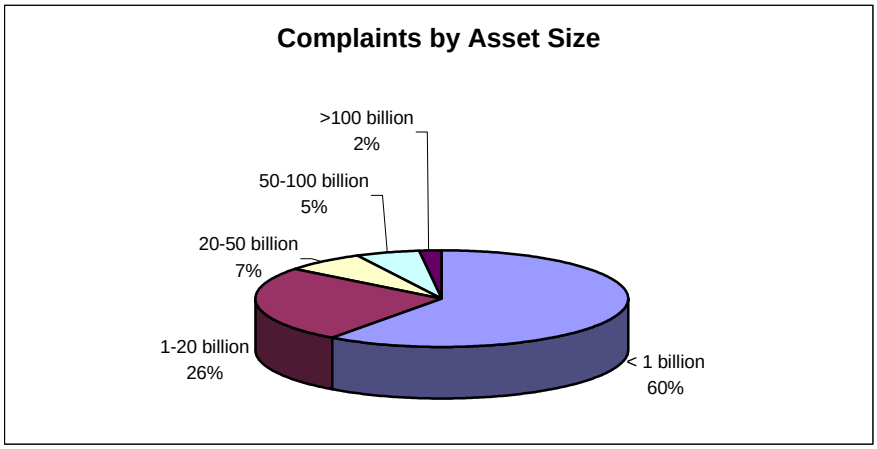
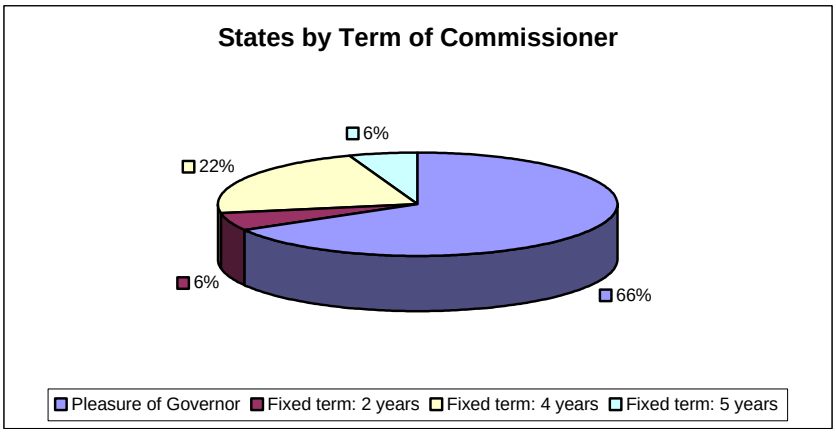
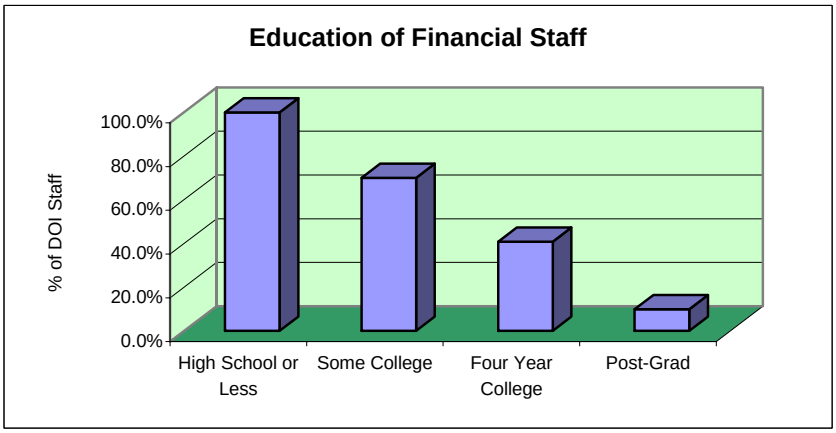


Exhibit 55. General Information about the State Insurance Departments





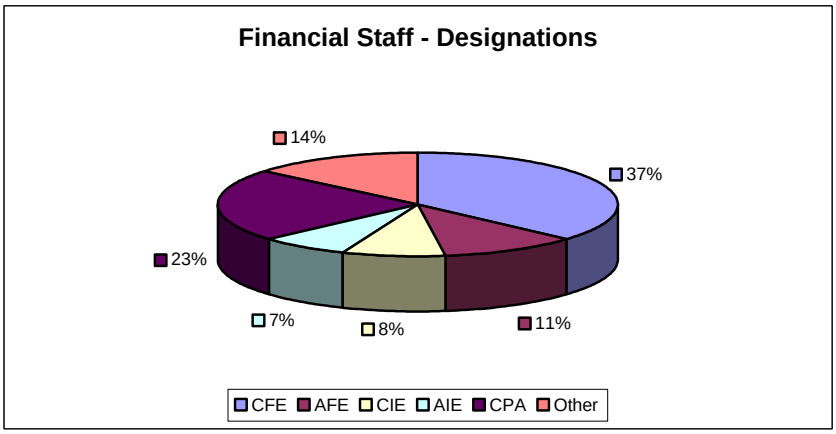


Exhibit 56. Financial Institution Regulatory Costs, 2002

	Number of Regulated Institutions	Total Budget (in millions)	Total Assets of Regulated Institutions (in billions)	% Budget/ Assets	Cost per Institution	Average Asset Size of Institution
DOIs and NAIC	7,173	$993	$4,778	0.0208%	$138,464	$666,176,371
OCC	2,203	$422	$3,900	0.0108%	$191,739	$1,770,313,209
OTS	958	$164	$1,400	0.0117%	$170,668	$1,461,377,871

Exhibit 57. Cost of Front-End and Back-End Regulation

	Front End Regulation	Back-End Regulation
State Insurance Departments	33%	67%
OCC	3%	97%

Notes:

1. State Insurance Departments:
Front-end regulation includes: insurer licensing, producer licensing, product approval, consumer complaints, and consumer and media relations.
Back-end regulation includes: financial review and verification, financial examinations, and market conduct examinations.
2. Office of the Comptroller of the Currency(OCC):
Front-end regulation includes Charter program.
Back-end regulation includes: Supervize, Regulate and Analyze Risk programs.

Exhibit 58. Insolvency Ratios of State Insurance Departments and OCC

Insolvency Ratios					
				Insolvency Ratios	
		2002	2001	2002	2001
State Insurance Departments [1]					
	Liquidations	15	20		
	Conservations/ Rehabilitations	13	8		
	Total	**28**	**28**		
	Total Domestic Insurers	**7,173**	**7,065**	**0.39%**	**0.40%**
OCC[2]					
	Voluntary Liquidations	2	5		
	Receivership	3	2		
	Total	**5**	**7**		
	Total National Banks	**2,150**	**2,137**	**0.23%**	**0.33%**

Notes:

1. NAIC 2002 Insurance Department Resources Report
2. OCC Quarterly Report

Exhibit 59. Average Duration and Number of Staff on the Exam Team by Type of Exams

Average Duration of Examinations by Type of Exams

		Average Duration of Exams (days)	
		Financial Integrity Exams	Market Conduct Exams
State Insurance Departments		190	105
	Asset Size	Safety and Soundness	Compliance Exams
OCC		18[(2)]	53
FDIC	< $1 billion	53	133
	$1-10 billion	72	206
	>$10 billion	98	295

Notes:

1. Length measured from notification of exam to issuance of final report.
2. OCC reported that banking institutions with asset size above $ 1 billion receive continuous safety and soundness examinations.

Average Number of Staff on the Exam Team by Type of Exams

		Average Number of People	
		Financial Integrity Exams	Market Conduct Exams
State Insurance Departments		3	2
	Asset Size	Safety and Soundness	Compliance Exams
OCC	< $1 billion	3-10	
	$1-10 billion	-	
	>$10 billion	20-30	
FDIC	< $1 billion	4	3
	$1-10 billion	5	4
	>$10 billion	5	5

Exhibit 60. Examiner Accreditation and Designations

	Designations	% of Financial Surveillance Staff
State Insurance Departments	CFE	37%
	AFE	11%
	CIE	8%
	AIE	7%
	CPA	23%
	Other	14%
	Examinor Accreditation Required	**% of Examiners Accredited**
OCC[(1)]	Yes	79%
FDIC[(2)]	Yes	95%
FRB[(3)]	Yes	72%
OTS[(4)]	Yes	95%

Notes:

1. Fifth year OCC examiners take the Uniform Condition Exam to get accreditation. Prior to examination OCC prepares examiners primarily through on the job training.
complete four core training schools, on the job training and technical evaluation.
3. FRB has the Federal Reserve Commissioning program, which takes from 1 to 4 years to complete.
4. OTS provides professional examiner development programs, which include formal classes, on the job mentoring and training, and written and presentation test. Upon successful completion of these training elements over 3 to 4 years, the candidate region makes an accreditation recommendation to the Professional Advisory Group.

Exhibit 61

Number of Staff Involved in Complaint Handling and Complaint Resolution and Average Duration of Complaint Resolution in 2002

	State Insurance Departments [1]	OCC	FDIC	FRB	OTS	Total Bank Regulators
Number of Staff	794	40	36	46[2]	14	136
Complaints	496,272	38,840	4,008[3]	5,730	6,273	54,851
Complaint Workload per FTE	**625**	**971**	**111**	**125**	**448**	**403**
Aver. Complaint Resolution (days)	59[5]	41	20[4]	60	55	NA

Notes:

1. 2002 NAIC Insurance Department Resources Report. Insurance departments' complaint data is not limited to LI, annuities, DI and LTC and includes all product types.

2. FRB's number includes both Board and Reserve Bank staff.

3. Number of complaints identifying institutions supervised by the FDIC, as opposed to the complaints forwarded to appropriate federal regulators with supervisory responsibility fir the institutions involved.

4. FDIC's complaint resolution data includes referrals to other appropriate supervisory agencies.

5. Average time for resolution of insurance departments' complaints is based on responses to the state insurance department survey, and is weighted based on the number of complaints closed by each state.

APPENDIX B

California Department of Insurance (CDI)

December 2003, January 2004
Interviews by Kristina Donkova

CDI Staff Interviewed:

Norris Clark, Deputy Commissioner, Financial Surveillance
James Johnson, Deputy Commissioner, Consumer Services and Market Conduct
Victoria Sidbury, Assistant Chief Counsel
Patricia Staggs, Assistant Chief Counsel
Keith Kuzmich, Acting Chief, Licensing Services Division
Woody Girion, Chief, Financial Analysis Division
Louis Quan, Chief, Life Bureau, Financial Analysis Division
Ron Rosen, Chief, P/C Bureau, Financial Analysis Division
Chuck DePalma, Supervisor, Field Examination Division
Al Bottalico, Supervisor, Field Examination Division
Jill Jacobi, Senior Staff Counsel, Legal, Corporate Affairs Bureau
Joel Laucher, Chief, Market Conduct Division
Tony Cignarale, Chief, Consumer Services Division

Organizational Structure of CDI

Insurance Commissioner: John Garamendi

The California Department of Insurance (CDI) is responsible for overseeing the industry and protecting the state's insurance consumers. The insurance department regulates, investigates and audits insurance business to ensure that companies remain solvent and meet their obligations to insurance policyholders. The Commissioner issues certificates of authority to insurance companies seeking admission into the California market and licenses agents, brokers, solicitors, bail bondsmen, underwritten title companies and a number of other insurance entities.[110].

The operations of the department are conducted by four branches: Financial Surveillance, Legal, Rate Regulation and Operations. Financial Surveillance reviews applicants for admission into California and monitors insurers already licensed to do business in California to ensure they are financially stable and viable as necessary to protect California consumers. The Legal Division works with companies that want to do business in California, and those that are doing business in California and need regulatory approval such as license amendments and product approvals, and also enforces insurance laws through compliance actions. Rate Regulation carries out the prior approval provisions of Proposition 103 and ensures that in their product approval companies comply with California Insurance Code. The Operations branch is comprised of several bureaus,

[110] Website of the California Department of Insurance.

among them are: Licensing Services, Consumer Services and Market Conduct[111]. The department has direct regulatory responsibility over approximately 213 domestic insurance companies, and about 244 thousand[112] licensed producers.

Company Licensing
Victoria Sidbury, Jill Jacobi

All insurers wishing to operate in California must obtain a Certificate of Authority issued by the California Department of Insurance. The insurance department accepts two application forms: a state-specific application that accounts for all of California's admission requirements and the NAIC Uniform Certificate of Authority Applications (UCAA)[113]. Insurers using the UCAA applications must also meet several California specific requirements before a Certificate of Authority can be issued. These requirements include: name approval, seasoning, individual affidavits and fingerprint cards, qualification by the California secretary of state, custodial arrangements, reinsurance arrangements, statutory membership, appointment of an agent for service of process, workers' compensation and title insurance deposit, etc.

The general review process is set by the California Insurance Code. Companies wishing to domicile in the state must first obtain a securities permit (Organizational Permit) and then apply for a Certificate of Authority. The information below applies to the process of issuing of a Certificate of Authority only.

The insurance department has created a review process that consists of a comprehensive legal and financial review of the applicant's business. The purpose of the review is to evaluate the qualifications of the applicant as an insurer with respect to its financial stability, competency and integrity of management, fairness in doing business and protection of policyholders.

California has an intake process whereby a submitted application is immediately reviewed by the department for completeness. This initial review ensures that the package has been submitted in the required format[114]. Each application should include: a cover letter, a profile of the candidate, the seasoning requirement, the article of incorporation, bylaws, individual affidavits and fingerprint cards, various service and custody agreements, annual financial statements, CPA-reports, a report of examination, market conduct reports, SEC filings, reinsurance arrangements, statutory membership and other requirements. CDI will not accept an application if it does not meet the format requirements. If the application is determined to be complete the insurance department notifies the applicant of the official date of filing. In case of deficiencies in the

[111] News Release of the California Department of Insurance, January 27, 2003.
[112] 2002 NAIC Insurance Departments Resources Report.
[113] California, being a chair of the NAIC ALERT working group, started accepting the UCAA applications in 1998. The ALERT working group was created to develop uniform certificate of authority application and facilitate and streamline insurance company admissions in the UCAA participating states.
[114] To speed up the review and approval process the department requires that applications be filed in a standardized format. The Department has created detailed instructions and checklists to help the companies in the application process. Additionally, sample language guidelines have been developed to make sure that applicants meet the requirements of the department. The Instructions for Submission of Application are used as background information in writing this section.

application, the applicant is given 10 days to provide a complete application, and if the company cannot comply with all the requirements in due time the application is returned.

The insurance department performs a two-stage review of the financial, legal and biographical information. At the first stage, the department performs a prequalification operational and financial review to determine whether the applicant meets the minimum requirements for conducting business in California. California has a seasoning requirement according to which a certificate of authority could be granted to a foreign insurer only if the company has actively transacted insurance business for three years. At the end of the prequalification stage the applicant is informed if the application package can proceed to the final qualification review or if further information should be submitted[115]. The final qualification review involves review of the additional financial information, statutory mandated membership and other legal documentation to determine whether the applicant meets all additional requirements for transacting business in the state of California. At the end of this stage the applicant is either issued a Certificate of Authority or a statement explaining why the application failed to meet the California specific requirements. The applicant is given the chance to perfect its application; if the company fails to do so, the insurance department would not issue a license but would allow for the application to be withdrawn. Withdrawn applications are not recorded in the NAIC databases.

Financial analysts, reporting to a senior supervisor in the Financial Analysis Division, are responsible for the analysis of the applicants' financial condition. Their findings get a high level of review and are reported to the branch chief who writes a recommendation memo to the Legal Department. The Licensing Background Review unit reviews the biographical information on the company and its managers and submits a recommendation on the background of the individuals to the Legal Department. The legal review incorporates the conclusions of the financial and background analysis and submits a recommendation to the assistant chief counsel who makes the final determination on the application and issues or denies the issue of a certificate of authority. A certificate of authority can be denied if a material deficiency is found, such as failure to comply with seasoning or capitalization requirements.

The Insurance Code of California has a mandate of 180 days in which the insurance department should review an expansion application and should either issue or deny a certificate of authority[116]. In view of the staff the review process established by the insurance department allows the applicants to control the application review and approval time. A company submitting a perfected application may receive admission to the California market in a period much shorter than 180 days. Although the department does not keep data on the duration of the approval process, the staff indicated that the average approval time ranges from 180 days for expansion applications, to 210 for amendments to existing certificates of authority, and 210-360 days for primary applications, which include approvals for both an organizational permit and an initial certificate of authority.

[115] California Insurance Code mandates that the Department should inform foreign applicants that have filed expansion applications whether their applications passed the first stage review within 30 days of the date of filing.

[116] California does not have statutory requirements about the time for review of applications for new domestic formations and amendments to existing certificates of authority.

Delays in company licensing occur occasionally, and they mostly result from failure of the applicant to comply with the requirements for admission, delayed responses to questions raised by the department, or inadequate staffing.

In view of the discussions for reciprocity in company licensing, the staff communicated that California has always been dedicated to a process that protects consumers. Those interviewed indicated that the department was ready to cooperate with other states and accept other standards only if they exceeded the standards in California. The insurance department does not support blind deference to the state of domicile; nevertheless the department is ready to cooperate with states on improving the company licensing process.

The department has 18 employees: 2 intake analysts, 11 attorneys and 5 paralegals. Additionally there are 5-6 staff in the Licensing Background Bureau, and 59 financial analysts that are partially engaged in company licensing. In 2002, the department received 24 expansion applications and issued 11 certificates of authority (three of the received and two of the approved applications were of life insurance companies).

Agent Licensing
Keith Kuzmich

Agent licensing is carried out by Licensing Services Division, which consists of two bureaus: the Producer Licensing Bureau and the Licensing Background Bureau. The Producer Licensing Bureau is responsible for the processing of licensing applications, administration of producer examinations, approval of continuing education courses and providers, and management and staffing of the producer-related call and email response centers. The Licensing Background Bureau is responsible for the thorough background screening of applicants with a prior criminal history.

California has not signed the Producer Licensing Model Act (PLMA); however the state is fully reciprocal with the other states in all the areas of non-resident licensure. In an effort to achieve reciprocity in producer licensing the California Insurance Code was recently amended and now it is at least 60% compliant with the provisions of the PLMA.

Effective January 1, 2003, six significant changes to the California Insurance Code took effect. California removed the limitations on the types of legal entities that qualified for business entity licenses; amended the definition of non-residents; allowed the licensing of non-resident surplus line brokers, allowed the issuance of a limited line license, enacted a provision that permits the commissioner to verify producer licensing status through the NAIC Producer Database, removed a provision which restricted the individuals that can act on behalf of business entities, removed the requirement for non-residents to file specified stipulation and waiver with their licensing application, and allowed for agent company appointments and broker bonds to be filed on a post-licensure basis. In order to achieve full compliance with the PLMA the state will have to overcome issues such as: examination requirements for producers re-domesticating to California, licensing requirements for holders of broker-agent licenses, and fingerprinting requirements.

The insurance department accepts the NAIC uniform individual and business entity applications for non-resident applicants. The resident applicants can submit the California state specific application. In order to receive a California license the non-resident producers need to submit an application, fingerprint card and a licensing fee. Through the producer database the department gets the necessary information from the state of domicile and waives the pre-licensing and examination requirements. Resident applicants additionally have to complete 52 hours of pre-licensing education. Both resident and non-resident applicants must respond to the background questions. After the application is processed the applicant is scheduled for a qualifying exam. At the time that the applicant is taking the examination, the applicant is also electronically fingerprinted at the exam site. The license is issued when the department gets clear checks from the FBI and the state DOJ.

Licenses are issued for a term of two years. California has continuing education requirements that differ for junior[117] and senior producers. Junior producers must complete total of 50 hours of continuing education, with 25 hours taken each year. Senior producers are required to complete total of 30 hours during the two-year period. Currently licenses could be issued prior to an appointment of a company or endorsement to a business entity license.

California uses three separate services for electronic application filing: FLASH, SIRCON and the NIPR. Currently, business entity applicants cannot use the online services. The FLASH system has recently been developed by the insurance department to allow both resident and non-resident license applicants to apply for a California license online. By using the FLASH service, the applicant completes the application and pays the application and examination fees online. Soon after submitting the application, the CDI sends an e-mail confirming receipt of the application, and provides instructions on how examinations could be scheduled through the Internet.

The SIRCON service has been developed by a third party to allow applicants to submit their insurance license applications online and pay their fees with a credit card. Currently this service is used by ten states and it has been customized to meet most state specific requirements. In October 2003, the department began to also offer an online application service that was developed and maintained by the National Insurance Producer Registry (NIPR), which is limited to non-resident applicants only.

While FLASH allows for producer applications to be received electronically by the insurance department, the applications going through SIRCON and NIPR are still submitted in hard copies to the CDI.

The interview indicated that 32% of all applications come through FLASH. Additionally, 15% of all renewal applications are submitted through a third-party vendor's on-line application service, known as RAPID. In view of the staff 48% of the October 2003 applications were submitted electronically, which was really encouraging for the CDI since processing staff could handle two to three times as many applications per hour electronically than they could manage manually.

[117] Producers that have been licensed for 4 years or less are considered to be *junior* producers.

Those interviewed indicated that there is no difference in the processing time of resident and non-resident applications. Delays in application review and approvals result mostly from staff shortages. The State of California, including the department has had a hiring freeze for the last two years and this made it necessary for the department to continue to work overtime on Saturdays to speed up the review process. Following the implementation of the online filing systems the average approval time decreased from 6.5 weeks to 2-2.5 weeks. The approval time could be further decreased when California resolves the issue of web-signature (currently applicants are required to mail a signed attestation form after the electronic application has been submitted). In the opinion of the staff this would probably decrease the approval time by another three days.

The staff indicated that they are satisfied with the producer licensing process established at the department. Those interviewed indicated that ensuring a continued commitment with the e-government initiatives of the PLMA would further streamline the process while preserving the protection of California's consumers.

The budget of the Producer Licensing Bureau, including the budget of the Licensing Background Bureau, is 3.34% of the total insurance department budget. The bureau reviews between 4,500 and 6,000 applications monthly. There are approximately 300,000 licenses issued to approximately 250,000 resident and non-resident producers in California.

Product Approval
Patricia Staggs

California has established a prior approval system where insurance products and the rates for certain products have to be filed with the commissioner for approval prior to use. For some products, for which the legislature has created specific requirements, the state has established a file-and-use regime. Additionally, there are products that are exempt from filing requirements. In general, the majority of products, including life products, are filed for review. However, some ordinary life products such as whole and term life products are not filed or reviewed.

The regular prior approval process involves full review of all product forms. The insurance department reviews the filing for basic compliance with state requirements and if such compliance is not established the filing is rejected. When a filing is determined to meet compliance, the insurance department performs a detailed review and the application is either approved or disapproved. In relation to the file-and-use regime the insurance department specifically identifies the products that can be filed and used. File and use provisions typically permit use of the filed products 30 days after filing unless the department has responded within that time.

Products that are exempt from filing are typically simple products, for which the law does not prescribe a review and which implementation generally does not create problems for the regulator.

All companies are expected to review all relevant product outlines and checklists no matter what submission procedure is applied. If a major/minor modification is made to an existing product, the review focuses only on the changes that are being made. The staff indicated that often changes pointed out by insurers were not as inclusive as necessary.

Product forms are disapproved when they fail to meet the statutory requirements. Often filings are disapproved for ambiguity of the meaning of the contract terms.

California is one of the states where the commissioner must approve the separate accounts of both domestic and non-domestic companies prior to use of variable annuity and life products. The process of initial variable authorization of selling variable products requires a longer and more substantive review on the side of the department, while the process of subsequent changes to the qualification has historically been significantly more streamlined.

The department does not collect information on the duration of product approval. The staff indicated that in the beginning of 2003 there were twice as many filings pending for review than in the beginning of 2002, however those interviewed could not explain if this resulted from a decrease in the time spent with a particular filing. To speed up the review process the CDI has created a deadline for the insurer's response. If the insurer fails to respond within 6 months the filing is considered withdrawn and the company would need to submit a new filing. The staff shared that on occasion it might take longer than a year to approve a filing, and this had happened typically in relation to disability income and long term care products. Reasons for such delays are very often slow responses from insurers and excessive workloads at the department. Those interviewed indicated that the department could be more efficient in terms of prioritization of tasks.

Currently the insurance department receives only paper filings. California has used the SERFF in the past but experienced significant problems, mainly due to the lack of user-friendliness of the application. The staff indicated that the insurance department would review the status of SERFF at the December 2003 meeting of the NAIC, and also shared that it was possible for California to do a pilot project with SERFF.

Asked about their view of Florida's I-File system, those interviewed noted that I-File had a lot to offer. Despite the fact that staff has not been able to compare the technical capabilities of I-File and SERFF, it was believed that I-File could bring many efficiencies to the insurance department.

California is not one of the states that that have adopted the CARFRA common product review standards. The state also voted against the Interstate Insurance Product Regulation Compact developed to create a more efficient review process for life insurance and annuity products. Asked about the view of the department on the compact, those interviewed indicated that California could not participate in standards that did not adhere to the minimum statutory standards adopted by the state legislature. It was also pointed out that the department was ready to cooperate with other states as long as California's standards were complied with. As evidence of this, it was noted that in December 2003 California, Florida and Texas signed an agreement to

provide a set of standards for the approval of new annuity and life products[118], which would allow insurers to make a single filing and, upon approval, to immediately begin marketing new products in the three states.

The department has 14 attorneys and 3-5 actuaries that deal with the review of product filings. Those interviewed indicated that product approval process could be improved. It was felt that the department could achieve significant improvements in the following areas: better communication with the industry; development of detailed guidelines and checklists about what the CDI wants to receive and review; and increased leverage of technologies.

Financial Analysis and Examinations
Norris Clark, Woody Girion, Louis Quan, Ron Rosen, Chuck DePalma, Al Bottalico

The Department performs financial analysis of all domestic and non-domestic insurers. The State has the greatest interest in its domestic companies, but detailed analysis is also performed of non-domestics with identified financial problems and a significant presence in California's market.

The analysis is performed in line with the NAIC financial regulation standards and is backed up by the Department's Early Warning System (EWS). The Department utilizes the NAIC Financial Analysis Handbook and the I-Site tool, which allows for the calculation of a multitude of ratios, which aid in determining the financial condition of insurers. In line with the NAIC analytical framework, the Department performs financial analysis on three levels to identify companies with potential areas of concern, to probe more deeply into problem areas and provide recommendations for further action. Analyses are based on year-end and quarterly results and include reviews of insurers' profiles, IRIS ratios, Management Discussion and Analysis reports, actuarial opinions, CPA reports, holding company information, investments, reserves, reinsurance agreements, affiliated transactions, etc. While domestic companies are analyzed on a quarterly and an annual basis, non-domestics are analyzed no less than once every two years based on priority, and structured ratio tests. Non-domestic companies identified as high priority are analyzed more often. Non-domestic companies that are determined to be commercially domiciled in California, based on their premium volume in California in comparison to their domestic state, are given a high priority and reviewed more often.

The EWS is a computer-based system that is used to capture salient information about a company. In addition to financial information the EWS is used to track other types of information from sources outside as well as inside the Department such as consumer complaint and claim settlement data. In the opinion of the staff, the EWS is the backbone of the Department's prioritization system, since it provides indications of potential future problems impacting the financial health of the companies. The EWS has five levels of priority with strict quantitative criteria for each level. The EWS-team meets every two weeks to evaluate the progress of troubled companies scheduled for review and/or follow up. Specific follow up activities are determined and a date is scheduled for subsequent progress reports.

[118] NAIC New Release, December 9, 2003: *California, Florida, Texas Agree to Uniform Standards on Annuity Products.*

The Department performs both routine and targeted field examinations. California statutes require that domestic companies be examined at least once every five years, however in actual practice companies are examined more frequently. Targeted exams are performed, based on information in the EWS, or information from other sources, and receive a high priority in the examination planning process. Companies that had significant changes in their financial condition or whose ratings were lowered are given higher priority in the examination planning process. Routine financial exams typically cover a period of 3-4 years with focus on the most recent year. They include a review of the company's financial statements but also include a review of company compliance with state statutes and regulations, reinsurance agreements, claim payments, affiliated transactions, problems identified by analysts, etc.

Currently the Department performs risk-based exams that are mostly based on assessment of the risk in retrospective (financial statements). Those interviewed indicated that the Department would introduce a more advanced risk approach, which will assess the risk prospectively, once the NAIC develops the appropriate framework.

The exam schedules are established early in the year and companies are notified about the pending exams at least 90 days in advance, except when priority examinations are scheduled. Insurers are sent a protocol letter and a set of examination questionnaires. This allows the examiners to better plan the scope of the exam and to more efficiently utilize the available resources. Once the fieldwork is completed the examiner in charge prepares a draft of the examination report, which is sent to the supervising insurance examiner for his/her review. Those interviewed communicated that all issues are disclosed to the insurer prior to leaving the job site. After review by the supervising insurance examiner and the chief examiner, the report is sent out on a formal basis to the company, which has 30 days for review, comments and response. After the insurer's response has been reviewed and considered, the report is officially signed by the commissioner and it becomes a public document. Typically it takes about 30-45 days from the time the report is sent to the company to the official filing; however the company might decide to waive off the 30-day requirement and the commissioner might officially file the report earlier. If there are recommendations in the report, the Department sends a letter informing the company that it has 60 days to submit an action plan or provide evidence on how it will comply with the recommendations.

The average number of staff on the exam team depends on the size of the insurer and varies between 1 and 2 for smaller companies and 6 or more for larger companies. Exams often include zone representatives from other states or external consultants. The staff communicated that external consultants are included in the exam teams because of their expertise, and because of the inadequate pay scale at the Department for this type of specialists. Most often external consultants are actuaries with specific knowledge in loss reserves. Other external consultants may have specific expertise in investment, reinsurance and information systems.

The duration of the on-site fieldwork depends on the size of the company and on the complexity of its operations, and may range from less than 1 month for smaller insurers to 1 year or more for the largest insurers. California has a requirement that reports of examinations be issued within 18 months after the as-of-exam date. In practice this requirement is generally met, however, some exceptions do occur. Exceptions primarily involve companies with material and complex issues

or examination findings, which may delay the completion of the examination and timely filing of the report.

The staff was satisfied with the established financial analysis and examination processes. Those interviewed communicated that California was a state that had one of the better financial programs in the nation. They were also pleased with the interaction between the financial analysts and examiners, and indicated that the early warning team adds enormous value to the process. In support of their satisfaction the staff informed us that California scored very high at the last accreditation review performed by the NAIC, which was an indication of the quality of the established processes.

Market Conduct Analysis and Examinations
Joel Laucher

The Market Conduct Division is responsible for market conduct examinations of domestic and non-domestic insurers. The two bureaus of the Division – the Fields Claims Bureau and the Field Rating and Underwriting Bureau – conduct examinations of companies to ensure their compliance with the California Insurance Code and the California Code of Regulations with respect to rating, underwriting and claim handling practices[119]. The insurance department generally performs routine exams with occasional targeted or follow-up exams.

Examinations can be scheduled based on complaint activity, special requests or a routine schedule. The routine examinations are focused on particular coverages or compliance issues. In its analysis and examination process, the Division reviews: consumer complaints received by the CDI to identify trends; financial statements for evidence of excessive or inadequate rates and to track changes in premium volume, and the NAIC's RIRS database for past enforcement actions to identify noncompliant trends. In view of the limited staffing, such analysis is performed for most insurers every 3-5 years.

The examination program of the insurance department is consistent with the NAIC uniform market conduct examination standards. California examinations focus on underwriting risk selection and placement, advertising, rating, termination practices, and claims handling (for timely and appropriate claims payment). Exams target personal automobile, homeowners, workers' compensation, small business package policies and individual life and disability coverages. Other commercial coverages are examined for insurers which are market leaders and complaint leaders in California. When companies are part of insurance groups, the Department would examine the companies either on a stand-alone basis or, if the staff of the insurers involved conduct common transactions (underwriting, rating, claims handling) for the group, the department would examine the entire group.

California was one of the states that participated in the first round of the NAIC Market Conduct Annual Statement Pilot Program, but currently the department does not require insurers to complete an annual statement. Asked about the plans of the Department to implement a risk-

[120] Enforcement actions against insurers include: formal legal action & stipulation; direct enforcement action; fines/ penalties; restitution; letters of non-compliance, suspension or revocation of license.

based examination program, the staff explained that the Department believed that regulation should be much more than crisis control and that established processes should protect consumers. In this sense, they would consider including risk-based examinations in their process depending on the specifics of the risk-based methodology.

When an examination is scheduled, the insurance department typically notifies the company of the pending exam several months in advance. The department works with the company to set a mutually acceptable start date. The typical duration of an examination of a life insurer is 24 working days, which includes an average of 15 days on-site review and remaining days spent resolving findings through correspondence and completing the exam report. In the opinion of the staff, the exam process takes an average of 3-4 months before the report is adopted.

California law requires that allegations of Unfair Trade Practices be made publicly available and be posted on their web site. All other findings are placed in confidential reports.

Asked about the reasons for delays, the staff indicated that most of the delays are in the resolution process, since companies seek legal analysis before making any commitments to correcting noncompliant practices. This results in continued correspondence between the Department and the insurer before a full resolution is reached.

In relation to their opinion on how states should deal with market conduct analysis and exams, those interviewed indicated that certain common issues could be dealt with through collaborative effort between the states. The staff understands that insurance is a national product, nevertheless state regulators should be responsible for the protection of consumers because of the wide variations in compliance between various insurer branches and claims offices located throughout the country, the localized, state-specific operation of many national insurers in terms of coverages written, procedures, and staff workload, and region-specific problems that result with insurers in underserved or niche markets. It was also indicated that market analysis could not replace the examination program despite its strengths in identification of noncompliant activities and changes in the marketplace.

The staff expressed the opinion that uniformity among states worked well in certain areas, however uniformity in all areas of market conduct was not really necessary. Clear benefits were seen in achieving uniformity in the definition of generally accepted terms, in communication with insurers regarding data requests, in the common data dictionary in relation to various statistical tools, and in standardization of various analytical reports. Nevertheless, it was felt that deference to the state of domicile should not be mandated since states should consider the local legal requirements in accepting the resolutions offered by insurers.

With respect to the recently issued NCOIL report, the interviewed agreed that improvements were needed in the market conduct process and market analysis. They supported improving of the national complaint database, development of strong compliance programs and standards for insurers, and the focus on more targeted exams. However, they disagreed with the notion of deference to the state of domicile, and the wide use of multi-state exams. It was felt that such exams were useful in limited circumstances, e.g. for states with similar laws and consumer protection priorities.

The staff is satisfied with the market conduct process, but it is constantly seeking to refine the department' procedures to improve efficiency and effectiveness. There are 55 staff positions dedicated to the market analysis and examination; the Division has a division chief, 2 bureau chiefs, 3 supervisors, 3 support staff, and the remaining positions are dedicated to performing analysis and examination.

Consumer Services
Tony Cignarale

The Consumer Services Division (CSD), within the California Department of Insurance, is primarily responsible for protecting consumers through education, the mediation and resolution of complaints, and the recommendation of enforcement action against licensees when deemed appropriate.

Complaints and inquiries are handled by three bureaus within the division: the Consumer Communication Bureau (CCB), the Claims Services Bureau (CSB) and the Rating & Underwriting Services Bureau (RUSB). CCB is often referred to as the Hotline, and its staff responds to telephone calls received through the Department's 800 phone line. The Hotline staff answers questions on insurance claims and underwriting practices, administers the CDI Earthquake and Automobile Mediation Programs, organizes the consumer education and outreach program, handles time sensitive complaints, and is responsible for publication of the Department's consumer educational brochures. CSB is responsible for investigating, evaluating, and resolving written consumer complaints involving claims issues for all lines of insurance except Worker's Compensation, which are regulated by the Department of Industrial Relations in California. RUSB is responsible for investigating, evaluating, and resolving written consumer complaints involving rating and underwriting issues for all lines of insurance (including Worker's Compensation). Consumer services are centralized in Los Angeles but serve the entire state.

Consumers can file complaints via telephone, Internet or in a written correspondence. The review and investigation of complaints occurs within three days of receipt, and the CDI contacts the appropriate licensees (insurers or agents). The department investigates complaints through telephone communication, written correspondence and/ or Internet. Within the respective bureaus the staff is trained to handle complaints involving all lines of insurance. Most cases (including life) are distributed evenly among all staff. Periodically, a bureau will establish a special unit to handle certain types of complaints when deemed appropriate. Examples: Northridge Earthquake; Southern California Firestorm; Independent Medical Review team; automobile total loss team.

The time needed to resolve a complaint varies in accordance with the complexity of the issues to be evaluated and resolved. Complex cases involve analysis of conflicting facts and applicable laws. Resolution in such cases may require lengthy investigation. Conversely, cases involving less complex issues may be resolved within hours, days, or a few weeks. Consumers are informed about the final resolution of complaints as quickly as possible but no later than 30 days

after the final action. Additionally, the CSD sends out consumer satisfaction surveys to a random selection of customers.

The CSD staff indicated that the division retains records on all consumer complaints involving rating, underwriting and claims issues. This information is gathered and trend reports are developed with the goal of determining whether further action against the licensee should be taken. The department collects and maintains a wide range of statistical information on complaints. On an annual basis it tracks: the number of complaints open and closed, types of alleged violations, amount of recoveries, number of complaints against insurers, etc. Additionally, the department prepares complaint comparison studies for automobile, homeowner's and life products in order to rank insurers based on their frequency of complaints and whether those complaints were justified. A Justified Complaint Ratio is used to determine which insurers are the worst performers. These statistics can lead to a number of actions, such as: enforcement action by respective bureaus; referral of case to the CDI legal department for formal legal action; initiation of a request for a market conduct examination; admittance to the department's early warning system, etc.

In the opinion of those interviewed, most complaints received involve insurance products such as automobile, homeowners, disability (including health and loss of income), bail bonds, surety bonds, life and annuity. The most frequent reasons for complaints include: cancellation of policy; non renewal (products other than life); rating factors such as misquotes, excessive premium charges, denial of claims; delay in claim processing; low claims settlement offer (products other than life), and surrender charges.

All legal actions taken by CDI are public information and are posted on the department's website. Insurers can appeal enforcement actions taken against them through the civil court system[120].

Currently the division has a staff of about 112 people. For the calendar year 2002, CSD has received 367,638 consumer telephone calls, handled 46,226 written cases and recovered $43.8 million for consumers[121].

View on OFC

While the California Department of Insurance recognizes the need for reasonable uniform and efficient standards in many areas of the regulatory process, it was felt that a federal charter, even if unintended, would create a large bureaucracy that might negate the effectiveness provided by the current state regulatory system. Many of the existing laws and regulations that were developed and tested over time in the state system would be eroded which, in turn, would have a negative impact on consumers. Additionally, the need to draft new laws might result in unintended loopholes and conflicting statutes, which would cause confusion for consumers.

[121] Website of the California Department of Insurance.

Those interviewed communicated that it would take years to streamline the systems within a federal structure, which would trigger confusion and conflicts between regulators, and would be detrimental not only to consumers but also to insurers and producers alike.

It was also indicated that state regulation provided focused ability to respond to regional issues of importance to consumers, to move quickly to address issues as they arise and to develop regulations or recommend legislation targeted at resolving developing issues.

The staff believed that the current state system had fostered competition for generations and they also added that it had not been established yet that a federal charter would improve the market conditions.

Florida Department of Financial Services (DFS)
Office of Insurance Regulation (OIR)

September 24, 2003
Interviews by Kristina Donkova

DFS Staff Interviewed:

Audrey Huggins, Bureau Chief, Agent and Agency Services, DFS
Hazel Muhammad, Senior Management Analyst Supervisor, Bureau of Agent and Agency Services, DFS
Gwen Chick, Applications Coordinator, OIR
Paul Johns, Financial Examiner/ Analyst Supervisor, Bureau of Life and Health Insurer Solvency, OIR
Jovita Ashton, Bureau Chief, Bureau of Life and Health Insurer Solvency, OIR
Joe Finnegan, Bureau Chief of Market Conduct, OIR
Alan Irvin, Financial Administrator, Bureau of Life and Health Insurer Solvency, OIR
Bob Norris, Financial Administrator, Bureau of Life and Health Insurer Solvency, OIR
Marta Arrington, Division of Consumer Services, DFS
Tom Terfinko, Division of Consumer Services, DFS
Frank Dino, Administrator, Bureau of Life & Health Forms & Rates, OIR
Don Dillard, Administrator, Bureau of Life & Health Forms & Rates, OIR

Organizational Structure of DFS and OIR

Head of Department of Financial Services: Tom Gallagher
Director of Office of Insurance Regulation: Kevin McCarty

In 1998, Florida voters passed a constitutional amendment, which combined the offices of the state treasurer, who oversees the Department of Insurance and also serves as the state fire marshal, and the comptroller, who also serves as the head of the Department of Banking & Finance. Beginning January 7, 2003, the duties and responsibilities of both departments fall under the new Department of Financial Services. The Office of Insurance Regulation and the Office of Financial Regulation (Banking) are governed by a Financial Services Commission, which has four members: governor, attorney general, chief financial officer, and the head of the Department of Agriculture and Consumer Services.

The primary responsibility of the Office of Insurance Regulation (OIR) is to regulate and enforce compliance with the statutes related to the business of insurance and the monitoring of industry markets. Bureaus within the OIR are organized into centers of regulatory expertise related to life and health, property and casualty, specialty lines and other regulated insurance entities. The six bureaus within the OIR are: Market Conduct, P&C Insurer Solvency, L&H Insurer Solvency, Specialty Insurers, P&C Forms and Rates, and L&H Forms and Rates.

The Bureaus of Life and Health Insurer Solvency and Property and Casualty Insurer Solvency underwent a comprehensive review in 2003 of solvency monitoring activities and practices by the National Association of Insurance Commissioners that resulted in the re-accreditation of the Office of Insurance Regulation.

Consumer services, agent services and insurance fraud divisions are not part of the Office of Insurance Regulation, but fall within the Department of Financial Services. The Division of Consumer Services (Consumer Assistance, Consumer Outreach, and Consumer Financial Affairs) provides services to consumers of the insurance, banking and fire marshal divisions.

Company Licensing
Gwen Chick, Paul Johns, Jovita Ashton

The licensing of life insurance companies is performed by the Application Coordination Section (ACS) of the Office of Insurance Regulation (OIR). Applications are received and reviewed for completeness. If the application is complete, it is scanned and is uploaded into the CORE (Company and Other Related Entities) System. Currently, ACS receives paper applications. Additionally, ACS also receives electronic filings via the NAIC website which must be transferred into paper format in order to be uploaded into CORE. Florida participates in the UCAA process and soon will begin receiving electronic information from other insurance departments regarding non-resident companies.

Once the application is uploaded into the system, it is assigned for legal, financial and management review. These reviews are conducted simultaneously, so it is essential that the reviewers communicate continuously as the applications are processed. The review team is headed by an in-house financial examiner (analyst) from the Bureau of Life and Health Insurer Solvency, who verifies the findings of the team. The management review includes a fingerprint check, performed by the FBI, and an assessment of the outside investigation reports prepared by a third party. The review team usually requires clarification and additional information from the applicants. If additional information is needed, ACS contacts the specific state Department Of Insurance.

Companies applying for a domestic license may use the Florida application or the UCAA Primary application. If a company chooses to use the package developed in Florida, it will go through a two-step process: the permitting process and the issuance of a Certificate of Authority. ACS has not received any new life company applications during the last 2-3 years. Companies applying for an out-of-state Florida license can use the Florida developed package or the UCAA expansion application. When a company applying for a primary or expansion license is a part of a holding structure, the ACS also requires and examines background information on the officers and directors of the parent company and its owners. Alien insurance agencies must establish a branch to operate in Florida. These companies establish a port-of-entry in Florida, receive a domestic license and are legally considered and reviewed as Florida-domiciled insurers.

If the application is complete and all the requirements have been met, the ACS has 60 business days to review and approve or disapprove the application. This period has been established by

the NAIC and Florida is committed to it. Last year ACS received 13 life expansion applications from out-of-state companies. 11 of these applicants were using the UCAA expansion application, and 2 were using the Florida package (the two companies filed the Florida application because the state has just started receiving the UCAA uniform applications).

The ACS will not approve an application if the company fails to meet all of the UCAA and Florida state specific requirements (capital, investment, management). Usually if the application cannot be approved, the company is advised to withdraw it, correct the deficiencies and re-submit. In case of denial, the information will be reported to the NAIC RIRS system, so that other states will be aware of Florida's decision. Additionally, companies are required to disclose earlier application denials in the biographical statements submitted with the application.

The ACS staff expressed the opinion that the uniform applications significantly expedite the review and approval process since company criteria are much clearer. The staff believes that the electronic filing might additionally expedite the process; however the head of the section was not aware if this would be possible soon. It is expected that the CORE system will be integrated into the NAIC system, which will improve the licensing of non-domestic companies. ACS has been using the CORE system and has performed electronic application review since July 2002. After the application function of CORE was implemented the review time decreased however no measurements of increased efficiency have been made. The Bureau of Life and Health Insurer Solvency has 9 in-house examiners (analysts), and two of them are engaged in company licensing. In the beginning of the year, the analysts mostly review the financial statements of the Florida domiciled companies, which should not have an impact over the speed of application review.

In 2002 ACS received 217 applications. These include applications of entities that are not considered insurance companies (surplus lines, warranty companies, etc).

During 2001, the Section received 293 applications. Of those processed, 78 were granted new licenses, 53 applications for acquisitions were approved, four applicants received permits to form domestic insurers, and 60 applications were withdrawn. One application was denied.

Agent Licensing
Audrey Huggins, Hazel Muhammad

Handouts: Data and charts on New License Applications (Internet and paper), Re-Examination Applications, Payment Methods, and Agent Licensing Statistics. Printout of Types and Classes of Insurance Agent Licenses.

The Division of Agents and Agencies Services is part of DFS, and is comprised of the division director's office, the Bureau of Agent and Agency Licensing and the Bureau of Agent and Agency Investigation.

The Bureau of Agent and Agency Licensing (BAAL) is responsible for the licensure and appointment of all life, health and variable annuity agents, property and casualty insurance

agents, bail bond agents, title agents, customer representatives, adjusters, reinsurance intermediaries, viatical settlement brokers, certain field insurance representatives and insurance-related entities and firms authorized to transact insurance in Florida. Annually, the bureau receives and reviews close to 70,000 applications for insurance licenses. The bureau oversees the qualification, examination, licensing and continuing education of more than 235,000 licensees and is responsible for maintaining licensing and administrative action records of more than 250,000 individuals and firms.

Audrey Huggins, Chief of the Agent and Agency Services Bureau, has joined the OIR in 2002, and has initiated various reorganization initiatives, among which development of a sophisticated producer filing and licensing system. She shared that she had significant experience in education licensure, but limited insurance experience.

Bureau of Agent and Agency Licensing issues perpetual licenses for agents, which are not renewed. The agents cannot start selling insurance products until they are appointed by an insurer, and the appointment is renewed every two years. If the agent fails to keep his/her appointment for four years, his/her license expires (it is not revoked). BAAL staff believes that having perpetual licenses and periodically renewed appointments is a good practice, since the appointing company conducts additional background checks of its agents. Additionally, if the agent misrepresents and becomes involved in fraudulent schemes, BAAL could go not only after the agent but also after the appointing company. The staff indicated that this is a very good business practice that guarantees better protection for the consumers of Florida, most of whom are elderly people with limited knowledge of insurance in securities products.

In practice, licensed agents can sell insurance products before appointments but only 15 days prior to the appointment (NAIC ruling). Florida has expanded this rule to 45 days, and if the agent does not have an appointment after the 45th day, he/she would be fined $250. The BAAL staff indicated that the fine is used as a preventive measure, not as a revenue collection means.

The requirements for licensing of resident agents include: the application, the application fee, and fingerprinting. Florida has fingerprinting requirements both for its resident and non-resident producers. Application review indicates that about 10% of all applicants fail to reveal arrests and felony arrests. Non-resident agents are required to provide certification from their state of domicile as well.

The license is issued at the exam location immediately after the exam (exam results are automatically uploaded into the agent's record). Licensing is dependant upon continuing education (CE). BAAL approves the providers of CE, their course offerings and instructors. The state-of-the-art system developed by the Bureau not only monitors agents, but also informs them about various courses that they should take and their locations throughout the state.

Soon the BAAL will stop accepting paper applications for both resident and non-resident agents. The online application has capabilities which significantly expedite the application process: it tells the applicant while he is completing the application if it cannot be approved; it processes credit card payments and is expected to process E-checks. Data provided by BAAL show that during the last year there was a 76% increase in the number of applications submitted online.

Currently agents cannot even download a printable version of the application because BAAL wants to receive only electronic applications.

BAAL is in the process of building a system for electronic company appointments, which will also allow for electronic credit cards and E-check payments. The work on these systems started about two years ago; prior to that the OIR had a mainframe system with very limited capabilities. Now the system holds producer records, monitors their CE profile, informs them of examinations, and checks if all fees are paid. The system can talk to the NAIC's Producer Database, and receives electronically the information about the certification of non-resident producers. Once the in-house systems are completely developed, they will be integrated into the NAIC's NIPR system to accommodate the out-of-state applicants and agents. This is expected to happen by the end of 2003. Currently, NIPR is not used at all.

The time for an approval of online application with credit card payment is less that a week (3-5 days max). If the application fee is paid by check, the approval usually takes about two weeks. Delays in application approval are related to positive answers on background questions, where the BAAL has to review the court documents and a committee makes a decision on the application. Another reason for delay could be the wrong association of application fee checks with applicants. This has happened frequently in the past but will be resolved by the use of E-check and credit card payments.

In the past the speed of application review was highly dependent on the time required for review of the fingerprints; it took between 6 to 12 weeks to get the fingerprint results. Now Florida has a live-scan process in 63 locations, and the results come back in 2-3 days. The process for non-resident applicants is longer because not all states have the live-scan technology.

Terminations of agents and appointments are handled by the Division of Agents and Agency Services. These happen for cause, or upon request of the individual agent or the appointing company. If a license is revoked, the agent cannot apply again for a specific period of time (there is a law enforcement rule for the waiting period).

Florida has not yet adopted the PLMA model because of its fingerprinting requirements. Once the NAIC has approved this requirement, Florida will adopt the PLMA provisions during the following legislative session.

The Division of Agents and Agency Services has 60 employees and 8 contract workers. The contract people are used to service the telephone bank for agents' inquiries. The division could not get more state positions approved but they had enough money in the budget for contractors. The sixty state employees perform the following functions: education and outreach, continuing education enforcement, records handling, and regulatory review.

The BAAL staff indicated that during the last two years they have been very satisfied with the agent licensing process. The systems introduced have improved the process and provided certain management tools that are not inherent in the NAIC's NIPR. BAAS's systems can track the work queues of the staff; work can be prioritized and organized; and they can connect to NIPR. Additionally, they can provide information to other states about Florida resident agents without

any human interaction. The budget constraints have put limitations on personnel when workload has been growing at 10% per year, and the new systems allowed for redundant work to be handled while staff focused on the "thinking" activities. All these improvements result in better service for customers.

BAAL will soon be faced with the challenge of reducing the number of the insurance agent licenses that Florida issues. Now the state has about 130 types of insurance licenses (more than any other state), which will have to be reduced to 5 limited lines. This is a requirement of the NAIC and BAAL has 6 years to bring the department into compliance.

Product Approval
Don Dillard

Handouts: Data and chart of the Life and Health Filings in 2002 by Months. Printout of the I-File Introductory Training.

The Bureau of Life and Health Forms and Rates (BLHFR) is responsible for the review and approval all life and health rate and form filings. In 2002 the bureau reviewed 9,278 life and health filings, which is an average of about 773 filings per month.

Florida has a prior approval system for most L&H products. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the Office for informational purposes only. The state has a 30-day statutory review period for all new products (the bureau does not differentiate between new filings and minor or major changes to existing products). The law provides additionally 15 days for the review, if needed. If final action has not been made by the 30th or the 45th day, the filing is deemed approved. The bureau has an in-house requirement that the product analyst should respond to the company in 14 days. In reality, it takes about 7 days for the analysts to respond to the company, and this is why the BLHFR staff believes that insurers cannot complain about delayed product approval in Florida. Florida has 1,169 companies licensed to sell life and/or health insurance. The Bureau has 8 policy form analyst positions and 12 actuarial positions.

The speed in product review and approval is attributable to new I-File system, where filing and review are both performed electronically. It took two years for the system to be developed; I-File was introduced 9 months ago and became effective on July 1, 2003. Now all filings are filed electronically and paper filings are not accepted. As a result the overall time to receive, review and process a filing to completion has decreased. Nevertheless the turn-around time depends on how fast the applying company provides information.

Updated checklists have been put into the new I-File system for use by both for product filers, and for product analysts. While reviewing the application, the analyst marks the areas where the application is not in compliance, which generates an automatic information note for the company.

Florida does not use the NAIC's SERFF filing system, although it was tested on a limited basis so that its capabilities could be determined. Florida is not a CARFRA member state and it has never received CARFRA filings. The Office of Insurance Regulation supports the interstate compact. The bureau is not using the NAIC uniform review standards, common filing transmittal documents, and the uniform coding matrix but the staff shared the opinion that, at least, these tools would probably be adopted soon.

The OIR has made several presentations of its I-File product and its capabilities. The staff communicated that several states expressed interest in I-File, among them Georgia, Louisiana and Maryland. Additionally, Texas, California and few other states attended presentations of the I-File system.

The staff expressed the opinion that in the future SERFF and I-File would probably be integrated, especially if Florida becomes an interstate compact member state.

The bureau has worked hard to improve the overall product approval process, and continues to improve the new I-File system. It allows for speed in filings' processing and approval and puts less strain on the industry (in the past insurers had to provide the bureau with three copies of every filing). The bureau will continue to get feedback from the industry, so that the product approval process is continuously improved.

Financial Analysis and Examinations
Alan Irvin, Bob Norris, Jovita Ashton

Financial analysis and examinations of life insurance and health companies are performed by the Life and Health Insurer Solvency Bureau.

The statute requires that companies are examined every three years, and the regulator is given the option to perform exams more frequently if necessary. In practice, domestic companies receive financial exams every three years, although exceptions exist. Newly licensed companies are examined every year for the first three years, while companies that have been under the same ownership for the last 15 years could be examined once every five years. In certain circumstances the bureau could accept a report of an independent auditor rather than perform an on-site financial exam, and the OIR has occasionally done that.

Most of the examinations are routine, full-scope exams; however the bureau can also perform targeted exams. These are performed when there is a need to review a particular area of concern, do a follow-up exam, or examine issues that have come to the attention of OIR.

An examination schedule is built upon the following factors: priority code (risk factor) assigned by in-house examiners, number of years since last examined and number of states in which licensed. The risk factor is a function of the analysis of the monthly, quarterly and/or annual financial statements, and each company is assigned one of four priority codes, which can range from first priority to no concern. The financial analysis is performed by in-house financial examiners (analysts), and is reviewed by a supervisor. They will recommend action to the

Bureau Chief if they feel targeted or full scope examinations are needed. The in-house examiner and offsite examiner keep each other informed of any developments of which they become aware of regarding the company under examination. In-house examiners might participate in onsite exams; however this has not been done recently. Nevertheless, in-house examiners are involved in the pre-exam planning process.

The analysis of the insurance groups might be performed on an insurance group level; however as each insurer is a separate legal entity, the examination is based on a stand-alone company level. If a company has a subsidiary, it will be reviewed together with its parent company. Alien companies that use Florida as a port-of-entry to USA are considered Florida domiciled companies. They have to establish port-of-entry and trustee accounts, and are subject to the same rules that apply to all US companies domiciled in Florida. The out-of-USA parent and its backing power are not considered in the calculation of various financial ratios.

The out-of-USA operations of the Florida domiciled companies are considered in the financial analysis of these companies. The bureau follows the NAIC standards and these operations are reported as assets and liabilities on the financial statements of the domestic companies.
All companies domiciled in Florida must comply with the relevant NAIC rules, as well as with the Florida state specific rules.

The bureau staff indicated that they value highly the work of the NAIC Financial Analysis Working Group (FAWG), which has established a very good process where in-depth questions are raised. Florida always participates in this forum, as the experience of this group can be very helpful in identifying problems and perhaps more importantly working together to find solutions to critical problems. The activities of the FAWG are beneficial for the applying and existing companies because the state-of-domicile explains the issues to the foreign regulators, which allows for less intrusion into the affairs of the insurer.

The duration of the exam (pre-planning to final ROE) is about 3-4 months. Variations occur dependant on the speed of information provided by the insurer, access to company's records, and number of examination staff (usually 2-5 people). Florida usually does not inform the company of the duration of the exam (this is not part of the written correspondence).

Examination findings are discussed during and after the examination. The company has 30 days after issuance of the draft exam report to review and provide feedback on the findings and/or requests a formal hearing. The ROE is not a public document until after it becomes final. This time is not included in the duration of a typical exam (3-4 months).

The bureau follows the NAIC Financial Examination Handbook, and the handbook and other information available to the OIR determine the scope of the exam. Reports of examination are issued after each exam. They become public only after becoming final reports and after any hearing that the insurer may have requested on the draft report. ROEs are not currently published on the OIR's website, but are available upon request. The posting of examination reports on the OIR's website is anticipated in the near future.

Market Conduct Analysis and Examinations
Joe Finnegan

Handouts: Organizational Structure of the Department of Financial Services. Printout of Market Conduct Examination Process & Procedures.

Market conduct analysis and examinations of insurers are performed by the Bureau of Market Conduct, which is part of the Office of Insurance Regulation. The Bureau of Agents and Agency Investigations, part of the Department of Financial Services, performs analysis and investigations of agents. The analysis, investigations and examinations of agents and insurers are completely independent and are performed by completely separate divisions within the DPS.

Until 1992, the state required that each company, domestic and foreign, receive a market conduct exam every three years. In 1992 the statute was changed and it ruled that companies should receive market conduct exams every five years. In 1997, it was decided that examinations should be conducted as often as the DFS deemed necessary, and all exams would be targeted.

Examinations might be triggered by any factor or combination of factors below:

- Issues disclosed by environmental scanning (market analysis of information coming from alternative sources such as news announcements, legal suits, and company settlement);
- Need for follow-up examinations based on previous exams or investigations;
- Referrals from other areas of the DFS (consumer complaints; finding of consumer, agent and legal services, rates & forms bureaus, etc.)
- Examinations of related and already sanctioned companies;
- Various multi-company issues (suitability, product renewal, re-underwriting, failure of prompt claim payments, etc.).

The Bureau of Market Conduct has developed a complex Market Conduct Business Process Model. The model is based upon various inputs (sources of information[122]), lists the companies that seem to have problems, and indicates the actions that have to be taken for these problem companies.

The model first identifies problem issues, then tracks them and gathers all the relevant data and information. This process results in the preparation of packets of information that are discussed at regularly scheduled triage meetings. At these meetings, all supervisors of the OIR and all the people that have participated in the preliminary investigations and exams discuss the reports and the justifications contained in the packets. The triage meeting might close an action (because it has been resolved) or might initiate an actual investigation or examination.

Each exam involves the following steps:

- Notification of the company and the NAIC;
- A Data call to the company;
- Scheduling of the exam planning meeting;

[122] Additional to the factors that can trigger an exam, the model considers factors such as drastic growth in premiums and claims, and the potential impact of market changes over the companies.

- Initiation of an onsite exam
- Preparation of a draft report;
- An Exam review meeting;
- Finalization of the ROE;
- Preparation of a market conduct exam packet that might include consent orders, penalty worksheets, and other legal documents as deemed necessary.

The statute in Florida requires that report of examination is prepared after each examination. However, there is no such requirement for investigations. The ROE must include letter of direction and a consent order if such was issued. If a company is in violation, it is subjected to two monetary actions: fine and return of premium dollars.

The goal of the bureau is to make adjustments in how the companies operate to preserve the market place and most efficiently serve the citizens of Florida.
In 1992 the law mandated that the insurance department could use external contractors for the examination, but only upon company's consent. The mandate was changed in 1993, when the company consent requirement was removed. Now Florida does not have any state insurance employees that perform market conduct exams, and all of them are done by independent contractors. Because exams are not routinely scheduled, the use of independent contractors ensures that available resources and time are more efficiently utilized. The bureau also performs desk investigations of individual and significant complaints that appear to indicate trends and unfavorable business practices.

The duration of the examination depends on its scope. Once a company has been identified for examination, it receives an exam call 60 days prior to the exam (preliminary examination of the company). The onsite exam lasts between 30-60 days, and completion of the report takes about 15 days. Florida statute allows 30 days to the company to review the report and provide feedback to the Bureau of Market Conduct. If the company has no further comments, an additional ten days are allocated for the drafting of the consent order. The statute again allows 30 days to the company for the review and approval of the consent order. However, exams could be pended, i.e. violations are not dealt with immediately in order to collect information on how the industry handled the issue and make sure that all companies are treated consistently.

The bureau uses various measurements to monitor the productivity, improve the market conduct processes, and provide annual performance evaluation reports. Measurements include: ratios for consumers assisted and favorably affected; investigations finalized; target exams concluded; fines and recoveries collected; investigations and exams referred to the Fraud Division; and DFS staff dedicated to the above functions.

Until January 2002, the DFS had six tracking systems, but at that point they were all consolidated. A very reliable new system was created that gathers data and identifies the main market conduct issues, and how these issues should be handled.

In a recently completed study of the NAIC (Market Conduct Report Card) regarding the achievement of exam uniformity in four areas (exam scheduling, pre-exam planning, exam procedures and exam reports) Florida reported complete compliance, except for one rule: failure

to send a notification letter to the company about the exam at least 60 days prior to the examination date.

The staff of the Bureau of Market Conduct supports the efforts of the NAIC in achieving uniformity among states (initiatives such as Market Conduct Annual Statement and Market Conduct Analysis Handbook were considered useful). In terms of the future approach to market regulation, the head of the bureau indicated that regulation will continue to spotlight the companies with the biggest market share but other factors, such as claims and previous exam violations, should be considered. It was also mentioned that multi-state exams were an efficient way to analyze the market conduct activities of a multi-state company, but only if such exams were targeted.

Consumer Services
Marta Arrington, Tom Terfinko

Consumer services, agent services and insurance fraud divisions are not part of the Office of Insurance Regulation, but fall within the Department of Financial Services. The Division of Consumer Services (Consumer Assistance, Consumer Outreach, and Consumer Financial Affairs) provides services to consumers of the insurance, banking and fire marshal divisions.

The Division of Consumer Services (DCS) has three major roles: staffing of the 1-800 consumer telephone line; processing of service requests and complaints, and education of consumers. The division takes daily about 1,500 calls; it processed annually about 35,000 complaints against insurers, agents and adjusters.

Florida has recently developed a new paperless system for complaint handling, which dramatically changes the complaint process. Now complaints can be taken over the phone, through a web site, or in paper. After the complaint is received the DCS sends a card that has information about the filing number of the complaint, the person who handles it and a brief description of the resolution process. Once the complaint is entered into the departmental system, it is automatically assigned to a specialist in the area where the complaint is applied. The specialist reviews it, summarizes it and prepares a package that is sent on the same day to the insurer in an email or fax. The company has 15 days to respond, and its response automatically goes to the service analyst, who reviews it and decides if this appears to be the appropriate response with all the information that is needed. If the service analyst is satisfied, he/she is obliged to respond back to the consumer.

DCS has 11 offices throughout Florida, where consumers can submit their complaint in person, by phone or in writing. DCS must do its own investigation of a complaint or refer it to a different area within the DFS if there is an indication of pattern or violation of statute. Investigations are performed when there is an adverse business practice and are performed in conjunction with the company's actions in response to the complaint. On occasions the DCS might coordinate complaint resolution with other state agencies, such as state attorney's office, secretary of the state or attorney general. This is usually done to assist classes of individuals that have been harmed and had/ had not filed a complaint.

The duration of the compliant resolution is about 25-30 days (from initiation of the complaint to notification that complaint has been closed). Complaints are resolved on a first-in-first-out basis, but priority attention is given to the immediate needs of the customer.

The products that give rise to most complaints are the flexible premium life/ universal products. Problems with the product are usually related to agents that have not explained well the options and premium payments of the product, customers that are generally not well educated and insurers that do not have easy-to-read product explanations. Additionally, the industry is very competitive and agents try to make products appealing, which usually results in a lack of thorough understanding by the customer.

The new system allows for the complaint information to be analyzed in many different aspects. Complaint ratios are calculated every year and are put on the department's website. Ratios are also calculated prior to exams. If trends are observed DCS might attempt to determine the consumers that have suffered but have not filed complaints. This is usually done in relation to class action cases. The only action the division can take against insurers is a fine of $500 for not responding back to DCS in time.

Iowa Insurance Division (IID)

August 14, 2003
Interviews by Kristina Donkova and Christina Amoiradaki

IID Staff Interviewed:

Susan Voss, Deputy Insurance Commissioner
Kim Cross, Financial Regulation Bureau
Angela Burke Boston, Producer and Product Regulation Bureau
Ann Outka, Consumer Affairs Bureau

Organizational Structure of IID

Commissioner of the Iowa Insurance Division: Therese M. Vaughan

The Iowa Insurance Division is responsible for all insurance business transacted in the state. The Insurance Division grants permission to companies wishing to sell insurance in Iowa and has general control over all aspects of their business, from the forms they use to the rates they charge. The division has direct responsibility over approximately 1,600 companies, health maintenance organizations, mutual hospital and health service corporations, and 57,500 insurance agents[123]. In addition, the commissioner also serves as the administrator of the securities act, which involves the licensing of brokerage firms and their agents, examining new securities offerings and investigating investment fraud cases.

The *Financial Regulation Bureau* is responsible for company licensing, monitoring of the financial condition of all licensed insurers, and compliance with Iowa statutes and regulations. This bureau is also responsible for the market conduct activities of insurers and agents. The *Product & Producer Regulation Bureau* is responsible for the licensing of insurance agents and the approval of policy forms and rate filings. The *Consumer Affairs Bureau* is responsible for handling consumer questions and complaints. When necessary, the bureau conducts investigations and can bring disciplinary action against insurance companies and agents. The Fraud Bureau investigates alleged fraud in all lines of insurance. In 2002 the Iowa Insurance Division had 93 employees and its annual budget was 7,017,964.

[123] Website of the Iowa Insurance Division

Company Licensing
Kim Cross

Handouts: Information on the Insurance Companies Authorized to Do Insurance Business by Types: Number of Companies and Business in Iowa.

The Iowa Insurance Division uses the uniform UCAA applications for both domestic and non-domestic companies. In addition to the general requirements of the uniform expansion application, Iowa has created two state specific requirements. In order to be eligible for admission in Iowa, foreign companies are required to demonstrate that they have been in continuous operation for three years; and to furnish an examination report prepared by a foreign insurance department within the last two years. Companies may provide additional information that would allow the Division to waive the two requirements.

The department has prepared detailed checklists that help the companies in the filing process, but depending on the company other information might be necessary. The review of the application starts after all the relevant information has been collected, the background check has been performed and the complaint profile has been reviewed. The insurance company applying is responsible for retaining a nationally recognized agency with experience performing these types of investigations. The report is then forwarded by the independent verifier directly to the Iowa Insurance Division. Certificates of authority issued to insurers are renewable annually. In Iowa, insurers file an Application for Renewal of Certificate of Authority that is due on or before March 1 annually. Iowa assesses a $100 fee for the renewal process. Foreign companies must pay the greater of what their state of incorporation would charge an Iowa company doing business there, or $100. The insurance division might decide not to renew a license based on numerous factors. In cases of foreign companies, the IID works with the domestic regulator to assess the situation and plans for the insurance company before a license is revoked or suspended. In the case of a domestic insurance company, the IID would communicate with all regulators in states in which the company is licensed. A meeting or conference call would likely be organized by the NAIC, but would be hosted by the Iowa Insurance Division. In the opinion of the staff, about 10-20 licenses are suspended each year.

The review of the primary application (application of a company that seeks domiciliation in Iowa) is generally longer, and it depends on the adequacy of the information in the application package. The review process includes: checking of the application package for completeness, financial analysis and operational analysis. The goal set by the NAIC for processing of a primary application is 90 days, and the goal for an expansion application is 60 days. In the opinion of the staff, the time to process a primary application is about 6 weeks (45 days). The time to process an expansion application is again within the NAIC requirement. The staff communicated that in the past it took much longer to process the Iowa state-specific application.

In view of those interviewed, delays result from incomplete applications or the necessity of the department to request additional information. The staff indicated that the detailed checklists significantly improve the filing process, nevertheless incomplete applications were still filed. The staff indicated that in 2002 only five life expansion applications were received. They were processed within prescribed timeframes.

Agent Licensing
Angela Burke Boston

Agent licensing is performed by the Product & Producer Regulation Bureau. Producer licenses in Iowa are issued for three years. In order to qualify for a resident license, an applicant must be a resident of Iowa; be at least 18 years of age; submit a completed uniform application; not have committed any acts that might prevent the issue of license; pass an examination, and pay the producer license fee. A non-resident applicant will be issued a non-resident license should she/he be licensed and in good standing in a foreign state; submit a completed application; submit a letter of certification, and pay the producer license fee. Candidates for Variable Life/ Variable Annuities Licenses must additionally provide evidence of active Iowa Securities License.

All licenses that require an examination are processed by an external vendor, Experior Assessments LLC. This service company conducts examinations, processes resident license applications, and prints licenses. The Insurance Division works closely with Experior and ensures that all exams reflect state requirements and professional standards. Resident applicants can send their applications to Experior through mail, phone, fax or online. If applicants apply for a license and register for exam concurrently, their license might be issued at any of the testing centers immediately after the exam. This means that by the time of the exam the IID would have reviewed the application, performed a background check, and confirmed that a license could be issued. However, if license authorization has not been issued by the insurance division at the time of the exam, Experior will mail the license to the applicant within 24 hours of receiving authorization from the IID. Non-resident applicants have to submit their applications directly to the Iowa Insurance Division. This can be done electronically through the National Insurance Producer Registry.

In Iowa a producer cannot receive commissions if s/he is not appointed by an insurance company. The appointment process is initiated by the insurer by submission of the NAIC Uniform Appointment/ Termination Form to the insurance division. This can be done electronically through the National Insurance Producer Registry.

Producer licenses are renewed every three years. Each year, in the beginning of the year the Iowa Insurance Division mails out a producer renewal report form to the producers whose license has to be renewed during that year. Both resident and non-resident applicants must return this completed form and pay the license renewal fee. Producers must obtain 36 credits for a period of three years in order for their license to be renewed. Non-resident applicants coming from states that have producer-licensing requirements do not have to obtain continuing education credits in Iowa. However, they have to file with the insurance division a certification letter from their states of residence that they are in compliance with the requirements of their resident states, unless their state is a participant in the Producer Database. The license will expire if the continuing education requirements are not fulfilled. Where a nonresident agent's home state participates in the Producer Database, certification letters are not required, and the license can be renewed electronically via the Division's website. The license can be revoked in cases of violations (e.g. theft), incompetence, or non-compliance with the Producer Licensing Model Act. In such case, administrative actions are initiated, such as license revocation, license suspension, fine or probation.

Currently 3 people work in the agent-licensing bureau. The bureau once had 5 positions. In the opinion of the staff, there is no need to hire more people.

Product Approval
Angela Burke Boston

Product approval is performed by Product & Producer Regulation Bureau. Iowa has a file-and-use process for life products and prior-approval for P/C filings.

Each life or health product filing should include the following: cover letter, insurer certification, actuarial memorandum, and retaliatory filing fee. The cover letter includes information about the insurer, indication of the principal changes (if the forms replace previous forms), a description of the forms, and home state approval (if the forms have been filed in the state of domicile). The certification is signed by an officer of the insurer and indicates that the forms are in compliance with all laws, rules and regulations of Iowa. The actuarial memorandum, describing the products and rates, helps the insurance division in verification of policy figures.

Applications can be filed electronically or in paper. The Iowa Insurance Division began accepting SERFF filings in late October 2001. Currently, the state accepts SERFF filings for the following life and health products: Individual Life, Group Life, Medicare Supplement, Credit Life and Disability, and Personal Liability. Now about 10% of applications go through SERFF (about 5,000 applications per year) and 90% are filed in paper. The average review time for a paper application is about 36 hours, while the review of a SERFF filing takes even less time. The review is made to determine that the application complies with relevant laws and regulations. In the opinion of the staff, the most typical reason for delays is the submission of incomplete filings.

Iowa is a CARFRA-member state. The matrix of state product deviations indicates that Iowa does not deviate from the CARFRA standards. Those interviewed were aware of only two filings that were ever made trough CARFRA. The staff was not aware why companies would not make CARFRA filings, but they pointed out that CARFRA could not speed the review process in Iowa since the state has a file-and-use regime for life products.

Iowa is leading the efforts for implementation of the interstate insurance product regulation compact. The state has already introduced the compact legislation to the state legislature and it was passed as-it-is in May 2003[124]. At this time no filings have been made.

According to staff, the file-and-use system might not be the best one in terms of consumer protection. It allows for a faster review but it might lead to potential problems in the future since all applications are not reviewed in detail.

[124] Currently the NAIC Interstate Compact Working Group is working on developing national uniform product standards for life insurance, annuity, disability income and long-term care insurance products.

The staff is satisfied with the operation of the departments. Currently 11 people work in the bureau: 3 in licensing, 1 attorney, 1 in accident/health, 1 in life, 1 in P/C, 1 life and health actuary, 1 P/C actuary and 2 clerical support staff.

Financial and Market Conduct Examinations
Kim Cross

The Iowa Insurance Division performs both financial and market conduct examinations. Examinations are categorized as either comprehensive or targeted.

The Code of Iowa requires that the Insurance Division perform comprehensive financial examinations of insurers doing business in Iowa at least every five years. While timeframes are not statutorily prescribed for market conduct examinations, the Iowa Insurance Division believes that it is expedient and a prudent use of resources to perform comprehensive market conduct examinations on the same schedule as financial examinations. In practice, the Iowa Insurance Division performs a comprehensive market and financial examination on domestic insurers every three to four years. Iowa focuses its efforts on its domestic industry and does not routinely practice extraterritoriality.

Scope of Comprehensive Financial Examination. Iowa utilizes the NAIC Financial Examiners Handbook in planning and performing examinations.

The United States is divided into four zones. Iowa is part of the Midwest zone, which includes 13 states. All states participate in the so-called zone examination system. Zone examinations were introduced to reduce the number of financial examinations of multi-state licensed insurers and to enable states to share resources. Zone representatives are selected by fellow states to participate in the examination on behalf of the zone. Examinations called by the Insurance Department are reported on a confidential database maintained by the NAIC called the exam tracking system ("ETS"). ETS distributes notification of the upcoming examination to each zone. Iowa has the ability to send an examiner to participate in a zone examination if the company has a significant presence in Iowa or it has concerns about the company.

Scope of Comprehensive Market Conduct Examination. Iowa utilizes the NAIC Market Conduct Examiners Handbook in planning and performing examinations. The scope includes, but is not limited to, reviewing company operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims.

The states have not yet adopted a zone examination format for market conduct examinations. In an effort to avoid duplication of effort and repetitive review of a company's operations, the Iowa Insurance Division has entered into a market conduct reciprocity agreement. The reciprocity agreement provides that Iowa will accept the comprehensive market conduct examinations performed by participating states and will not duplicate effort. Each participating state makes the same representations. Currently, participating states include Kansas, Nebraska, North Dakota and South Dakota.

Target Examinations. Target financial examinations and market conduct examinations, on both foreign and domestic companies, are called as deemed necessary by the Insurance Division. Targeted exams could be triggered by disclosure of an adverse trend in the financial condition of the company (targeted financial exam) or by consumer or legal issues (targeted market conduct exams).

Duration of examinations. The time that it takes to perform a comprehensive financial and market conduct examination will vary from company to company. In general, the length of time will range between one week and six months. The range is attributable to the size and complexity of insurers' operations.

Exam Scheduling. The Iowa Insurance Division utilizes the criteria listed in the NAIC handbook to schedule examinations. In determining priorities, a number of indicators are considered, including but not limited to - in no order of preference, statutory examination requirements, complaint analysis, compliance with laws and regulations, previous exam findings, issues within the holding company, form reviews.

Troubled Companies. The Iowa Insurance Division utilizes the NAIC Troubled Company Handbook. The handbook defines a troubled company as one "…that is or is moving toward a financial position that subjects its policyholders, claimants, and other creditors to greater-than-normal financial risk, including the possibility that the company may not maintain compliance with the applicable statutory minimum capital and/or surplus requirements".

Iowa's on-going financial analysis of companies is critical in detecting troubled or potentially troubled companies. Financial analysis helps to identify troubled companies at an early date and regulatory courses of action may be initiated as appropriate.

The Iowa Insurance Division employs a number of tools when a company is potentially troubled. There are several broad categories of action (i) monitoring, (ii) surveillance, (iii) regulatory action and (iv) delinquency proceedings.

Monitoring. This function includes the customary ongoing efforts of the Insurance Division to review the operations of the insurance company. These efforts would include, but not be limited to, examination of the company's financial condition, financial analysis of information regularly reported to the Insurance Division and evaluation of non-financial information.

Surveillance. This function includes information collection and analysis beyond monitoring efforts. This process may include, but is not limited to, a closer review of a company's operation and financial information. It may also include requiring more frequent reporting of financial information or analyses from the company, performing special examinations of the company, and discussing operations or transactions with the company.

Regulatory Actions. This function goes beyond the monitoring and surveillance functions. Examples of potential regulatory actions include but are not limited to, the following:

Hearings/Conferences
Implementation of a Corrective Plan
Restrictions on Activities
Notice of Impairment
Cease and Desist Order
Supervision (confidential)

Delinquency Proceedings. These proceedings are instituted against an insurance company by the Insurance Division for the purpose of conserving, rehabilitating, reorganizing, or liquidating the insurance company. These delinquency proceedings directly involve the Polk County District Court. Examples of potential delinquency proceedings include:

Rehabilitation
Liquidation
Dissolution

The nature, timing and extent of regulatory action depend upon the particular circumstances of the situation.

Communication.

Other States. The Insurance Division routinely forwards copies of final financial examination reports to all states where the company examined is authorized to do business.

Additionally, in the event that a domestic company is 'troubled', the Insurance Division would facilitate communication with all states where the company is authorized to do business. The NAIC Financial Analysis Working Group provides a forum for states to address issues relating to troubled or potentially troubled nationally significant companies. A representative from the Insurance Division regularly attends these meetings.

Interdepartmental. The Deputy Commissioner and Chief Examiner regularly provide updates to the Commissioner and senior staff. The division employs four examiners-in-charge ("EIC"). Each EIC communicates with the legal, consumer complaint and financial analysis bureaus. After each exam, the reports of examination are communicated inside the department.

Closing Comments.

In the opinion of the staff, financial exams are better at assessing risk than market conduct exams. However, the staff was convinced that increased similarity of evaluation methods and standards between financial examinations and market conduct examinations would result in better risk assessment.

Consumer Complaints
Ann Outka

Handouts: Information on filing of consumer complaints; Tips for consumers on how to resolve a complaint; Complaint Information Checklist; Consumer Complaint Form; Notification Card sent out to consumers after receipt of a complaint; Instructions to Insurers for Responding to Inquiries from the IID; Information on Complaint Ratios; Information on IID Orders and Administrative Actions.

The Consumer Affairs Bureau is responsible for providing consumer information, investigating complaints against companies or agents, and protecting consumer interests.

The insurance division has established clear guidelines for consumer complaint handling. In case of questions or concerns, consumers are first instructed to contact the insurance company or agent and request an explanation from them. In case of dissatisfaction with the explanation, consumers should call the Iowa Insurance Division, whose staff will evaluate the circumstance and may ask for a written complaint to be filed. Complaints can be filed via fax, mail, email or online. Consumers are required to include a detailed summary of the problem, to provide documents supporting the claim, and to describe a reasonable resolution, as they see it. Once the insurance division receives the complaint, it contacts the appropriate parties and sends a notification to the consumer that his/her complaint has been received. The notification has information about the identification number of the complaint, the average time for resolution and a brief description of the resolution process. On its web-site the division has indicated that after it receives a response from the agent or the company, it will begin reviewing the information and will take one of the following actions: initiate corrective action (violation of an insurance law), require an insurer to complete a reasonable investigation (insurer has not made thorough and fair investigation), or close the complaint (no violation was found).

After the complaint is received, its information is coded and is uploaded into the division's IT system. At that point the IID sends a letter to the insurer or agent explaining the complaint and requesting information. Attached to the letter, the division sends instructions for responding to the inquiries and complaints. The insurers/ agents are informed that they should respond to the division within 10 business days. In the response, the insurer/ agent has to provide information on the actions taken regarding the complaint, company/agent's position regarding the issues raised, and all documentary evidence supporting the position of the company/ agent. The IID reviews the information and documentation provided by the company/ agent, but only occasionally performs independent research.

The Iowa Insurance Division stores and periodically performs analysis of the complaint data. The IID follows the NAIC analytical guidelines for its analysis. Complaint ratios[125] are calculated and are posted on the division's website. The staff indicated that complaint ratios are calculated for companies that have ten or more complaints. At any time, consumers can access the division website and can get information about the complaint profile of each insurer for the following types of insurance: private passenger auto, homeowners, individual health, group

[125] Complaint Ratio is the number of complaints received by IID per each million dollar of direct premium written by any insurer in Iowa for a particular line of insurance.

health, life and HMOs. All information on complaints used to be public; however beginning July 1, 2003 the identification specifics became confidential. Additionally, consumers have access to all administrative actions and orders taken by the division against insurers and producers.

Currently the consumer complaint operation has a staff of 9 people: 1 supervisor (attorney), 1 asst. supervisor (attorney), 3 complaint analysts (1 attorney), 3 analysts (for the initial review), and 1 clerical support staff. Each year the Consumer Affairs Bureau receives approximately 4,500 questions and consumer complaints.

The Consumer Affairs Bureau has six additional people doing media relations and consumer outreach, including the Senior Health Insurance Information Program.

View on OFC

The staff indicated its belief that if no uniformity was achieved in certain key areas in due time, the federal charter for insurance might become an option. Those interviewed indicated that there was a very strong interest in the OFC, especially from companies selling life, annuities and some health products. In the opinion of the staff, the OFC discussions are a wake-up call to the regulators. Those interviewed believed that activities such as the interstate compact might be more effective for the quality of regulation than federal proposal, because it was not clear what the charter could do. Iowa has already been very effective in achieving a stable and efficient regulatory system, and initiatives such as the NAIC CARFRA and SERFF could additionally bring efficiencies.

New Jersey Department of Banking and Insurance (DOBI)

October 23, 2003
Interviews by Kristina Donkova

DOBI Staff Interviewed:

Donald Bryan, Director, Division of Insurance
Gale Simon, Assistant Commissioner, Life & Health
Lynda Klebold, Chief, Life Bureau
Nancy Hritz, Chief, Valuation Bureau
Karen Mitchell, Assistant Commissioner, Financial Surveillance
Robert Kasinow, Assistant Chief Insurance Examiner, Field Operations
Lee Barry, Assistant Commissioner, Consumer Protection Services
Anne Marie Narcini, Manager, Consumer Protection Services

Organizational Structure of DOBI

Commissioner of NJ Department of Banking and Insurance: Holly C. Bakke
Director of Insurance: Donald Bryan

The Department of Banking and Insurance (DOBI) is primarily responsible for the regulation and monitoring of state's banking and insurance entities. The Division of Insurance (DOI) monitors and examines the policies, practices and financial condition of insurance companies, and licenses and regulates insurance producers. The division has direct regulatory responsibility over approximately 108 domestic insurance companies, 120,000 licensed producers and 1,146 public adjusters[126]. In addition, the division works with the Department of Law and Public Safety to enforce insurance fraud laws, administers the Unsatisfied Claim and Judgment Fund, regulates the training and licensing of real estate agents and brokers and investigates consumer inquiries or complaints regarding these industries.

The *Life and Health Bureau* of the DOI is responsible for L&H insurance company licensing and L&H product approval functions. The *Financial Solvency* and *Financial Examination Bureaus* are responsible for financial surveillance of insurers, and the *Office of Consumer Protection Services* is responsible for producer licensing, regulating the market conduct activities of insurers and producers, and handling consumer complaints.

[126] Website of the NJ Department of Banking and Insurance.
New Jersey is issuing licenses to former limited lines registrants in accordance with the uniform producer licensing statute, which is to be completed by 12/31/03.

Company Licensing
Gale Simon, Nancy Hritz, Donald Bryan

Handouts: General Eligibility Requirements for Life, Health, Annuities and Variable Life and/or Annuity Authority; Charts of the One-Step and the Two-Step application processes; Final Admission Application package; Admission Requirements for Foreign and Alien Life and Health Insurers; Comparison of Life & Health Admissions Committee Activity (1999-2003).

The NJ DOI has two separate procedures for licensing insurers. If applicants are following the UCAA Expansion Application format, the DOI will process the application in one step, which includes immediate payment of the application fee. If the applicant follows the procedure outlined in NJAC 11:2-1, the DOI will process the application through a two step approach: the applicant will provide a Letter of Intent as step one and the application fee will be due with the Final Application.

Under the **two-step application procedure**, the applicant files a preliminary application (Letter of Intent) that includes the following information: name of applicant, insurance holding company chart and registration statements, type of insurance proposed to be written in the state, most recent annual statements, current certificate of authority from its state of domicile, and most recent reports from rating agencies. The submission is reviewed for completeness and a decision is reached if the applicant meets the eligibility criteria. If eligible, an application package is sent to the applicant. If the submission is not complete the applicant is given 45 days to respond to the notice of deficiency.

The applicant is required to submit the completed Final Application within 60 days of the receipt of the application package. The application package includes the following information: copy of charter, copy of bylaws, six copies of current annual statement, analysis of profits and surplus, certificate of valuation, copy of most recent financial ROE, statement of ownership, agreements for re-insurance, tender offer materials, corporate plan of operation, present business plans, proposed plan for conducting insurance business in NJ, ranking compared to other insurers in the state; copy of most recent market conduct ROE, biographical affidavits, etc.

The application is reviewed for completeness, and then the applicant is advised of any deficiencies and is given 45 days to correct them. Once the application is determined to be complete, the staff prepares the documentation for review by the L&H Admissions Committee. The L&H Admissions Committee meets monthly to review the pending applications. Following review it makes a recommendation for issue of authority or requests additional information. If such information is requested the applicant is given 45 days to respond. Once the committee makes a recommendation, it is forwarded to the commissioner for his/her review and ultimate approval (sign-off). The licensure is effective on the date of the commissioner's sign-off.
DOI has set a target timeframe for the two-step application process of 60 days.

The **one-step application procedure** has been developed for the review of the uniform application and follows the two-step procedure with the exception of the requirement for filing of a Letter of Intent. Again, the target timeframe for application review is 60 days. UCAA applications have been received since January 2002, and in 2002 only three UCAA applications were filed.

NJ statutes require that all alien insurers follow the two-step procedure outlined in NJAC 11:2-1. These companies can establish port-of-entry, invest into a US company or establish a US subsidiary.

Currently, DOI accepts only paper filings. Despite the fact that DOI has prepared detailed application checklists and follows the UCAA guidelines, companies continue to provide incomplete applications, which can significantly hinder the review and approval process. On occasion, the Admissions Committee might not be able to hold its monthly meeting due to scheduling difficulties and six to seven weeks may pass between meetings. The DOI is trying to follow the timeframes developed by the NAIC, but at this time they do not consistently meet them. The target timeframe set by the division is 60 days and the maximum timeframe is 113 (calendar) days. According to the staff, the average time for application review has been 6 months. The staff communicated that based on its current experience with the various NAIC online systems they did not expect that the online review would speed up the review process.

DOI might decide not to grant an approval for financial reasons, lack of feasibility of the business plan, or improper treatment of policyholders. In such cases, the company is advised to withdraw its application and resubmit when the issues are cleared (usually after 1-2 years). If the application gets an official rejection, this information is recorded into the company's profile into the NAIC database.

In view of the discussions of reciprocity in company licensing, the staff communicated that currently the domestic states are not aware of the future plans of a company to expand into other jurisdictions. This limits the knowledge of the domestic regulator, creates a misleading assessment of the risk, and does not allow for the other states to rely upon the analysis of the domestic regulator. New Jersey has discussed improving the reciprocity in company licensing with the states in the North East Zone, and believes that the progress in this initiative might be used as a basis for a national reciprocity plan. In the view of the division, there should be guarantees that the insurer is not over-extending itself financially.

There are three people in the Life & Health area that do application review of insurance companies and other entities (charitable organizations, viatical companies, etc), and all of them have financial backgrounds. In 2002 the L&H Admissions Committee approved 6 new admissions and 7 extensions of authority. Additionally, 3 applications were deferred, 1 was denied, and 2 were withdrawn. At the end of the year, there were 3 pending admissions and 5 pending extensions of authority.

The staff is satisfied with the established application review process. Through the Admissions Committee the DOI has been able to pool experience from variety of areas. The division is trying to work on the timeframes, but other than that they are happy with the processes and procedures.

Agent Licensing
Lee Barry, Anne Marie Narcini

Agent licensing is carried out by Consumer Protection Services. New Jersey is one of the states that have been certified to comply with the reciprocity requirements. Resident and non-resident applicants can use the NAIC uniform application or the NJ application, which is based on the uniform application. DOBI is accepting uniform applications for new licenses and for adding new lines of business to an existing license. Staff shared that perhaps 90 -95% of the non-resident applicants use the NAIC uniform application, and 5 - 10% of non-resident applicants use the NJ application. The insurance department does not have such information on residents since most of them complete the application electronically with the testing vendor.

According to the staff, New Jersey does not significantly deviate from the NAIC Uniform Producer Licensing Standards. New Jersey has a pre-licensing education and training requirements, as well as criminal check requirements for its first-time domestic producers. The criminal check requirement for non-domestic producers was removed in 2002.

All licenses are renewed every 4 years, and DOBI does not require appointments for producers to begin selling insurance products. Very often companies do appoint producers and in such cases they are required to inform the DOBI (no appointment fee is necessary). Under reciprocity provisions, the state issues a license for the same lines of authority to a non-resident applicant as those held in his/her state of residence. Non-residents can obtain broader authority than in their home states if they complete New Jersey education and examination requirements.

The Office of Consumer Protection Services is also responsible for license terminations. The DOI has established a very detailed procedure for license revocation. If complaints, market conduct analysis or investigation indicate that a producer (resident or non-resident) should be subject to disciplinary proceedings, an Order to Show Cause is drafted and is submitted to the Attorney General's office. Once the Order to Show Cause is issued, the producer is given the right of an administrative hearing, and after the final decision s/he is also given the right to an appeal. This long process could be shortened if a settlement agreement is reached with the producer. If the license of a non-resident producer has been revoked by its domiciliary state, the DOBI may not necessarily follow the above procedure but instead may terminate the non-resident license in New Jersey, consistent with notions of reciprocity.

DOBI has mostly a paper-based review and approval system. Non resident applications, coming through the NIPR, are processed electronically, very often without any human involvement and with an approval and license issuance within a day. New Jersey recently began receiving electronic application through the NIPR and has seen a steady increase in the number of electronic submissions in the first two months of implementation. The division tries to keep the processing time for non - electronic applications to within 30 days, and the staff is convinced that once the NAIC State-Based Systems project[127] is fully implemented and both resident and

[127] New Jersey is one of the four states that are currently licensed for SBS. This project, initiated by the states and carried out by the NAIC, has the goal to automate the regulatory functions of the insurance departments. Currently

nonresident applications can be submitted electronically, the approval time will be significantly reduced. In the area of producer licensing the SBS project handles resident and non-resident individual and business entity licensing, license renewal, company appointments and terminations, and tracking of continuing education credits for resident producers.

In view of the staff, the post-GLBA initiatives of the states and the NAIC have had a significant impact on non-resident but little impact on resident licensing. As a result New Jersey has dropped the requirement for a criminal history check on non-residents, and made it possible for electronic applications to be received through the NIPR. The staff expressed the opinion that reciprocity among states works very well and uniformity in all areas of producer licensing is not really necessary. Uniformity in continuing education and pre-licensing requirements might further improve the process, however no benefits were seen in uniformity of licensing fees, licensing and appointment cycles.

There are 17 people in Licensing and Insurance Education Unit of Consumer Protection Services. The staff disclosed that about 13,000 – 15,000 new applications are reviewed and processed annually, and that there are about 120,000 resident and non-resident producers in New Jersey.

Product Approval
Lynda Klebold

Handouts: Types of Insurance – Definitions of Life, Annuity and Health Insurance; Description of Filing Statutes; Standard Provisions for Individual Life Insurance; Regulation Dealing with Individual Life Insurance; CARFRA Review Standards for Term Insurance; New Jersey Deviations for CARFRA Term Standards.

New Jersey has a prior approval system where most life, health, and credit insurance, annuity and variable contracts, and the rates for certain products, have to be filed with the commissioner for approval prior to use. The commissioner must also approve separate accounts for domestic companies prior to use. The state has adopted several initiatives to help speed up the product review and approval process. In 1995 there was a significant change to the NJ statutes that introduced a "deemer" provision on both new submissions and resubmissions. The statute provides that any policy or contract filed with the commissioner for approval should be deemed approved upon expiration of 60 days following the initial submission, and upon 30 days following resubmission of a previously disapproved form. The insurance company has also a "deemer" provision on its response to the DOI (unique to NJ). If the company does not respond to all disapproval reasons of the DOI within 60 days for an initial submission and 30 days for a resubmission, the filing is deemed withdrawn. Given these time frames, it normally takes about 180 days for the review and approval of a filing: 60 days for the DOBI to review the initial submission and disapprove for noncompliant provisions, 60 days for the company to respond to the DOBI's disapproval, 30 days for the DOBI to review the resubmission and cite any

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SBS handles E-Licensing (company and producer), E-Company Demographics and State Admin Interface. Very soon it is expected to handle also: E-Continuing Ed/ Pre-Licensing, E-Complaints, E-Relationships, E-Regulatory Actions, and E-Fraud.

continuing noncompliant provisions and 30 days for the company to respond to the problems cited with respect to the resubmission. According to the staff, none of the filings are deemed approved, the actual review time may be shorter than the required 30 or 60 days depending on the speed and quality of the insurer's response.

New Jersey also offers a broad spectrum of file-and-use options. In a regulation the department has specifically identified the products that can be filed and used. Each year the commissioner holds a hearing where companies and interested parties suggest products that can be made available for sale through this certification file-and-use regime and without a prior approval. Additionally, insurers can file with the commissioner and use products that are the same as or substantially similar to products that have already been made available for sale in at least 42 other states where the combined population equals or exceeds 2/3 of the total US population in 40 states. Such product filings have to be accompanied by a certification memorandum, which includes a statement that the filing is made in accordance with all relevant statutes and regulations. If insurer is found by the commissioner to be in violation of the certification or if the form does not comply with certain specific statutory provisions, the form may be disapproved. The staff was not able to identify the percentage of products filed for prior approval or file-and-use.

New Jersey is one of the twenty-two CARFRA-member states that have adopted the common review standards, and according to the staff the department has received just one CARFRA filing. The staff believes that CARFRA is still a viable initiative, however they expect that CARFRA would probably be replaced by the Interstate Compact when it is launched. DOBI strongly supports the interstate compact and expects to support the final standards, so that they are recommended to the state legislature. The staff believes that by clearly defining the terms of the various product contracts, the Compact makes it possible for issues to be addressed similarly within all the states.

According to the staff, the most important reason for delay in product approval is lack of familiarity of the insurers with the New Jersey filing requirements. In its effort to bring the principles of the statutes in line with current market trends, the DOBI periodically issues and updates regulations on the implementation of various NJ statutes. Despite the fact that regulation drafts are open for interested parties' comments, and meetings are organized to discuss improvements of the product approval process, insurers continue to file outdated documents and data.

In March 2003, the Life and Health unit of DOBI started receiving filings through SERFF. SERFF was initially introduced to the P/C, and later to the L/H section. The department is currently going through a learning curve regarding how to best facilitate the paperless review, and the DOI has just received recommendations from SERFF on how to overcome certain usage and implementation difficulties.

In relation to the new NAIC speed-to-market tools[128], New Jersey has partially embraced the new self-certification program. One of the limitations for this program has been the quality of the

[128] New NAIC speed-to-market tools: Uniform Review Standards, Self-Certification Program, Common Filing Transmittal Documents, and Uniform Product Coding Matrices.

self-certification used. For this reason, the DOI is now working with ACLI to develop certain certifications. The staff communicated that depending on the quality of certification and the accountability of the person providing the certification the department might become more comfortable with this new speed-to-market tool.

Currently, DOBI has about 12 people that deal with product review and approval. The department is generally satisfied with the product approval process in the sense that consumers are well protected. Staff communicated that the process could be improved if regulations were issued more quickly. Currently, regulations are opened for industry discussions for a period of 60 days, which both improves the quality of regulation but slows down the speed with which standards are brought into conformity with widely accepted market standards. According to the staff, after the changes in 1995 insurers now have little complaints about approval time. The department tries to address all concerns in the regulations that are periodically reviewed and updated.

Financial Analysis and Examinations
Karen Mitchell, Robert Kasinow

New Jersey performs financial analysis of both domestic and non-domestic companies. The insurance department is primarily responsible for all NJ-domiciled companies, but occasionally does some analysis of non-domestic companies based on selected ratios. On the examination side, the department has the right to examine a non-domestic company, but it rarely utilizes this right.

Financial analysis is based on quarterly and annual financial statements. The DOI follows the process described by the NAIC Financial Analysis Handbook: ratios are calculated, trends are identified and analyzed, and holding company and inter-company agreements, CPA, SEC reports and actuarial opinion are reviewed and analyzed. As a result of the analysis companies are prioritized based on their financial condition and risk.

New Jersey has a five-year examination cycle. Each year the department builds a list of companies that would receive a routine financial examination during the year. In the third quarter of the year, DOI sends a pre-examination planning questionnaire to these companies informing them of the forthcoming examinations. Approximately a month before the exam, there is an official phone call and/or onsite meeting to the company. Companies that have received a high-risk rating based on the financial analysis might be included in this list, or in the targeted-exams list. The routine examinations follow strictly the NAIC Financial Examiner Handbook. The NAIC Troubled Company Handbook is mostly used in targeted exams of financially unstable companies.

The goal of a typical onsite exam is to determine compliance with the Financial Examiner Handbook, and with the relevant NJ statutes and regulations. Exams are typically balance sheet oriented, and through testing and further questioning the examiner additionally reviews management records, plans of operations, inter-company agreements, reinsurance transactions, etc. The DOI often uses specialists (external consultants) for the review of key risk areas. The

use of consultants is mostly determined by the need for expertise and not by the need for additional funding. Following each exam, an official report of the examination is prepared and provided for review by the insurer (company is given 30 days for comments). By the end of the exam all violations and recommendations are discussed and accepted by the company, and from that point the analysis department becomes responsible for the company (it has to monitor its compliance with recommendation and enforcement actions). Exam reports are not published on the web site, but are available to the public upon request. The ratings assigned to the company following the examination are not included in the report and are not disclosed to the company, or to the public. Despite this procedure, the company is very well aware of its risks and areas of concern. The insurance department makes sure that failures are never an option, and tries to come up with various measures to strengthen the company and protect the consumers through capital increases, limitations of certain operations and product writing.

New Jersey has the option to participate in association exams but this rarely happens due to issues related to availability of staff. The last association examination was of a non-domestic company that wrote significant portion of its business in New Jersey, but staff described this as a rare event.

Depending on the size of the company, the complexity of its operations, and the number of the staff included in the exam team, the average duration of the exam is about 6-8 months (from official notification to filing of the report of examination). According to the staff, delays in the exam result mostly from complex issues that are usually settled through negotiations between the company and the DOI. Currently, DOI has 25 field examiners and about 10 office analysts, who are responsible for 108 domestic insurers.

As of the moment, the DOI performs risk-based exams that are mostly based on assessment of the risk in retrospective (financial statements). However, the department is working on a more advanced risk approach, which will assess the risk in perspective: it will try to determine how the company will be managing its risks going forward in a specific market environment under specific market conditions.

In an effort to increase the effectiveness of resource utilization and quality of regulation, the insurance department is working on improvement of the communication between analysts and examiners. In November, external consultants will come to the DOBI to present Financial Analysis 101 to field examiners, and Financial Examinations 101 to in-house analysts. Following these presentations, examiners and analysts will be divided into groups that will discuss and work on actual analysis and examination cases. The DOI believes that by improving the communication, examinations will focus upon the most crucial areas of operation of the different insurers.

The DOBI is satisfied with its financial analysis and examination processes. The department is convinced that the introduction of the forward-looking risk-based exams will significantly strengthen the system thorough more proper assessment of the risks inherent in the companies.

Market Conduct Analysis and Examinations
Lee Barry, Anne Marie Narcini

The Office of Consumer Protection Services is responsible for market conduct examinations of both insurers and producers, and the process is very similar for these two groups. New Jersey does not have a specific requirement about the frequency of the market conduct exams, and exams are often called for review of carrier/producer-specific issues. Additionally, the insurance department performs typically targeted exams: through these it is trying to examine more companies and focus on problem areas.

Market analysis is based on complaint data, annual reporting requirements, and particular issues of importance to the department. Currently New Jersey is not using the market conduct annual statement, but the staff indicated that depending on its final form and content the DOI might decide to implement it.

The insurance department uses the NAIC Uniform Market Conduct Examination Standards. Market conduct exams are performed mostly of insurers, however producers are examined when consumer complaints indicate problems or negative trends. Often the examination of an insurer might necessitate examination of its agents.

An insurer might be examined for reasons that include: consumer complaints that reveal problems, changes in laws, or as a follow up of previous exams. Each examination is initiated by a data call, a letter to the company that lists the information that the company should generate and provide to the examiners. Usually this information is analyzed in-house through sampling and testing. The onsite examination looks into the problems, formulates the issues, and determines recommendations. All findings are documented into the report of examination, which is submitted to the company for its review. The company has 30 days for review and comments, and after these comments are considered by the department, and if appropriate, changes are made to the report based on those comments, and the report is officially adopted by the commissioner. Following its adoption, the report becomes public information. Currently the department does not publish the report on its web site, but this is expected in the future. The length of time from the initial call letter for a typical exam to final adoption of the report is generally between 6-9 months, and the longest exam has been a little over a year[129]. The staff shared that sometimes companies may contribute to delays because upon review of the draft report, they are provided with the opportunity to comment and provide more evidence that they are not in violation.

On occasion New Jersey participates in multi- state market conduct exams coordinated through the NAIC. These exams are called when there is evidence of a national problem, and the states that participate may include the state of domicile, the state of commercial domicile, and the states where the perceived problem has had the greatest impact. The most recent multi-state examination, in which New Jersey has participated, has been of a P/C company.

In the view of the staff interviewed, the future of market conduct regulation is based on deference to the state of domicile, unless there are some very atypical state issues. This idea is feasible especially with respect to the limited resources of the states. Any other alternative to that

[129] This has been a full scope examination of a particularly large NJ domiciled company.

involves multiple examinations of insurers and numerous duplications in the regulatory process. Additionally, market regulation will be based on market analysis of electronically collected data, which the state will use to identify problems.

In relation to the recently released NCOIL report, the staff commented that waiving an exam as a result of a self-certification was not a good policy because very often the certification was about issues that were not of interest to the insurance department. However, those interviewed indicated that if the certification did happen to address the particular issue, then the DOBI might give some consideration to the self-certification.

The staff is generally satisfied with the market conduct process. They believe that risk is properly assessed and that consumers are well protected. Those interviewed communicated that the staff is competent and has the necessary skills and capabilities to adequately regulate the market conduct activities of both insurers and producers. It was also indicated that more examinations would have been performed if more resources were available. In the view of the department, delays in examinations result from the different capabilities of the insurers' information systems, which often slow down the exam process. This issue goes beyond the pure standardization of data, since companies cannot provide the needed data because their systems are not built consistently.

Consumer Protection Services
Lee Barry, Anne Marie Narcini

The Office of Consumer Services performs the following consumer services: consumer complaint handling, consumer advice and assistance and consumer outreach. The bureau is de-centralized: there is one central office in the capital, where investigations are conducted and two satellite consumer centers in the South and in the North of the state.

Consumer complaints are received through the central and satellite offices, the Ombudsman, Commissioner's office, legislature, other state offices or the NAIC web site. Consumer complaints are handled through the Office of Consumer Protection Services or the Ombudsman[130]. Formal consumer complaints are accepted in written form only, and can be filed online, in a written letter, through email, or in person.

Once a complaint is received it is assigned a number and is put into the computer system through scanning and coding. At this point complaints are prioritized based on urgency and are sent to an investigator for review. An automated letter is sent to the consumer for the routine complaints, and a formal letter about the complaint is electronically faxed to the insurer. The insurance department reviews the information provided by the insurer and makes its decision.

In several statutes and regulations New Jersey has indicated how consumers could file complaints: a regulation requires that policy forms should have language that consumers should contact the Office of the Ombudsman for complaints and inquiries; provision in a law indicates

[130] The Office of Insurance Ombudsman was created five years ago to investigate consumer complaints, monitor the implementation of various insurance laws, respond to consumer inquiries, and publish and disseminate buyers' guides and comparative rates.

that consumers should contact the insurance department for cancellations and denial of policies, and another regulation indicates that in claim settlement consumers should contact the insurance department about additional information.

According to the staff the average time for complaint resolution is about 60-90 days. Those interviewed indicated that variable products typically give rise to more complaints and these complaints also take longer to resolve.

The DOBI performs semi-annual statistical analysis of the complaint data per company. Upon identification of unusual patterns market exam and enforcement staff may become involved. Very often upon detection of an unfavorable trend the company is advised to identify (and make payments and reimbursements to) all other consumers that might have suffered by the violation but never filed a complaint.

Information about violations and corrective action is also included in any applicable adopted market conduct reports and/or in final enforcement actions, and is available to the public. The most typical enforcement/corrective measures taken against insurers are: remediation, interest payment, and fines (license suspension generally occurs in the case of producers, not insurers).

The Office of Consumer Protection Services has 25 people that deal with consumer complaints, and the Office of the Ombudsman has 10 people. The insurance department receives annually about 12,000 written consumer complaints, and processes about 48,000 inquiries.

OFC Comments

Considering the fact that there is more than one model for the OFC, the staff found it difficult to clearly describe their opinion of the effect of the charter on the industry. It was indicated that the different areas of regulatory oversight should always be the responsibility of a single regulator, otherwise consumer protection would be disrupted.

Those interviewed pointed out that a federal regulator couldn’t reflect all the differences among the states resulting from population, geographical, historical or social issues. Additionally, it was indicated that federal regulators could not deal as effectively with consumer complaints as states could because they generally do not have the staff for consumer service and protections and leave these activities to courts and law-suits, which generally are not the best means to resolve insurance complaints. Those interviewed were worried by the fact that the federal government had not done a good job in the regulation of self-funded and some welfare arrangements, and in the protection of their consumers.

The benefits of uniform regulation across states was clearly understood, nevertheless it was not clear how claim disputes and other issues particular to the individual jurisdictions could be settled. Despite the fact that dual regulation would probably result in increased uniformity, it would certainly prevent the recognition of specific regional differences. Additionally, dual regulation might result in dilution of standards in some areas where currently insurance regulation is strong.

The DOBI staff was worried that there is no natural expertise in the current federal government regarding the insurance business and the risk inherent to it. The fact that the banks do not engage in the business of underwriting insurance (but only in sale of insurance) means that bankers and bank regulators do not understand this business and do not have the knowledge to get involved in it.

New York State Insurance Department (NYSID)

August 21, 2003
Interviews by Kristina Donkova and Christina Amoiradaki

NYSID Staff Interviewed:

Peter J. Molinaro, Senior Deputy Superintendent
Salvatore Castiglione, Assistant Deputy Superintendent and Bureau Chief, Consumer Services & Licensing Bureau
Kashyap Saraiya, NYC Office
Clark J. Williams, Assistant Director, Licensing Services Bureau
Melissa Pingel
Others

Organizational Structure of NYSID

Superintendent of the New York State Insurance Department: Gregory Serio

The Insurance Department ("NYSID") is responsible for the supervision and regulation of all insurance business in New York State. The NYSID seeks to ensure soundness and prudent conduct of insurers, protection of policyholders, elimination of fraud, criminal abuse and unethical conduct, and to foster growth of the insurance industry.

The NYSID carries out its supervisory function by issuing licenses to agents, brokers, reinsurance intermediaries, adjusters, and bail bondsmen; conducting examinations of insurers to determine their financial condition, treatment of policyholders and claimants, and underwriting practices; and auditing each company's annual reports. The regulatory function is performed through determination of qualifications of insurers; regulation of rates, certain retirement systems and pension funds; review of policyholders' complaints; supervision of the liquidation, rehabilitation, and conservation of insolvent insurers; and approval of corporate formations, mergers, and consolidations.

The operations of the NYSID are carried out in seven locations; in addition to its main office in Manhattan, the agency has staff in Albany, Buffalo, Rochester, Syracuse, Oneonta and Long Island. The Liquidation Bureau, a separate office under the jurisdiction of the Superintendent, is charged with rehabilitating or liquidating insurance companies and is located in New York City[131].

The department supervises and regulates about 1,540 insurers and 200,000 producers. In 2002 the total number of staff was 903, and the overall agency budget was $125,419,000[132].

[131] Information is taken from the website of the New York State Insurance Department.
[132] Data about number of insurers, producers and staff are taken from website of the New York State Insurance Department and 2002 Annual Report of the Superintendent of Insurance to the New York Legislature.
Data about 2002 department budget comes from 2001 NAIC Insurance Department Resources Report.

Company Licensing

In December 2000, the NYSID adopted the NAIC ALERT Program. As a result, all insurance companies were required to use the NAIC uniform certificate of authority applications (UCAA) and after March 2001, the NYSID no longer accepted the previously used New York state licensing package.

In addition to the requirements of the uniform applications, New York has some state-specific requirements. NYSID has to approve the name of the company applying for a license (NYSID suggests that companies have their names approved prior to application filing). The state of New York's surplus requirements, based on the lines of business for which the company is applying, might vary depending on the review of the company's financial projections and plans of operations. Based on the investigations of the officers and directors of the insurers and their parent companies, the NYSID requires that an officer or director be removed if they are deemed to be untrustworthy. Prior to licensing, the NYSID reviews all reinsurance agreements, and makes sure that there aren't any clauses of extra contractual obligations that violate New York State laws. All companies applying for a New York-domestic license must be incorporated through the NYSID and, if applicable, must obtain a permit to solicit stock subscriptions and a license to sell securities. Foreign property and casualty insurers, filing an expansion application, must prove that they have continuously transacted insurance business in their home state or country for at least three years. Life insurers must provide annual statement (Schedule S Part 4), showing reinsurance ceded to unauthorized companies, prepared on a New York basis for the past 3 years. The NYSID has the right to perform an examination of foreign insurers or to request their examination reports from the home state regulator. Alien insurers can enter the New York market if they buy a US company or US Branch or if they acquire a New York domestic license or form a US Branch (the NYSID cannot rely on the home regulator in assessing its risk and operations).

According to the Title 11 of the Compilation of Codes, Rules and Regulations of the State of New York, licenses issued to domestic insurers are for an indefinite term and expire with the expiration or termination of the corporate existence of the company. Licenses issued to foreign or alien insurers are for a period of one year, and are renewed after the company files its annual financial statements.

The NYSID might decide not to grant a license due to non-compliance with relevant New York State laws and regulations, lack of feasibility of business plans and plans of operations, insufficient capital, unacceptable reinsurance or holding company arrangements, or improper treatment of policyholders.

The goal of the NAIC for timeliness in processing primary (domestic) and expansion (foreign) applications is 90 and 60 days, respectively, with it understood that the clock stops once additional information is requested. The average time required to process a new company license application by the NYSID is about six months. Review time is strongly dependent on the applicant's response time to requests for additional information, and resolution of issues

identified by the NYSID. The processing of a new business line application takes less than 60 days.

Asked about the extraterritorial application of New York laws and the incidents of re-domestication of New York domestic companies to other states, the staff shared that the main reason that companies left New York was agent compensation rules. The interviewed also conveyed that now more and more foreign companies were applying for a non-domestic license in the state.

The staff is satisfied with the process of company licensing established at the NYSID. There are 5-6 people that are responsible for application review and approval (Life Bureau – one or two part time; Health Bureau – one part time; Property Bureau – two; Office of General Council – two people part time).

Producer Licensing

Producer licensing is carried out by the Licensing Services Bureau. New York is one of the states that recognize both agents and brokers. Insurance agents are people or organizations that are authorized by one or more insurance companies to sell insurance. Insurance brokers are agents that represent the buyers and try to assist them in finding the best policy through comparison-shopping.

The submission requirements for resident applicants include: filing of a completed application, the score report of an exam taken within one year, proof of accumulation of continuous education credits, a clean background check, and payment of licensing fee. The requirements for non-resident applicants additionally include a clean certification from the state of domicile and proof of compliance with the home state continuous education requirements. For non-resident producers, if all answers to the background questions are negative, the NYSID automatically approves and issues a New York license (New York is fully reciprocal with the NIPR participating states). If a producer applies for an expansion application for product lines that he/she is not selling in her/his state of residence, he/she needs to meet all requirements for NY-domiciled producers. In such cases, it is easier for these producers to get an expansion license in their state of domicile and then apply for a NY expansion license.

NYSID uses the NAIC uniform applications for both its resident and non-resident producers. Currently domestic applications are submitted through the NYSID's online system, via fax or in paper. Non-domestic individual applicants, holding valid licenses outside of New York, can use the National Insurance Producer Registry. The NIPR system significantly reduces the processing time, since the home state certification is automatically transferred to NYSID. The staff estimates that 90% of the licensees transact their business with the NYSID online. It is expected that by the end of the year, the online utilization rate will reach 100%. Those interviewed indicated that about 85,000 applications are renewed each year, and on average it takes about 3 minutes for the renewal. The average time for processing a producer application is about 24-48 hours.

The online system used by the NYSID is very flexible and it has been designed in collaboration with several life insurers. The system allows for online appointments and terminations, license renewals, and electronic payments. It is expected that electronic check payment will become operational soon. The system is used for domestic residents and brokers, and the NYSID uses NIPR for non-resident producers. The staff commented that NYSID worked with the NAIC in the development of NIPR and the producer database (PDB). Those interviewed pointed out that GBLA came after the NAIC and the states had initiated the producer improvement process.

The producer licensing process has been dramatically improved during the last 1-2 years. Recently, New York has passed legislation that makes the insurance licensing process more uniform with the laws of the other states. These changes have a direct impact on the agent appointment process for life and property agents, since they are no longer required to have an appointment in order to receive a license. Currently, agents require an appointment after they execute an agency contract, and the company is given 15 days to issue the appointment.

New York supports reciprocity in producer licensing. The licensing process is extremely seamless and, technically, producers receive national licenses. In the opinion of those interviewed, potential run-to-the-bottom is always possible but it is not realistic. So far, there has not been any evidence that anyone has been hurt. The strength of the existing reciprocity arrangements among states lies in the common producer database: it gives easy access to up-to-date information, and allows for solid consumer protection. Now the only recognizable difference between the states is in the fingerprinting requirement (New York does not have such a requirement).

There are 58 people in the Licensing Services Bureau that deal with producer licensing. The staff disclosed that there are about 200,000 licensees in New York, and the majority of them sell life products.

Product Approval

New York has a prior approval system, where no policy form can be used until it has been filed with and approved by the NYSID. Taking into consideration the amount of life product filings made each year, the NYSID is trying to expedite the review process as much as possible. As a result, it has developed alternative approval procedures for product submissions, in addition to the two statutory submission options under Section 3201(b)(1) and (6) of the Insurance Law. In addition, the NYSID utilizes an internal triage procedure in processing policy form submissions made under the regular prior approval procedure.

Policy forms filed under the regular prior approval process receive a full review. Until the late 1990s, the NYSID staff provided lengthy, detailed comment letters to insurers on their product filings to bring forms into compliance. Often, numerous exchanges of correspondence were needed to bring forms into compliance with applicable requirements. The process was inefficient and did not result in timely approvals. To expedite the approval process and improve the quality of submissions, the NYSID prepared product outlines for all life and annuity products sold in New York and adopted necessary procedural changes, including a 15-day time limit for

responses to Department comment letters, a limit on the number of exchanges of correspondence between the Department and insurer on each product filing, and standards to reject poor quality, non-compliant submissions without full review. As a result, the length of time for the review and disposal of filings has decreased significantly.

In 1997, an alternative policy form approval procedure was enacted. The new procedure in Section 3201(b)(6) of the Insurance Law is designed to expedite approval and prevent delays by deeming forms to be approved if the NYSID fails to act in a timely manner. Under this procedure, the company has to provide certification that the filing complies with all relevant New York statutes and regulations. The NYSID has 60 days to reject the filing outright and 90 days to approve, deny or make comments on the filing. Otherwise, the forms are deemed to be approved. Insurers have not generally chosen to use this procedure since, if the NYSID does not act on their filing, it still takes 90 days for the forms to be deemed approved and their forms are not reviewed or affirmatively approved. In the opinion of the staff, today there are few deemer filings because other submission options exist.

In 2000, the NYSID issued Circular Letter No. 27 to establish another expedited approval procedure based on completed product checklists and appropriate certification signed by an officer of the company. Under this prior approval with certification procedure, the NYSID reviews the submitted certification and checklist(s) which set(s) forth the statutory and regulatory requirements for the form(s) submitted. A transmittal letter is attached to the submission package. The submission letter contains information required by the applicable product outline(s) and a discussion of any innovative features of the product and any negative answers on the checklist. Insurers choosing to use this procedure must include a statement in the submission letter that clearly indicates that the insurer has chosen the "prior approval with certification" procedure. The average disposal time for files submitted under this procedure is currently 34 days. The NYSID has a process for updating the checklists to reflect innovative features.

The triage procedure is used at the discretion of the product manager responsible for the cursory review. The manager makes the decision to triage a submission based upon his/her expectation that the filing can be disposed of (approved, rejected or closed right away) within a short timeframe generally not exceeding 15 minutes. Unlike the certification procedure, companies don’t have to formally request triage for their filings. Each unit manager considers the possibility of triaging every incoming file. However, companies are advised to contact the NYSID and discuss the filing before making the submission if they think it may be triaged. Regardless of notification, the NYSID cannot guarantee that the submission will be triaged, it is simply helpful if the submitting company does so. If the submission cannot be triaged, it will be assigned to an attorney and automatically placed in the attorney’s regular prior approval queue. This process reduces the list of pending filings and expedites approval.

No matter what submission procedure is chosen, prior to making a filing companies are expected to review all applicable product outlines and checklists, which are available on the NYSID web site. If a non-substantive modification is made to an existing product, there may be no need to fill in a checklist, as long as each change is specifically described. At this time about 30% of all filings go through the certification process.

Those interviewed indicated that the New York Insurance Law requires approval of separate account plans of operations for both domestic and non-domestic companies. Any approval of a separate account agreement will not be effective until the separate account plan of operation has been approved. The staff also clarified that the out-of-state filings of New York domiciled companies must be filed with the NYSID pursuant to section 3201(b)(2) of the New York Insurance Law. Such filings will be accepted as long as the issuance would not be prejudicial to the interests of policyholders (i.e., solvency protection). Such forms are not approved for delivery in New York.

In May 2000 the NYSID began accepting electronic filings through SERFF from life companies doing business in New York. This electronic filing and review system allowed the NYSID to reduce the amount of paperwork for both the company and the NYSID and permits a more expeditious transmission of correspondence.

New York is one of the states that participated into the development of the CARFRA product approval standards. In the opinion of the staff, CARFRA was not effective because it did not establish uniform product approval standards. CARFRA permitted each member state to have state-specific deviations. NYSID has received just three filings through CARFRA.

Under the proposed interstate compact, state deviations from uniform standards would not be allowed. The staff clearly understands that life insurers compete with other financial institutions and that uniform product standards will help insurers compete more effectively.

NYSID has been having regular meetings with the Life Insurance Council of New York to discuss and work on various speed to market issues: improving the quality of the product filings made by the companies, and implementing NYSID initiatives to speed up the approval process.

Asked about their opinion on Florida's I-File, the staff stated that they were ready to cooperate in product approval with Florida but they would stay with SERFF.

Currently, the NYSID has 11 attorneys, three actuaries and four support staff in the Life Bureau that deal with product review and approval. The professional staff is assigned to specific product areas and develops an expertise in one or more fields. NYSID receives annually about 7,000 – 10,000 policy forms.

Financial Analysis and Examinations

By law, the NYSID is required to conduct examinations of all domestic insurers, and is given the authority to examine all other insurers that operate or are authorized to operate in the state of New York. The examinations of life insurers are performed by the Life Bureau, which conducts mostly combined (financial and market conduct) exams. In general, the purpose of the financial exam is to verify that financial statements and the conduct of a company are in compliance with all laws, rules and regulations of the state. The goal of the market conduct exam is to determine if policyholders are treated fairly, therefore it focuses on complaint handling, marketing and sales, claims, rate and form filings, policyholder services, privacy issues and board initiatives.

The NYSID collects quarterly and annual financial data from its companies, and the information is uploaded into a central file system. All examiners have access to the central file system, from which they can retrieve various documents on each company (i.e. reports on examination, complaints and company profiles).

Financial exams are performed every 5 years at minimum. The exams may either be full-scope or targeted, depending on the risk-profile of the company. The NYSID is moving towards risk-focused exams, and it has developed a pre-examination process that determines the scope, duration and number of staff assigned to each exam. The pre-examination involves analysis of the available financial data, legal analysis, and analysis of the company's investments.

People from different bureaus within the NYSID and units within the bureau can participate in the exam. The NYSID follows the NAIC Financial and Market Conduct Examiners Handbook and, in addition, has developed other examination procedures. The scope of a typical combined exam includes reviews of financial statements, company history, management and control, corporate records, plans of operations, market conduct activities, company growth, fidelity bonds and other insurance, reinsurance, welfare and pension plans, etc. The exam team also reviews the corrective actions taken by the company with respect to the violations and recommendations noted in previous reports. Examinations are not limited to domestic operations and policyholders. If a New York-domiciled insurer has subsidiaries or affiliates also domiciled in New York, these companies would be examined together, to the extent possible. The duration of an examination depends on the size of the insurer. On average, an examination lasts about 4 months; for large companies, it could take up to 12 months.

The examiners, in conjunction with other NYSID staff that have knowledge regarding the examined company, write the reports on examinations. Throughout the examination process, there is constant communication between the different bureaus within the NYSID. Reports are published on the web site, and are uploaded into the central filing system. If the report has recommendations for certain corrective actions, the company has two months to reply as to how it would comply. In case of a failure to take corrective action, the NYSID might initiate a targeted examination.

The NYSID uses the NAIC system to call zone examinations. Those interviewed indicated that the NYSID rarely participates in examinations called by other states, however, examiners from other insurance departments often participate in NYSID exams.

The staff interviewed indicated that a market conduct analysis handbook was needed. In response to this, it is noted that the NYSID recently reached out to all life insurers to discuss the following: sources of meaningful market conduct data for effective analysis; the development of a market conduct analysis function, and improvements to the current market conduct regulatory process. The NYSID also indicated that it is reviewing its existing standards regarding marketing and sales, underwriting, complaint handling and claims practices in order to promote higher standards in connection to market conduct activities.

The Life Bureau has a staff of 150 people, approximately 50 of which are field examiners. In 2002, the Life Bureau performed 62 examinations of life insurers, charitable organizations, welfare funds, pension funds and fraternal societies.

Consumer Complaints

Handouts: 2002 Annual Ranking of the Automobile Insurance Complaints, 2002 New York Consumer Guide to Health Insurers, New York State External Appeal Program Annual Report

The Consumer Services Bureau is responsible for responding to consumer complaints and inquiries, and investigating the actions of licensed producers. The operations of the bureau are decentralized. It has offices in four locations in the state (Buffalo, New York City, Long Island, and Albany), which perform the following functions: complaints and inquiries handling, outreach to consumers, disaster assistance, background investigation of agents, brokers, new insurers, officers, directors and managers. The disaster assistance function deals with such events as 9/11 and the recent blackout.

The NYSID has a very sophisticated complaint database. The NYSID is aware of all complaints that originate in the state; information about the complaints filed directly to the insurers is gathered during the examinations. This data is used to identify patterns and monitor trends.

If an insurer denies a claim, the NYSID Regulation No. 64-2-16 requires that the insurer advise the consumer to contact the NYSID for an independent review. Consumers can file complaints via fax, mail or online. The NYSID strongly encourages consumers to file their complaints online because they receive immediate acknowledgement. All complaints must include: information about the complainant, the licensee (insurer, broker, agent or adjuster), and the policy, as well as a detailed description of the complaint. When a complaint is filed, a complainant file is created within 24 hours. At that point, a letter is sent to the complainant, informing him of the filing number, and another letter is sent to the company describing the complaint and the information that the insurer should provide in response. NYSID investigates complaints based on the paperwork provided by the insurer.

The NYSID monitors patterns in the complaint data. If a pattern is identified, NYSID identifies all other people that may have been mistreated by the insurer but have not filed complaints. Identification of a complaint pattern might lead to product cancellations, fines, stipulations (company admits a wrong-doing and agrees to pay fine, take corrective action and prevent such actions in the future) etc. If the NYSID identifies patterns in the complaints against a NY domiciled company, it would also review the profile of consumer complaints filed against the company in other states. The complaint database allows for comparison among companies to be made based on product types. The most typical comparison figure is upheld[133] complaints as a percentage of total annual premiums (ratio of 1.0 indicates one upheld complaint for every $1 million in premium). Each complaint and company that gives rise to complaints is monitored and analyzed.

[133] Upheld complaints are those closed complaints where the insurance department agrees with the consumer.

All the complaint information is public information, however the individual complainant information is not. The NYSID publishes a quarterly report on all disciplinary actions taken against insurers and producers, and it is posted on its web site. The most drastic measure against producers is license suspension or revocation (usually for money theft). These statistics are also used for an annual ranking of insurers, and for reports to the legislature. Currently, the NYSID does not publish the report ranking life companies, however it can be generated upon request.

New York has an external appeals process. The external reviews are performed by organizations certified by the State of New York. To request an external review, the complainant must complete an application, which has to be submitted to the NYSID within 45 days of receiving an adverse decision. For a standard review, the review organization must make a determination within 30 days.

The Consumer Services Bureau has a staff of 111 people. Annually, the bureau responds to approximately 450,000 calls. In 2002 the NYSID closed approximately 83,000 complaints and investigations. In view of the staff, it is not only the quantity of consumer service provided that they are proud of, but also the level of personal service that a complainant gets. The outreach efforts are of great importance to the NYSID, especially services provided to business and private residencies in and around the World trade Center after 9/11.

View on the OFC

The staff indicated that it is difficult to take any position on federal chartering, especially since nothing is known about the standards that would be used. The NYSID will stay close to the NAIC, since the solution to all existing problems is in future cooperation with the state insurance departments.

In general terms, state insurance regulation is closer to the people served by its insurance agencies and closer to changes in the market place. Those interviewed voiced serious concerns about the centralization of authorities. It was pointed out that the federal government is not capable of immediate reaction and close contact in a situation of disaster.

The fact that the federal charter might be optional is confusing for the industry. The uniformity proposed by the charter cannot be achieved if the federal charter is optional. The recent NARAB initiative demonstrated to the industry that problems could be resolved through means other than federal regulation.

Federal regulation provides for a base level of protection of consumers and this level will be lower than the level of protection under the current state-based system. Our project should try to calculate not only the savings for the industry and the consumer, but also the value of the regulation that will result from the reorganization.

Texas Department of Insurance (TDI)

August 26, 2003
Interviews by Kristina Donkova & Ellen Hatch

TDI Staff Interviewed:

Betty Patterson, Senior Associate Commissioner, Financial Program
Audrey Selden, Senior Associate Commissioner, Consumer Protection
Jack Evins, Director, Advertising Unit
Valerie Brown, Director, Complaints Resolution, Consumer Protection
Melissa Hield, Director, Special Projects, Consumer Protection
Danny Saenz, Deputy Commissioner, Financial Analysis and Examinations
Godwin Ohaechesi, Director, Company Licensing & Registration
Matt Ray, Deputy Commissioner, Licensing Division
Cindy Carpenter, Director, Accident and Health Section Life/Health Division
Jacqueline P. Murphy-Robinson, Director, Life, Annuity & Credit Section Life/Health Division
Lynda Nesenholtz, Special Advisor

Organizational Structure of TDI

Commissioner of the Texas Department of Insurance: José Montemayor

The Texas Department of Insurance carries the responsibility for the financial stability of the insurance industry and availability of quality insurance products for all consumers at reasonable prices and under reasonable terms. The regulatory operations of the department are separated into eight programs. The Financial Program licenses insurance carriers, monitors the solvency and market conduct of licensed insurers, and rehabilitates the financially troubled companies. The Life, Health and Licensing Program regulates policy forms, licenses insurance agents, and monitors compliance with relevant insurance statutes. The Consumer Protection Program assists consumers by resolving consumer complaints, providing insurance information via telephone, online and through publications, and reviewing insurance advertising. The department has direct regulatory responsibility over approximately 1,978[134] domestic insurance companies.

[134] See 2002 Annual Report to the Governor and Legislature.

Company Licensing
Godwin Ohaechesi

The department has been using uniform UCAA application since 2001. While the UCAA forms are used by multi-state companies, insurers writing in Texas only prefer and still use the Texas-specific application. Applications can by filed electronically or in paper form. Electronic filings still require a few documents to be filed as hard copies. Instructions for electronic filing can be accessed through the TDI web page or the NAIC web site. Currently the only deviation from the UCAA is Texas' fingerprinting requirement. Electronic filings have been made 2 times, and they were related to expansion applications. The staff shared that electronic applications could speed the filing process for the company, especially if part of the information has been pre-populated. NAIC is working on pre-populating most of the information.

TDI licenses about 40 companies per year. The average time necessary to process an expansion application is less than 60 days (from the date a complete application is received). When an application is received, the department checks it for completeness. Then the application goes through financial review and operational review. The goal of the financial review is to determine the economic feasibility of the business plans of the company. The staff reviews the financial statements and other information provided, and the company's compliance with various statutory requirements. The operational review includes background checks and management assessment. TDI performs a detailed analysis of the competence, fitness and reputation of the officers and directors of the company, as well as of the person having control of the insurer. The criminal background check is performed through the Texas Department of Public Safety (DPS) and Federal Bureau of Investigation (FBI). All the checks and analytical work are performed simultaneously. TDI reviews the report of examination from the state of domicile, and it usually performs further investigation if necessary. TDI generally relies on the states of domicile, and investigations are performed to check the past experience of the company. TDI staff explained that Texas has a bigger market than most other states and examination reports might not be sufficient to determine potential risk, particularly if the company has no experience in the risk(s) it is seeking approval to write. An alien company can participate in the Texas insurance market by applying for registration as a surplus lines carrier or it can establish a US Branch with Texas or any other state as the Port of Entry.

TDI does not have a license renewal process. The license is effective until revoked.

The Director of Company Licensing characterized the department as large and well staffed. Delays are mainly due to incomplete application and necessary follow-ups.

The staff indicated that there was very good communication among the states. NAIC had been very effective in facilitating the activity of the states, however there was room for improvement. The staff shared that a licensing model act, which would establish uniform licensing standards, was needed.

Agent Licensing

Producer licensing is performed by the Life, Health and Licensing program. Each year TDI licenses about 50,000 agents and adjusters. Licenses are renewed every two years after payment of a renewal fee and attestation of completion of 30 hours of continuing education has been presented (Limited Lines licensees must complete only 10 hours every two years). TDI has posted all agent-licensing requirements on its web site. Additionally, the insurance department has developed a handbook that describes the agent licensing process.

The examination activity is outsourced with a private vendor, who organizes agents' examinations; reviews applications and sends the application information to the insurance department. All domestic applications are filed in paper, but if they go through the outside vendor, they are uploaded into the department database. The criminal and background check is a significant part of the application process. Texas is one of the largest states that have a fingerprinting requirement[135]. There are currently 15 testing centers that have electronic fingerprinting capabilities, which significantly reduces paperwork.

Texas is one of the forty-seven states that have satisfied the uniform producer licensing criteria, and it accepts both individual and business non-resident licensing applications. TDI grants reciprocity to every state, and accepts all the certifications presented by non-resident producers. Texas does not require a fingerprint card from non-resident applicants that are licensed and in good standing in their home state. Currently Texas is accepting only paper non-resident applications but after December 2004 it will begin accepting electronic non-resident filings for individual applicants as well. In keeping with the reciprocity standard Texas will not expand the license of a non-resident to include lines that the agent does not currently sell in its home state. The insurance department uses a different application for its resident agents. This application is reviewed more closely, and it includes a notarized signature of the agent and a fingerprint card requirement.

The department tries to automate its operations as much as possible. License renewals, company appointments and electronic payments (for appointments and renewals) can be processed electronically. Renewal notices are automatically sent to each licensee 90 days prior to the license's expiration date.

92% of all filings are approved in 15 days. The time for license renewal is much shorter. Delays mostly result from incomplete applications: lack of certification from the state of residence (for paper applications), lack of appointment by an insurer, etc. Incomplete applications can be processed if the needed information is not crucial for its approval. If the information is not presented in time, the application is rejected and the whole process starts all over again. License revocations go through the legal or consumer protection division.

Currently Texas has 265,343 licensed insurance producers. TDI generates annually around $5 million from license renewal, $2.5 million from new licenses, $4 million from company

[135] Currently 12 states have fingerprinting requirements.

appointments, and $190,000 from continuing education (CE) courses. Additionally, TDI generates revenues for the state from the companies that carry out the CE courses.

Product Approval

Product approval is carried out by the Life, Health and Licensing program. Texas has a broad spectrum of product filing options. When a company is making a product filing it must clearly indicate under which filing mode it is being submitted. The filing modes are:

- Prior Approval;
- File and Use;
- Exempt from Review;
- Correction to a Pending Filing;
- Resubmission of a Previously Disapproved Form;
- Exact Copy of a Previously Approved One;
- Product Similar to a Previously Approved One, and
- Substitution of a Previously Approved or Exempted Form.

Texas has established file-and-use regime for life and accident & health products. However the commissioner has the authority to change a company to a prior approval system anytime if it is determined that it is abusing the file-and-use regime. For products filed for use, the company has to provide a certification that the filing complies with all relevant statutes and laws. At the expiration of 60 days, the filing is deemed approved unless prior to that date TDI affirmatively approved or disapproved the filing, unless the insurer has requested in writing prior to that date that the approval period be extended for an additional period not to exceed 45 days.

When products are filed for approval and the review indicates that significant corrections should be made, the filing is disapproved. If the review indicates a small number of corrections are necessary, the reviewer will contact the insurer and request corrections to the filing. For filings that have been disapproved, the insurer is given the chance to resubmit the disapproved filing within 45 days. The review of a resubmitted filing is much faster than that of a new filing. Filings that are exempt from review require certification of compliance with all applicable laws and rules.

Texas participated in the development of the uniform CARFRA standards and is one of the twenty-two CARFRA member states. According to the staff, TDI has received several life and annuity filings. The department approves a filing only after all state deviations have been addressed. The matrix of state product deviations indicates that like many other states Texas has deviations from the uniform standards for three CARFRA products (annuity, Medicare supplement, term life). The insurance department is not aware of what prevents the companies from making CARFRA filings.

Staff indicated that TDI strongly supports the interstate compact, and TDI has led a team in developing the annuity standards. The Texas Legislature would have to initiate an adoption of an interstate compact and the legislature does not meet until 2005 (next session).

TDI is constantly improving the product approval process. The insurance department has periodic workshops with industry participants. Additionally, the Life/Health Division has management that work with staff to assist with the review of new and innovative products. Until recently TDI could not accept product filings through SERFF, because state-filing rules did not allow for electronic filings. Effective August 1, 2003 TDI started accepting annuity filings through SERFF and as of August 26, 2003, three filings have been received. It is expected that TDI would start receiving life and, accident & health filings through SERFF in 2004.

Staff indicated that the average turnaround time for the combination of all product-filing modes is 30 days. The time for approval of innovative products is generally longer. Those interviewed pointed out that delays occur rarely. Some of the delay is due to a slow insurer response. They discussed a case when the product approval took longer than a year. In 2001 an insurer filed an amendment to a variable annuity contract and the insurance department requested additional information. Due to slow company response the product was approved in 2002.

In general the staff was satisfied with the product approval process. They pointed out that the department was trying work with the industry to identify the areas where improvement could be achieved.

Financial Analysis and Examinations
Danny Saenz

TDI performs financial analysis of its domestic companies on a quarterly basis and performs analysis of foreign insurers as needed, based on priority and market share. The financial analysis is based on quarterly and annual financial statements and depends on the life curve of the company. Each company is assigned to a financial analyst who is responsible for monitoring the companies on an ongoing basis. When a company is a part of an insurance group, the financial analysis additionally considers the following factors: relationship among affiliated companies, management discussion and analysis reports, SEC filings for the public companies, independent auditor reports, actuarial opinions, AM Best Reports, etc. All of these documents are currently submitted to TDI in hard copies. The insurance department also receives company information electronically from the NAIC databases. In the opinion of the staff, currently there is a push for all companies to submit all of this information electronically.

These reports are also used by an early warning system, which calculates various ratios and informs staff when the ratios are out of range. These ratios are periodically summarized by the analyst in a report that goes to their analysis supervisor. Three supervisors assess all the 2,100 reviews prepared each year, and when necessary they have the right to request additional information from the analysts or other staff.

The TDI has a priority list of the companies that it regulates. This list is unofficial and is based upon: NAIC FAST score, financial analyst assessment, complaint profile, actuarial opinion, etc. It is used to schedule reviews, and examinations. The insurance department develops its examination schedule in advance and revises the schedule throughout the year for various reasons, which may include insufficient travel dollars or staff to conduct examinations.

Texas has a three-year examination cycle, however, certain insurers may be deferred to a five-year examination cycle if the company to be examined has met certain financial solvency standards. Examinations are performed out of three field offices: San Antonio, Houston and Dallas. The list of the companies that have to be examined is prepared in Austin, and the field offices are responsible for scheduling the examinations depending on their available resources. About 170 exams are performed per year. Of these, 10-15 are targeted financial exams, and 10-15 are market conduct exams.

Texas uses the NAIC Financial Condition Examiners Handbook in performing its financial examinations. No risk ratings are assigned to the companies based on the findings of the examination. Before the end of the onsite exam, the team has an exit meeting with the management of the company and discusses the examination report and its recommendations. Later on the report is officially sent to the company, and management of the insurer has 15 days to appeal the examination if they disagrees with the examiners findings. In case of no appeal, the report is deemed adopted and is sent to the regulators in the other states where the company is licensed to operate. At that point all databases are updated based on the findings in the report of examination. Examination reports are considered confidential by law and may not be disclosed to the public.

In general, the standard is for exams to be completed within 18 months of the as of date of the annual statement. Due to the lack of examiners, travel dollars and cooperation from management examinations sometimes take longer to complete. Companies are billed for the examination hours and travel expenses of examiners. The money received for these examinations is credited to the State's general revenue fund and not specifically maintained for the sole purpose of the Texas Department of Insurance. Insurers are allowed to write off or credit these examination expenses against their premium taxes; however insurers maintaining their books and records out of state may only write off salary expenses and not travel expenses against their premium taxes.

The most common actions against companies include: fines and penalties, limitations on transactions with affiliated parties; and limitations on writing product lines. If the financial condition of the company is in danger, it can be put under supervision or conservation. When a company is under supervision, it still has its management team but TDI examiners approve the operations of the company. When the insurer is under conservation, it is basically under management by the TDI, which is responsible for the rehabilitation of the company. If no rehabilitation is possible, the company is put into liquidation, under which a special deputy receiver is contracted to oversee the receivership estate. The receiver works with the state guarantee funds, and deals with the sale of product lines and portfolios, and payments to policyholders and claimants. The state guarantee fund may immediately assess the surviving insurers depending on the premium volume that they write in a particular line.

TDI has the option to participate in NAIC Zone Examinations, but it very rarely participates in zone exams called by other states. In the last 5 years there was only one occasion when a TDI examiner participated in an exam led by another state. This is due primarily to a lack of sufficient resources. Most often examiners from other states participate on TDI initiated exams.

In Zone exams the out-of-state examiners primarily review areas their state is concerned with, however, they do review other items as assigned by the Examiner-in-Charge.

The NAIC Financial Analysis Working group actively assists the examination process. It organizes annual meetings and quarterly conference calls to discuss the financial condition of the nationally significant companies. The purpose of these meetings and phone calls is to facilitate cooperation among the different states. They also point out concerns regarding problematic companies. TDI has rarely been surprised by adverse developments in its domestic companies; such surprises come mostly from developments in the foreign companies.

Financial examinations and analysis areas have undergone significant restructuring during the last 3-4 years. Four years ago the analysis and examination functions were merged. The current system allows for much better examination scheduling, communication and coordination of issues and concerns regarding particular insurers. A team concept in examinations has been introduced where senior examiners are put in charge of teams responsible for certain companies. Despite the fact that analysts are responsible for particular companies, they rarely participate in the onsite examinations; however, they do communicate and provide information with the on-site examination team. TDI has considered including the analysts in the on-site examination process, initially in the Austin office, however this initiative is hampered by the lack of travel dollars.

TDI has signed agreements with the following institutions: OCC, FDIC, state banking departments, and insurance regulators in Mexico and the UK. In 2002 TDI performed coordinated exams with the SEC on privacy and annuities issues. The SEC reviewed the investment side of the business. In Texas few financial institutions have acquired insurance agencies, but there are not any Texas-domiciled insurers that have entered the banking business.

The department has about 50 financial examiners (22-24 in Dallas, 12-14 in Houston and 12 in San Antonio), and 6 market conduct examiners (1 assistant chief examiner and 5 examiners). TDI currently has 5 vacancies for field examiners and 2 vacancies for financial analysts. The total number of staff in analysis and examinations is 131, which is 14% of the total agency staff[136]. Data presented by those interviewed indicates that the overall budget of the financial examination and analysis division is 14.5% of the entire agency budget[137].

Market Conduct Examinations
Danny Saenz

TDI is not mandated by law to perform regular market conduct examinations, however the TDI does have the authority to perform market conduct examinations as the need arises. TDI has developed its own market conduct examination procedures and utilizes the NAIC Market Conduct Examiners Handbook on an as needed basis. TDI usually does not perform comprehensive market conduct exams, but instead performs examinations of specific issues and

[136] The full time equivalent of agency staff is 947.
[137] The overall agency budget is $50,884,739. The budgets of the Examination and Analysis areas are respectively $4,740,315.84 and 2,617,986.61.

concerns. TDI would like to perform more market conduct exams but it would require more resources than are available.

The insurance department performs about 10-15 market conduct exams per year; of these 1-2 are comprehensive exams. Market conduct issues are reviewed on a limited basis as part of a scheduled financial exam and if material concerns are encountered they may be referred for a more detailed market conduct examination. TDI believes that the industry might carry certain risks that are not perceived by the regulator due to the regulator's limited resources. If there are concerns about market conduct issues, other areas of TDI might be engaged in reviewing the problems wherever they arise (complaints, claims, agent, management and analysis bureaus).

TDI has a set of procedures that vary with respect to the area that is being reviewed. They use the NAIC Market Conduct Examiners Handbook on a limited basis, because it is too detailed for the focused exams that they perform.

Texas does not generally perform or participate in multi-state market conduct exams although Texas has passively participated in multi-state exams initiated by other states in the past. The staff indicated that states need more coordination in terms of uniformity of rules and standards, and acceptance of the reports issued by the domestic states. Uniformity and standards in market conduct are much needed in order for the states to be more efficient and effective in market conduct regulation. A way to accomplish this is to establish an accreditation program for market conduct similar to the accreditation program already in place for financial regulation.

Market conduct review started in 1988 in the Consumer Protection area. At that time there were 15 examiners. Later on the market conduct review responsibility was shifted between the financial examinations and consumer protection areas. In 1994 there was a push to institute a true market conduct division. The head of the division communicated his desire to create a division that monitors the insurers, the overall industry and the market place.

In relation to the recently issued NCOIL report, the staff indicates that TDI is ready to rely upon the findings of the companies about their market conduct issues.

TDI is generally satisfied with the financial analysis and exam process but not satisfied with the market-conduct review process at the national level. In the market conduct area, the following should be achieved: better exam coordination; better automation to support the pre-examination and exam processes; better utilization of the Teammate software for maintenance of exam work papers; development of model laws for standardization and accreditation; development of a system for an online examination scheduling that would facilitate the companies in preparing all the documentation needed by examiners, and development of a centralized database for company related exam and analysis documentation.

Consumer Complaints
Audrey Selden, Jack Evins, Valerie Brown, Melissa Hield

Handouts: Written responses to interview guide questions on consumer complaints (answers included in quotes in the following notes), Printout of online consumer complaint information and forms, sample complaints data including complaints by line of coverage, partial list of complaint inquiry system (CIS) codes, TDI plastic bag with consumer information.

At TDI most consumer complaints (80-85%) are handled by Consumer Protection (CP) Complaints Resolution staff. HMO complaints are handled by the HMO division in Life, Health & Licensing program (LHL), and certain complaints about commercial and personal lines are handled by Property & Casualty program staff.

TDI accepts complaints in any written form, and all complaints are filed centrally in Austin. Consumers may file complaints on-line (website or email), or on paper (mail or fax of a print copy of the complaint form). For walk-in customers, the staff takes down the information on a complaint form, and in emergency situations TDI may take the information over the phone. Complaints are scanned into a database so that TDI staff can view the actual complaint and share the information internally. The database, the Complaint Inquiry System (CIS), is compliant with the NAIC Complaints Database System (CDS). The department submits data on closed complaints to the NAIC CDS in quarterly reports. Since CIS does not have identical coding to the NAIC database, the Texas department has a program to convert its data to NAIC codes.

When a complaint is received, it is date-stamped, scanned into the Complaints Workflow System, and routed to a complaints intake specialist who enters it in the Complaint Inquiry System (CIS). Then TDI sends the insurer, agent, or other insurance entities a copy of the complaint with a request for information about how the matter was handled. The letter and the complaint are faxed or mailed to the company. The company has ten days to respond. During this time, the complaint is held in a pending file. When the company's response is received, it is scanned and attached to the electronic complaint. Based on a review of the information provided, the complaint specialist may then request additional information from the complainant. Another request to the company may be necessary. When the complaint specialist has reviewed all information provided, the specialist writes a closing letter to the complainant. The file is sent to an auditor who reviews the entire file and the closing letter. The auditor closes the file in CIS. If the auditor finds that the specialist needs to do further analysis, or there is an error in the file, the auditor returns the file to the specialist. After any errors are reconciled, the file is closed. The closing letter is printed and mailed to the complainant along with a copy of the company's letter, then a copy is attached to the file. About ten percent of the closed files receive a second audit as part of CP's review to make sure performance measure data is accurate. Finally, closed files are stored in an electronic "file cabinet." Complaint data is available on the TDI website. TDI believes that being open about complaint data helps keep the industry in check. In FY 2003, the department's average processing time was 55 days.

TDI is usually aware of only the complaints filed by consumers with TDI. Additionally, the insurance department requires companies to keep a log of all complaints filed with them. This requirement is patterned on model NAIC complaint law. TDI's Market Conduct examiners may

review these complaint logs during the course of their examinations, and Legal staff may review them as part of an enforcement investigation. The Legal department also reviews data for trends and patterns. Consumer Protection staff are the owners of the complaints database (CIS).

As examples of the types of statistical information they maintain on complaints, CP provided several sample queries and indicated a willingness to run additional queries on request. Out of all lines of coverage, individual life came in 9th for number of complaints at 1,407, disability income in 12th at 646, and annuities 15th at 394.

CP does not currently send out a consumer satisfaction survey to complainants after the complaints are closed. However, as part of their FY 2004 business plan they are developing a survey that will distinguish relative satisfaction with the CP service versus satisfaction with the result of the complaint.

The Legal and Compliance Division may take action based on complaint data. Possible actions include a fine, penalty, restitution (requires an administrative order), and license revocation. All producer and company actions are reported to the NAIC system.

In FY 2003, TDI returned over $48 million to consumers; the Consumer Protection budget was $3.6 million. The CP section is staffed by 22 complaints specialists, who resolve consumer complaints by reviewing the complaint documents and applicable statutes and rules, 16 administrative technicians who enter complaints in the database, type and fax correspondence, and one manager. Complaints Specialists are assigned to P&C or Life, Accident and Health (LAH) complaints.

View on OFC

Those interviewed indicated that efficient state-based regulation is best for the consumer. In their opinion efforts should be directed to making the state-based system more efficient. Staff also stated that the federal bureaucracy would never be able to address all consumer issues the way that the states can do it; it would create various job issues in the states, and would not be able to deal with the differences in regional specifics. The staff believes that state insurance departments are and would be the best option for insurance regulation.

APPENDIX C

Federal Banking Regulators Survey Responses Summary

In 2003 four federal banking regulators (FDIC, FRB, OCC, OTS) completed two questionnaires for this project. The first survey covered primarily safety and soundness examinations and enforcement issues. The second survey focused on consumer complaint processing and compliance examinations. A compliance examination assesses a financial institution in terms of its fulfillment of federal law and regulation, with emphasis on consumer protection and non-discrimination. The discussion in this summary highlights certain aspects of bank or thrift supervision programs of the federal bank and thrift supervisory agencies and should not be viewed as a comprehensive overview of the agencies' supervisory operations.

Budget

The four federal regulators are all self-funded. OCC and OTS both receive the vast majority of their funding, 96.2% and 90% respectively, from assessments charged to regulated institutions. OTS' self-assessments on thrifts are based on three components: the thrifts size, its condition, and the complexity of its portfolio. OTS' other sources of revenue include application fees, interest, rents and subleases, and exam fees. OCC also has a small percent of funding from investment income on U.S. Treasury Securities. FDIC and FRB receive funding primarily from earnings. The Bank Insurance Fund earns interest on U.S. Treasury Obligations and Deposit Insurance Assessments. The Federal Reserve System derives the majority of its income from earnings on U.S. government securities acquired through open market operations.

Total Budget Over Last Five Years (in millions)

	1999	2000	2001	2002	2003
FDIC	1215.8	1186.5	1115.8	1216.1	1100
FRB	541.9	570.2	518.4	556.7	597.1 (a)
OCC	384	391.9	420.1	422.4	451.1
OTS	154.3	158.6	162.3	163.5	157.7

(a)Estimate.

Compliance and Safety & Soundness Examination Funding

	% of Budget Spent on Examinations	Self-funded
FDIC	48%	Yes
FRB	73%	Yes
OCC	85% (a)	Yes
OTS	77%	Yes

(a) OCC's entire Supervise program including customer assistance and enforcement is 85% of budget.

Safety & Soundness Budget Allocations

	% Spent on Examination Personnel	% Spent on Travel	% Spent on Training	% Spent on Systems
FDIC	72%	7%	1%	9%
FRB	55.7%	4.8%	11%	-
OCC (a)	-	-	-	-
OTS	84%	8%	3%	8%

(a) OCC does not have publicly available information that would provide breakdown in these areas.

Information on the budget allocations to particular program areas was limited by the tracking systems of the regulators as well as the amount of financial data publicly available. OCC's budget, for instance, is tracked by 4 major program areas: supervise, charter, regulate, and analyze risk. The supervise area includes 3 subprograms: examining, enforcing, ensuring fair access & fair treatment. Costs are not broken down to the subprogram area. Expenses for OCC's charter program, including organizing and licensing, are 3% of its overall budget.

OTS spends about 1% of its budget on consumer complaint processing and 1.3% on enforcement. In addition, OTS has recently converted to a new billing system and will be able to track budget allocations on charter applications in the future. FDIC reports spending 0.46% of its total budget on assisting consumers with complaints. FDIC also plans to implement a new cost management system that will enable the corporation to capture total costs of processing enforcement actions as well as other items.

Examination Personnel

Safety & Soundness Examination Staff

	Total # of FTEs Supporting S&S Exams	Total # of Examiners	Total Assets of Regulated Institutions	Total # of Institutions Regulated
FDIC	2,758	1,755	$33.4 billion	
FRB	2,584	1,234	$1.9/$8.2 trillion (a)	950/5,128 (a)
OCC	2,372	1,882	$3.9 trillion	2,150/53 (c)
OTS	730	526	$1.4 /$5.3 trillion (b)	958/1,021 (b)

(a) The first number is for FRB-regulated, state-chartered member banks, the second for bank holding companies, including those operating as financial holding companies.
(b) The first number is for OTS regulated thrifts, the second for thrift holding companies.
(c) The first number is for national banks and the second is federal branches of foreign banks.

Examiner Pay

	Avg. Years of Examiner Experience	Avg. Examiner Pay	Range in Examiner Pay
FDIC	12 to 20 years (a)	$68,477	$36,849-$111,020
FRB	13.7 yrs.	$74,743	$53,133-$104,023
OCC	15.5/16.6 yrs. (b)	$79,578	$30,000-$150,000
OTS	19.3 yrs.	$82,029	$34,600-$147,242

(a) This range was given as "average tenure", so average years of experience is likely to be less.
(b) The first number is for years of OCC experience, the second for total government experience.

Examiner Accreditation

	Examiner Accreditation Required	% of Examiners Accredited
FDIC	Yes	95%
FRB	Yes	72%
OCC	Yes	79%
OTS	Yes	95%

The average examiner at OCC, OTS and FDIC holds a bachelor's degree. In addition all four banking regulators have accreditation requirements for examiners. FRB has the Federal Reserve Commissioning Program, which takes from 1 to 4 years to complete. Fifth year OCC examiners take the Uniform Condition Exam to get accreditation. Prior to examination OCC prepares examiners primarily through on the job training. OTS has accreditation requirements for safety and soundness/compliance, information technology, and trust examiners. The accreditation process takes approximately 3-4 years and includes formal classes, on the job mentoring and training, written tests and oral presentations. Similarly FDIC requires commissioned safety and soundness examiners to complete four core training schools, on the job training and a technical evaluation. The training schools focus on an introduction to examinations, financial institution analysis, loan analysis, and examination management.

OCC, OTS and FDIC note that examiners dealing with derivatives analysis typically have additional training. FDIC examiners who hold the title "Capital Markets Specialists" preferably should have a Certified Financial Analyst (CFA) certification. Similarly OTS' Capital Market Specialists receive specialized training annually and some of these specialists hold a CFA designation. OCC examiners dealing with derivatives analysis are typically credit experts that have experience with capital markets. Although not required, these examiners generally attend specialized training courses including the FFIEC Capital Markets course.

Enforcement Staff

	Total # of FTEs Supporting Enforcement	Avg. Years of Experience
FDIC	**238**	**15 yrs.**
FRB (a)	**-**	**-**
OCC	**39**	**25/10** (c)
OTS	**11**(b)	**22 yrs.** (d)

(a) FRB did not provide information regarding Enforcement Staff level or years of experience
(b) 11 FTEs are exclusively devoted to enforcement, and another 7 FTEs in regional offices engage in some enforcement activities.
(c) Examiners in the OCC's Special Supervision Division average 25 years experience, while attorneys in the Enforcement & Compliance Division average 10 years.
(d) Average given specifically for attorneys.

The three regulators who gave information on enforcement staff all report that attorneys have J.D. degrees. The attorneys in the enforcement area at OTS receive training annually on issues relating to regulation of insured depository institutions and fraudulent activities. OCC does not require enforcement training but staff are encouraged to attend FFIEC bank fraud, FFIEC White Collar Crime, and other courses such as deposition training and trial advocacy.

Safety and Soundness Examinations

Federal regulators generally conduct safety and soundness examinations annually. All four regulators note that some institutions receive examinations on 18 month intervals under specifically delineated conditions. For instance, OTS' regulations require small institutions (assets of $250 million or less) to be examined within an 18 month interval as long as it is well capitalized, was shown in last examination to be well managed and in good condition, does not have a formal enforcement proceeding, and has not changed ownership in the last year. OTS also pointed out that it has the discretion to conduct additional examinations if necessary. FRB's exam cycles depend on asset size, ratings and institution type. FRB exams also may include additional targeted examinations as needed.

Three of the regulators (FDIC, FRB, OCC) report that they occasionally combine safety and soundness examinations with compliance examinations. FDIC notes that the examination due date, per statutory requirements, or staffing constraints sometimes precludes the scheduling of concurrent examinations. As part of a restructuring plan announced in 2002, OTS began conducting a melded examination, with both safety and soundness and compliance functions. This combined examination now produces one report of examination and has a more comprehensive assessment of an institution's risk profile. OTS continues to maintain specialists in both areas, while instituting a training process for all examiners to adopt a broader level of expertise.

Safety and soundness examinations include on-site visits for institutions by all of the federal regulators. The one exception is that FRB may conduct either on-site inspections

or off-site reviews for bank holding companies. The determination of the appropriate type of supervisory activity depends on the size and complexity of the bank holding company.

The average length of time for safety and soundness examinations and on-site visits varies by regulator.

OCC Safety and Soundness Examinations for Institutions of Different Asset Sizes

	Avg. Length of Exam (a)	Avg. Length of an On-Site Visit	Avg. # of Examiners for On-Site Visit
Assets >$10 billion	Continuous	Continuous	20-30
Assets $1-10 billion	On-going	On-going	10-20
Assets< $1 billion	-	2-3 weeks	3-10

(a) Length measured from notification of exam to issuance of final report. Continuous refers to resident on-site examinations. On-going refers to dedicated staff with on-going focus on the institution but no resident staff.

OCC has 20-30 in-residence staff at the 10 largest banks it regulates. Staff include an examiner in charge (EIC) and team leaders. At the EIC level there is a formal rotation on a 3-5 year cycle. The rotation is important because of the complexity, the need to learn new areas and to re-evaluate and look at institutions in different ways. Team leaders are also rotated though less than EICs. Additionally there are at-large teams in geographic regions that flow from one large bank to another to supplement the work at particularly points.

FDIC reported the following data for safety and soundness examinations:

FDIC Safety and Soundness Examinations for Institutions of Different Asset Sizes

	Avg. Length of Exam (a)	Avg. Length of an On-Site Visit	Avg. # of Examiners for On-Site Visit
Assets >$10 billion	98 days	74 days	5
Assets $1-10 billion	72 days	47 days	5
Assets< $1 billion	53 days	30 days	4

(a) Length measured from notification of exam to issuance of final report.

FDIC also notes that the length of time from the start of an exam to the issuance of a final report is dependent not only on asset size, but examination findings, and if a joint examination, coordination with the State authorities. Additionally the actual length of time spent on-site to conduct an examination is dependent on not only asset size, but complexity, tenure of senior management, and prior examination ratings. The examination staff for an on-site visit includes one examiner in charge, one asset manager, one operations manager, and one or two examiners, depending on the size and complexity of the institution, to review credit relationships. The FDIC, with the cooperation of other regulators, have assigned “dedicated” examiners to each of the eight largest insured banking institutions to monitor their operations and provide more timely

information about emerging risks. FDIC examiners reportedly work closely with their counterparts at the federal financial regulatory agencies that are the primary supervisors of those institutions and provide real-time access to information on those institutions. So FDIC has one in-residence examiner assigned to each of its five largest regulated institutions (with assets ranging from $1.187 billion to $364 million).

OTS tracks examination time in "person days", which is defined as total exam hours divided by eight. OTS uses six categories of asset sizes for analysis.

OTS Safety and Soundness Examinations for Institutions of Different Asset Sizes (time in "person days")

	Avg. Length of Exam (a)	**Avg. Length of an On-Site Visit**
Assets > $15 billion (b)	572	527
Assets $5-15 billion	253	208
Assets $1-5 billion	161	116
Assets $0.5 million -$1 billion	137	92
Assets $250-500 million	112	67
Assets < $250 million	85	40

(a) Length measured from notification of exam to issuance of final report. OTS provided average lengths based on the tracked duration of an on-site visit plus an additional 45 days to account for the notification period and office review process.

(b) This category is somewhat skewed since it includes WAMU, which has assets in excess of $277 billion.

OTS determines the size of the examination staff for particular assignments based on the complexity of the operations and availability of resources. The number of exam staff may vary during the duration of the on-site visit. On occasion OTS shares on-site examination duties with the staff of other regulators. OTS does not have in-residence examiners assigned to its largest institutions. The organization believes that a resident examiner, after time, may get too close to institution personnel, policies, and practices. Instead OTS uses a portfolio approach. A team of examiners are assigned to a particular examination and are rotated every few years. Nonetheless OTS ensures that a few key examiners remain on the same examination for two consecutive years to ensure continuity. OTS also monitors the financial condition of institutions. Additionally OTS maintains almost continuous contact with large and complex institutions.

Enforcement Actions

Enforcement Actions in 2002

	FDIC	FRB	OCC	OTS
# of Actions (a)	**162**	**32**	**157**	**38**
Cease & Desist Orders	**44**	**-**	**36**	**17**
Civil Money Penalties	**66**	**-**	**23**	**2**
Prompt Corrective Action	**-**	**-**	**1**	**3**
Removals & Prohibitions	**15** (b)	**-**	**28**	**8**

(a) FDIC, FRB and OTS specifically note that this data is for formal actions as opposed to informal actions.
(b) FDIC reports removal & prohibitions of a director or officer, rather than for "institution affiliated parties" which is broader category used by OCC and OTS.

In addition to the above chart, in 2002 OCC indicated 69 formal agreements and OTS listed 8 supervisory agreements. For 2002 FDIC also listed 14 voluntary terminations of insurance, 4 notices of cease and desist charges, 4 notices of intention to remove/prohibit, 7 orders of investigation, and 8 miscellaneous actions. OTS noted that informal actions are usually the first step in resolving problems and occur many more times than the formal enforcement (listed in above chart). FRB indicated that there were 116 informal actions in 2002 (more than twice as many as the formal actions).

FDIC provided the following breakdown of enforcement actions by asset groups of its regulated institutions:

FDIC Enforcement Actions in Last Five Years by Asset Group

Total Assets	2002	2001	2000	1999	1998
>$10 billion	2	1	0	0	0
$1-10 billion	0	12	11	7	5
< $1 billion	203	222	214	136	159
No data**	1	2	5	6	3
Totals*	206	237	230	149	167

* Includes actions initiated by the FDIC, another Federal regulatory agency, or State Authorities.
**Actions taken against entities that are not financial institutions, therefore no asset information available (i.e. data processing centers).

OTS does not keep enforcement action data correlated by asset type. However OTS representatives estimated that 90% of the industry that is under $1 billion would have roughly 90% of the enforcement actions. Similarly OCC suggests that the overwhelming majority of enforcement actions taken against banks involve community banks.

Required Reports

Several of the federal banking regulators gave information on the reports they require from the regulated institutions. The FDIC notes that it may require financial institutions to report on various situations, such as progress with formal and informal enforcements,

an update on an order to correct safety and soundness deficiencies (i.e. capital restoration plan), financial (balance sheet, income statement, statement of cash flows) information, or applying for deposit insurance. Reporting frequency depends on the type of information being provided to the Corporation. For example, progress reports related to enforcements are generally required on a monthly basis; however, there may be an instance where a progress report is required more frequently, depending upon the severity of the action. Reports related to enforcement actions are not available to the public.

Every National Bank, State Member Bank and insured Nonmember Bank is required by the Federal Financial Institution Examination Council (FFIEC) to file consolidated Reports of Condition and Income (Call Report) as of the close of business on the last day of each calendar quarter, i.e. the report date. The specific reporting requirements depend upon the size of the bank and whether or not it has any foreign offices.

The FDIC is responsible for overseeing insured financial institution adherence to the FFIEC reporting requirements, including the observance of all bank regulatory agency rules and regulations, accounting principles and pronouncements adopted by the Financial Accounting Standards Board (FASB) and all other matters relating to a Reports of Condition and Income Report submission. Reports of Condition and Income are required by statute and collected by the FDIC under the provision of Section 1817(a)(1) of the Federal Deposit Insurance Act.

FDIC collects, corrects, updates and stores Reports of Condition and Income data submitted to them by all insured national and state nonmember commercial banks and state-chartered savings banks on a quarterly basis. Reports of Condition and Income data are a widely used source of timely and accurate financial data regarding a bank's condition and the results of its operations.

The information is extensively used by the bank regulatory agencies in their daily offsite bank monitoring activities. Reports of Condition and Income data are also used by the public, the Congress of the United States, state banking authorities, researchers, bank rating agencies and the academic community. FDIC is fully responsible for maintaining an accurate and up-to-date Reports of Condition and Income data base readily available to all users.

OCC uses the FFIEC Call Report for information and analysis between examination dates for well-managed community banks. In the case of troubled community banks, additional reporting information concerning the problem area(s) are required. Sometimes this information is requested under the terms of an enforcement document. For Large Banks, resident OCC examiners are routinely copied on internal bank documents and reports (i.e. problem loan report, shared credit report, etc.).

OTS requires annual reports to the SEC from Stock Thrifts and Holding Companies, a preliminary examination response kit (PERK) including financial and other data prior to an examination, a thrift satisfaction survey, the loan application register, community reinvestment act information, and a minority thrift certification form. OTS also requires the following on a quarterly basis: thrift financial report (TFR) for information and off-site analysis between examinations, holding company registration statement, deposits and

savings accounts by office, and CMR report. Many other types of reports are requested as necessary.

The Federal Reserve System also receives the FFIEC's Call Report and, similar to the other regulators, requires numerous reports from bank holding companies and other supervised entities.

Compliance Examinations

The OTS, OCC, FRB and FDIC all conduct examinations on two different cycles for smaller and larger banks. FRB and FDIC use the CRA definition of small banks: institutions with less than $250 million. OCC, on the other hand, supervises community banks, which generally have less than $1 billion in assets, as well as larger banks.

As noted previously, OTS now conducts melded examinations, which include both compliance and safety and soundness disciplines. The examinations are scheduled based on the statutory timeframes for safety and soundness examinations. OTS conducts examinations every 12 months for institutions over $250 million in assets and every 18 months for the rest. In addition OTS schedules CRA examinations during some regular supervisory examinations based on the thrift rating and in the case of small institutions the requirements of the Gramm-Leach-Bliley Act (GLBA).

Similarly, the FRB, FDIC, and OCC all conduct CRA examinations for small banks based on the GLBA required schedule. Although the GLBA does not address the frequency of compliance examinations, all three regulators conduct at least some combined compliance and CRA examinations. The frequency of examinations for FRB and FDIC is dependent not only on the size of the institution but also its rating. OCC uses risk rather than rating to help determine the frequency of examinations. The somewhat similar schedules of FRB and FDIC are as follows:

FRB Small Bank Examination Frequency

Compliance Rating	*CRA Rating*	**Next Compliance Examination**	*Next CRA Examination*
1 or 2	Outstanding	No sooner than 60 months	No sooner than 60 months
1 or 2	Satisfactory	No sooner than 48 months	No sooner than 48 months
1 or 2	Needs to Improve or Substantial Noncompliance	No sooner than 48 Months	12 Months
3, 4, or 5	Outstanding	12 Months	No sooner than 60 months
3, 4, or 5	Satisfactory	12 Months	No sooner than 48 months
3, 4, or 5	Needs to Improve or Substantial Noncompliance	12 Months	12 Months

FDIC's practice is to conduct compliance-only (consumer regulations excluding CRA, listed in the table below as "comp") and a combined compliance & CRA examination on a rotating basis, listed below as "both," if the CRA rating is Satisfactory or better.

FDIC Small Bank Examination Frequency (in months)

	CRA Ratings			
Compliance Ratings	**Outstanding**	**Satisfactory**	**Needs to Improve**	**Substantial Non-Compliance**
1	60-72 (both) 30-36(comp)	48-60(both) 24-30(comp)	12-24	12
2	60-72 (both) 30-36(comp)	48-60(both) 24-30(comp)	12-24	12
3	60-72 (both) 12-24(comp)	48-60(both) 12-24(comp)	12-24	12
4	60-72 (both) 12 (comp)	48-60(both) 12(comp)	12	12
5	60-72 (both) 12(comp)	48-60(both) 12(comp)	12	12

FRB and FDIC's frequency of examinations for large banks are also quite similar as seen in the following tables:

FRB Large Bank Examination Frequency

Compliance Rating	***CRA Rating***	**Next Compliance Examination**	***Next CRA Examination***
1 or 2	Outstanding or Satisfactory	24 Months	24 Months
1 or 2	Needs to Improve or Substantial Noncompliance	24 Months	12 Months
3, 4, or 5	Outstanding or Satisfactory	12 Months	24 Months
3, 4, or 5	Needs to Improve or Substantial Noncompliance	12 Months	12 Months

FDIC Large Bank Examination Frequency

	CRA Ratings			
Compliance Ratings	Outstanding	Satisfactory	Needs to Improve	Substantial Non-Compliance
1	24-36	24-36	12-24	12
2	24-36	24-36	12-24	12
3	12-24	12-24	12-24	12
4	12	12	12	12
5	12	12	12	12

The OCC uses an integrated risk-based approach to supervision. The goal of this approach is to maximize the effectiveness of their supervision process by assessing all bank activities, including compliance, under one supervisory plan. The supervisory plan for community banks (generally banks with less than $1 billion in total assets) is carried out over either a 12 month or 18 month cycle. An 18 month cycle is allowed for smaller banks in good condition. All other community banks are on a 12 month cycle. OCC's supervisory plan for review of compliance in larger banks is carried out over a three-year cycle with supervisory activities being conducted throughout that cycle. Resident staff at OCC's 5 largest banks carry out continuous compliance supervision.

Compliance Examinations in 2002

	Total # of Examinations	**# of Routine Examinations**	**# of Targeted Examinations**
FDIC	1,838 (a)	-	-
FRB	369	369	0
OCC	739 (b)	739	31/27 (c)
OTS	386	373	13

(a) FDIC's records does not distinguish between routine and non-routine examinations.
(b) OCC opened 739 compliance exams in 2002, but not all may have concluded in that year.
(c) OCC lists targeted exams which are in addition to the routine examinations. The first number is for expanded scope money laundering and the second is for expanded scope fair lending exams.

Rather than conduct a targeted examination, FDIC might simply advance an examination date to the earlier part of the range, if a significant event occurs requiring an on-site visit. Alternatively, they might address the situation without conducting an examination or any on-site visit, such as the routine correspondence that occurs when they receive a complaint from a consumer about a specific institution. FDIC believes this process preserves flexibility to conduct the supervisory process that is most effective for any given situation, without creating undue burden on the financial institutions in less serious cases.

FDIC generally conducts non-routine examinations only if there are substantial risks identified through consumer complaints or some other major external issue, such as allegations of discriminatory practices. This would occur on an institution by institution basis. If a full examination was required, examiners would use the normal criteria to set the scope, with particular emphasis on the specific issue.

FRB requires a rigorous interim monitoring exercise at the midpoint of the examination cycle for banks with less than $250 million in assets and CRA ratings of Satisfactory or Outstanding, and Consumer Compliance ratings of 1 or 2. The objective of the monitoring event is to evaluate the operational, structural and environmental changes between examinations that could affect a bank's overall compliance risk indicator or compliance rating.

At the completion of the monitoring activities, including an onsite supervisory visit, if necessary, the FRB examiner must determine whether the bank's compliance program is likely to warrant at least a satisfactory rating were a complete examination to be conducted. If the examiner determines from the information reviewed, and other examination routines undertaken, that the bank's compliance rating would be likely to receive at least "satisfactory" were a full examination conducted, a letter is sent to the bank indicating that its compliance program remains at least satisfactory. If however, the monitoring activities cannot support a conclusion that the bank's compliance posture remains consistent with at least a satisfactory compliance rating, a complete risk-focused consumer compliance examination must be conducted and a new compliance rating assigned. Additionally, if ongoing surveillance of a financial institution indicates that its compliance risk profile has significantly deteriorated since the last compliance examination, a complete risk-focused consumer compliance examination may be conducted.

FRB considers the accelerated frequency of these expedited compliance examinations to be non-routine. However, the Board does not track how many of these non-routine compliance examinations are conducted each year.

In responding to a question about non-routine examinations, OCC discussed expanded scope money laundering and fair lending examinations. In selecting banks for expanded scope money laundering examinations, a number of factors are generally considered, such as the strength of the bank's BSA compliance program, its compliance history, location (high intensity drug trafficking area (HIDTA) or high intensity money-laundering and related financial crime areas (HIFCA)), whether it offers high risk products or services (e.g., international remittances, letters of credit, and private banking), extent of exposure to high-risk countries (as identified by the Financial Action Task Force or in the International Narcotics Control Strategy Report (INCSR)), extent of cash surpluses, etc. During 2002, the specialized examination program focused on banks identified as high-risk for terrorist financing. The examinations of these banks addressed USA PATRIOT Act requirements and included an evaluation of banks' anti-terrorist financing systems and controls.

For fair lending exams, the OCC has developed a process to identify banks with high fair lending risk. The process, in general, focuses on determining whether the bank's policies and procedures enable management to prevent, or to identify and self-correct, fair lending problems.

A number of factors are used in the assessment of risk such as strength of the bank's fair lending compliance program, its underwriting and decision making processes, its loan product mix, and its pricing and marketing practices. HMDA and market share data, consumer comments, and information from other regulatory agencies, such as DOJ and HUD are also used to assess a bank's fair lending risk.

OTS weighs numerous factors to determine which institutions to examine for non-routine examinations. Supervisory staff evaluates management actions taken in response to previously identified deficiencies, supervisory directives, enforcement actions or particular application approval conditions that are sufficiently serious as to warrant accelerated review. They also may consider management responsiveness to changes in the institution's operations or market circumstances that cause its risk profile to warrant an accelerated review. Staff may investigate a particular consumer complaint in exigent circumstances such as those that raise significant allegations of discriminatory conduct. And finally OTS staff may supplement the supervisory record where a functionally regulated entity poses material risk to an institution.

Scope Criteria

Beginning on June 30, 2003, the FDIC began using a revised examination process that formalized many existing risk-focused processes and procedures. This process was designed to tailor the examination scope to the particular risks specific to an institution and to conduct the examination from a top-down approach, rather than strictly a burden-intensive transactional review. The procedures include determining risk and evaluating the institution's compliance management system.

OTS has a similar risk-focused and top down examination approach. The compliance oversight examination program focuses on a core group of regulatory concerns and is supplemented by evaluating other regulatory requirements based on an institution's particular operational risk profile. The OTS examiner-in-charge reviews financial reports, prior examination findings and corrective actions, complaint history, institution audit reports, other pertinent materials, and the results of initial interviews with management to determine the scope of the compliance examination. The Examiner in Charge uses these sources to obtain a perspective on the institution's business strategies, operational complexity, internal control track record and any changes that may have impacted these items during the exam period. This review provides the examiner with an institution risk profile that guides decisions about how to implement relevant examination programs.

FRB and OCC also report risk-based approaches to determine the scope of examinations. OCC notes that supervisory activities are tailored specifically to the risk profile of each bank and must be sufficient to confirm or change the applicable composite and component ratings.

In community banks, OCC examiners assess the quantity of risk and quality of risk management for five functional areas of compliance – fair lending, BSA/AML/OFAC regulations, lending regulations (including FDPA), deposit regulations, and other

consumer regulations. These assessments along with a review of audit, internal controls, complexity of the bank's compliance environment, compliance management systems, previous problems that require follow-up, and complaint information are then used to develop the scope of consumer compliance supervisory activities.

In OCC's larger banks (generally those with assets greater than $1 billion), they perform a risk evaluation. This evaluation considers factors such as changes to consumer regulations, new product and service offerings, the effectiveness and scope of the bank's compliance management system, audit reliability and scope, significant deficiencies at prior examinations, the amount and significance of consumer complaints, and the bank's system of internal controls. The scope of any particular compliance activity is based on the results of this evaluation.

FDIC's Compliance Examinations

	Avg. Duration of Exam from Notification to Final Rpt	**Avg. # of Staff Involved in Exam**	**Avg. Length of On-Site Visit (in calendar days)**	**Avg. # of Examiners for On-Site Exam**
Assets >$10 billion	295 days	6	120 days	5
Assets $1-10 billion	206 days	5	48 days	4
Assets <$1 billion	133 days	4	21 days	3

OTS reported the average duration of compliance examinations and of on-site visits in person days. A person day equals the total exam hours divided by 8.

OTS' Compliance Examinations

	Avg. Duration of Exam from Notification to Final Rpt	**Avg. Length of On-Site Visit**
Assets >$10 billion	228 person days	183 person days
Assets $1-10 billion	103 person days	58 person days
Assets <$1 billion	69 person days	24 person days

FRB and OCC did not report typical durations for compliance examinations. FRB noted that its examinations are conducted in phases with irregular periods of time between them. OCC may complete compliance activities in larger banks over a 3 year period. So there is no longer a one-time event known as a compliance examination. The activities have been broken into separate segments, which are carried out at different times over the 3 year cycle. OCC also noted that for its 5 largest banks, compliance supervision is carried out on a continuous basis by resident staff. For community banks, OCC does

sometimes complete a one-time compliance examination. The average duration for such exams is 53 workdays.

FRB's Staff Time Spent on Compliance Examinations

	Avg. # Hours on Exam	Avg. # of Hours for On-site Exam
Assets >$10 billion	2,113 person hours	763 person hours
Assets $1-10 billion	1,550 person hours	588 person hours
Assets <$1 billion	408 person hours	184 person hours

FRB does not track the average number of days on-site for a compliance examination by asset size. From a sample of the compliance examinations conducted in 2003, the average length of the on-site portion of the examination was distributed as follows:

One week: 68 percent
Two weeks: 24 percent
Three weeks: 6 percent
Four weeks: 2 percent.

The FRB, OCC, and OTS all report that 100% of compliance examinations include on-site visits in all asset groups. FDIC states that generally all of its examinations have an on-site component. However, FDIC notes processes such as targeted complaint investigations, which are not tracked in their examination database, do not usually involve an on-site review.

Enforcement Actions As a Result of Compliance Exams

	# of Actions in 2002	**# of Actions in last 5 yrs**
FDIC	**115**	**619**
FRB	**1**	**5**
OCC	**7**	**Not available**
OTS	**1**	**18 (a)**

(a) OTS lists number of actions from 1997-2001.

Desk Audits, Market Analysis, and Technology

None of the federal regulators report conducting "desk audits". Nonetheless, the FDIC believes the concept is inherent in its risk-focused procedures. Depending on the size, structure, and complexity of an institution, examiners may interview various financial institution employees to determine the process and procedures used in its compliance management system. These interviews are conducted to identify potential risks and are not intended to test the individual knowledge of the interviewee.

Additionally OTS notes that its examiners do conduct off-site reviews in preparation for and scoping of upcoming compliance examinations. The reviews include, but are not limited to, analysis of complaint data to identify problem areas, prior examination findings and recommended corrective actions, as well as general financial information and lending data relevant to fair lending and CRA performance.

Additionally none of the federal regulators report having a formal market analysis program. However FDIC reports that its policy and examination support staff in Washington are involved in many current-events and timely issues in order to develop agency positions and supervisory activities for upcoming issues. OTS reports since the consumer complaint processing function is performed in each region, consumer complaint analysts and their managers are in regular communication with supervisory staff to assess how particular institutions may compare with their peers in terms of consumer complaint trends and track records. In addition, OTS regional staff also avails itself to the national database of compliance regulatory violations to conduct comparisons of how institutions compare with respect to type, frequency and impact of violations identified in the course of compliance examinations.

FDIC and OTS mention market data reports. OTS complaint analysts regularly prepare summaries of substantive issues that have arisen in connection with an institution's consumer complaint record. The summaries are reviewed by the examiner-in-charge during the scoping process for an upcoming examination. OTS compliance examination data is available for download in a variety of forms that facilitate national, regional, field manager caseload, statewide or other comparisons. At a regional level, comparison of complaint experience is monitored on a regular basis. OTS staff can then distinguish among the associations in their regions on the basis of thrift promptness in responding to complaints, characteristics of consumer relations in processing complaints and substantive issues arising from complaints. Based on this familiarity, the region can focus more attention to the institution deserving greater scrutiny. In addition, OTS regional offices can use their access to the compliance violations database to select institutions with particular records to supervise more closely.

Depending on the particular issue at hand, FDIC policy and examination support staff in the compliance area will typically use internal data to determine the potential impact of an issue on the supervised institutions. Using various data sources, such as examination data and CALL report data, they determine the number of institutions engaged in or effected by, various practices or issues. From a macro-perspective, this helps the FDIC determine and develop changes necessary within its examination programs.

In addition, FDIC notes that individual examination findings in the past have helped reveal large-scale deficiencies in bank service providers. For example, a pattern of violations discovered during a routine examination of a small institution revealed programming problems in the computer systems of a large-scale data processing service provider. This provider serviced several hundred institutions throughout the country. Through this routine examination, the service provider was advised of this issue and was able to implement corrections that affected all of its client institutions using the particular system.

OCC did point out that they use external data such as the CTR and SAR systems in evaluating compliance with the BSA. Their internal complaint database is used in

consumer compliance, fair lending, and CRA examinations. Aggregate HMDA data are used in CRA and fair lending examinations.

FDIC also discussed their use of technology that generally occurs on each examination, specific to the needs of that particular examination. For example, their examination staff use a computer program to develop performance context and market data information during the evaluation of an institution's compliance with the CRA. This program contains demographic data from the US Census to identify the income and personal demographics of the population within various areas.

This program also accepts bank-specific data that the institutions provide to examiners. Typically this is in the form of a computer download. FDIC examination staff have the capability to accept these downloads and manipulate the data into useful formats for a variety of examination processes, including CRA, Fair Lending, and other transactional sampling, when necessary. This data is also useful in determining the various products that the institutions are engaged in, for the development of the overall risk-assessment. OCC uses a similar computer program in its CRA examinations. OCC's program also helps to develop performance context and market data information during CRA exams.

OTS primarily uses spreadsheet manipulation to assess the institution's complaint or compliance exam violation data. Additionally, OTS uses PCi's CRA Wiz product for (1) conducting CRA performance analysis that includes market peer comparisons and (2) for doing lending comparisons in aide of fair lending examinations.

Complaint Processing

For the purposes of this survey, the definition of complaint includes communication submitted by or on behalf of a covered person primarily expressing a grievance that does not represent an inquiry or a request for information.

FDIC points out that its Consumer Affairs Program is required by federal law. The 1975 Federal Trade Commission Improvement Act required each of the federal banking agencies to establish a separate office to receive and respond to complaints about financial institutions supervised by each agency. A 1979 Executive Order expanded this mandate to require the agencies to systematically track, investigate, and respond to consumer complaints, and to integrate the analyses of complaints into the development of supervisory policy.

Complaint Processing

	# of FTEs in Complaint Processing	# of Complaint Offices	Avg. Duration of Complaint Resolution	% of Complaints Resolved in 30 Days
FDIC	36	8	20 days (b)	73% (b)
FRB	46 (a)	13	60 days	17%
OCC	40	1	41 days	25%
OTS	14	4	55 days	N/A

(a) FRB's number includes both Board and Reserve Bank staff.
(b) FDIC's complaint resolution data includes referrals to other appropriate supervisory agencies.

The FDIC has Consumer Affairs staff located in the Washington, DC office, the Consumer Response Center in Kansas City, Missouri, and in all regional and area offices except Boston (Atlanta, Chicago, Dallas, Memphis, New York, San Francisco). Staff in the regional and area offices report to the Senior Consumer Affairs Officer located in Kansas City and to the Chief of the Consumer Affairs Branch in Washington, DC. Policy development and program oversight are carried out in the Washington, DC office, while the Consumer Response Center has responsibility for investigating and responding to consumer complaints.

FRB has complaint offices in the following cities: Washington, DC, Boston, MA, New York, NY, Philadelphia, PA, Cleveland, OH, Richmond, VA, Atlanta, GA, Chicago, IL, St. Louis, MO, Minneapolis, MN, Kansas City, MO, Dallas, TX, and San Francisco, CA. The OCC's Customer Assistance Group is located in Houston, Texas. OTS' consumer complaint staff work out of their regional offices in Atlanta, Dallas, Jersey City, and San Francisco (Daly City).

FDIC's performance goal for Consumer Affairs requires 90 percent of all written consumer complaints to be responded to within timeframes established by policy. The relevant policy time frames as articulated in the *Consumer Complaint and Inquiry Manual* include: 15 days for referrals to other agencies; 60 days for completion of complaint investigations involving FDIC-supervised financial institutions; and 120 days for completion of investigations involving illegal credit discrimination. Consumer Affairs consistently meets and exceeds the 90 percent performance goal. OTS did not provide data for the percentage of complaints resolved within 30 days. However, OTS noted that its practice is consistent with the FDIC and OCC policy of resolving complaints within 60 days.

OCC notes that telephone and e-mail complaints may be resolved during the point of first contact.

2002 Consumer Complaints

	# of Complaints Received	# of Complaints Closed	# of Complaints Investigated by Regulator	# of In-Person Meetings with Consumers
FDIC	8,408/4008 (a)	8,257/3,815 (a)	2,763	Not tracked
FRB	5,730	5,711	2,757	18
OCC	38,840	38,738		Approx. 24
OTS	6,273	5,399	7,026 (b)	N/A

(a)The first number represents complaints received by the FDIC, including those forwarded to appropriate federal regulators with the supervisory responsibility for the institutions involved. The second number indicates complaints identifying financial institutions supervised by the FDIC.
(b) OTS includes both complaints initiated in 2002 and those filed in a previous year but resolved in 2002.

OCC notes that all written complaints are reviewed by a Customer Assistance Specialist and for the most part forwarded to the bank for a written response. If they find the bank's response to be lacking in sufficient detail or if they disagree with the response, Customer Assistance seeks additional information from the bank. Occasionally, OCC uses its on-site examiners to provide additional data. OCC does not encourage in-person meetings with consumers, but it does receive about 2 walk-ins each month. Similarly since OTS processes complaints through direct correspondence or by phone, it does not generally conduct in-person investigation meetings.

Complaint Procedures

	Follow-up w/ Institution About Referred Complaints	**Require Written Response From Institution**	**Complaint Activity Database**	**Use Complaint Data to Inform Compliance Exams**
FDIC	Yes	Yes	Yes	Yes
FRB	Yes	Yes	Yes	Yes
OCC	Yes	Yes	Yes	Yes
OTS	Yes	Yes	Yes	

FRB state member banks are required to research complainants' allegations and submit a written response to the Reserve Banks within a specific time period (usually within fifteen business days). OTS requires all referred complaints to be answered by the institution and then reviewed further by the regional office.

Consumer Access

Consumers can contact the FDIC by mail, email, telephone (1-800-ASK FDIC), facsimile, or through the customer assistance form located on the FDIC's website. While consumers can call and discuss their concerns with staff, complaints must be in writing in order to initiate an investigation. FRB reports that consumers may file complaints via email, telephone, website, and U.S. mail. OCC and OTS allow consumers to file complaints by all of the same means except through the website. In addition, OTS encourages consumers to make use of its web-based resources to address any

informational inquiries. However, to process a complaint involving personal financial information, OTS requires an authorizing signature. Such complaints may be initiated by email if the regional office subsequently receives a signed version of the complaint.

Final Consumer Contact

	Final Letter to Consumer About Resolution	**Send Out Consumer Satisfaction Survey**	**Complaint Data Available to Public**
FDIC	Yes (to all who file written complaint)	Yes	Yes (Ann. Rpt & By Request)
FRB	Yes	Yes	Yes (FOIA & Ann. Rpt)
OCC	Yes (to all who write to them)	No	Yes (FOIA)
OTS	Yes	No	No (Except Some Aggregate Data)

The FDIC implemented a consumer satisfaction survey in the second quarter of 2003. While OCC does not send out a consumer satisfaction survey, it reportedly receives 100s of thank you letters from assisted consumers each year. OTS also does not use a consumer satisfaction survey, although it does report sending out an annual thrift satisfaction survey to institutions. The survey encourages management to discuss exam related issues as well as any concerns or suggestions related to any department of OTS.

OTS does not publish complaint data. However, they may provide certain information in aggregate form if requested in accordance with FOIA.

Percent of Complaints by Company Asset Size

	> 100 billion	**$50-100 billion**	**$20-50 billion**	**$1-20 billion**	**<$1billion**
OCC	85%	10%	3%	1%	1%
OTS	61% (for >$20 billion)			29%	10%

The FDIC and FRB do not track complaints by the asset size of the financial institutions.

Complaint Databases and Data Use

FDIC logs all complaints (and inquiries) on the Specialized Tracking and Reporting System (STARS). STARS in an on-line database that includes, for each complaint and inquiry, the consumer's name, address, financial institution, summary of the complaint/inquiry, and classification and resolution codes. The database also electronically stores copies of correspondence related to the file, and allows for a wide range of reporting about complaint volume and trends. STARS has a number of

"canned" reports and also an ad hoc reporting capability. FDIC believes consumer complaints are an integral part of the examination process. Examination procedures require that complaints about financial institutions be reviewed prior to compliance exams.

FRB has the Complaint Analysis Evaluation System and Reports (CAESAR) Database. When a complaint is entered into the CAESAR Database, it is given codes to identify the complaint. The codes describe the product type, such as credit cards, checking accounts and real estate loans; and the consumer's allegation –discrimination, fair credit reporting, billing errors or interest rates. The coding system allows them to capture the number and volume of complaints received by the Board and by the twelve Reserve Banks, this includes state member bank complaints and other bank complaints. CAESAR also captures information about current issues such as identity theft, predatory lending, and privacy issues. Complaint staff share complaint data about a bank prior to a compliance examination.

OCC utilizes commercial-off-the-shelf software from the REMEDY Corporation to track and manage their complaint volumes. With this software they can run various reports on both issues and by bank to determine if there are systemic problems with a bank product or with a bank in general. OCC captures the major bank products and tracks that down to the particular regulatory site. Complaints are tracked by consumer information as well as by the bank in question. Complaint data is an integral part of the OCC's supervision process. Consumer complaint data is available to their examination staff using several on-line tools developed by the Customer Assistance Group.

OTS also has a complaint activity database. For all complaints the agency maintains consumer identification information, institution identification information, complaint codes, an instrument code, a disposition code, filing history and comments. As a part of the supervisory process, OTS considers complaint information and analyst reviews when determining the scope of an upcoming examination.

Satisfaction with Complaint Process

FDIC and OTS report satisfaction with their complaint handling processes. FRB is also satisfied with its process, but notes that they are currently reviewing their workflow process to identify ways to maximize efficiency and effectiveness. FRB would like to make better use of technology and automation and hopes to streamline some of their current procedures. OCC believes it has built the premier consumer complaint processing and tracking system. OCC regularly meets with the largest national banking organizations each year to review with them their complaint volumes and trends and to provide peer data.

Causes of Delays

FDIC reports complaints that are unusually complex or require an on-site investigation tend to take longer to complete than other complaint investigations. FRB believes there are several reasons for delays: complex or multiple issues contained in a single complaint and obtaining documentation from banks and consumers. OTS also cites the complexity

of allegations for causing complaint processing delays. In addition OTS notes two other general reasons: (1) the age of the transaction underlying the complaint, or (2) changing allegations or rationales that are uncovered during the course of investigating the complaint. OCC finds delays in two main categories: Customer Assistance Group (CAG) delays and Bank delays. As for CAG delays, OCC reports that on occasion complaint volume may spike and exceed their ability to process on a timely basis. In those cases they will authorize overtime for the staff to assist in "catching-up". For bank delays, these could stem from both an increase in complaint volume without a corresponding increase in staff or when the bank and the OCC may disagree as to the final disposition of a case. In both cases CAG works with the bank to try to facilitate reasonable response times.

Dual Charters

OCC reports that the percentage of charter conversions (from federal to state and vice versa) is less than 1% per year for the number of banks supervised. OTS provided data for charter conversions broken down in the following ways. An average of 0.8% of thrifts change charters "intra" OTS per year. All "intra" OTS charter changes were from a state OTS-thrift charter to federal OTS-thrift charter. Charter conversions to an OTS thrift charter have averaged 0.9% per year, while charter conversions from an OTS thrift charter averaged 1.8% a year. Transfers from an OTS federal charter to a state, non-OTS, charter averaged 0.9%.

The FDIC and the FRB track the number of institutions that transfer to and from other regulators, but do not differentiate between other federal and state regulators in these figures. Nonetheless the percent of switching institutions is clearly low. During the period of 1998 to 2002, the average number of institutions that transferred to the FDIC as a primary regulator as a percentage of the total number of FDIC-supervised institutions was 0.47%. During the same period, the percentage of institutions supervised by the FDIC that transferred to other regulators from the FDIC as a primary regulator was 1.14%. FRB reports that for the three year period ending in the fourth quarter of 2002, an annual average of fifty-one financial institutions converted charters from either National or State Nonmember to become a State Member Bank, regulated by the Federal Reserve System. For the same period, an annual average of six State Member Banks converted to either National or State Nonmember charters.

OTS has identified two thrifts that changed charters more than once. The first institution went from a federal mutual savings institution to a state stock savings bank then back to a federal stock institution in 1995. The second institution went from a state mutual savings bank to a federal stock saving bank then back to a state stock savings bank in 1998. Neither the FRB or FDIC track the number of institutions which have switched charters more than once. OCC states that they are aware of no institutions that have switched charters more than once.

The OCC and FDIC do not believe that the ability of a bank to opt for either a federal or state charter inhibits effective enforcement of consumer protection laws. FDIC points out that federal consumer protection laws are enforced against institutions that hold both federal and state charters by the appropriate federal financial institution regulators. Unless pre-empted, state consumer protection laws also apply to all institutions that fall within the appropriate state's jurisdiction. Furthermore OCC notes that both the state banking regulators and the OCC enforce consumer protection laws.

OTS believes in charter choice and that institutions should have the right to choose the best charter that fits their particular niche or business strategy. OTS reports that it works closely with, and has a good working relationship with state banking regulators and other federal bank regulators. And, based on past experience, OTS finds that good working relationships tend to enhance rather than inhibit effective enforcement of consumer protection laws.

The FDIC, OCC, and OTS all are unaware of any instance in which an institution has changed charters in order to avoid consumer protection requirements. OTS further notes that if they knew or heard of such a strategy they would notify the appropriate state/federal banking regulator.

APPENDIX D

Regulation of Insurers under Current Proposals for Optional Federal Chartering					
Provision	**American Bankers Insurance Association (ABIA)**	**American Insurance Association (AIA)**	**ACLI Bill**	**Schumer Bill**	**LaFalce Bill (H.R. 3677)**
Federal Regulatory Agency	Office of the National Insurance Commissioner (within Treasury)	Federal Insurance Chartering Office (within Treasury)	Office of National Insurers (new bureau within the Treasury)	Same as ABIA	Office of National Insurers (within Treasury)
Scope	All insurance and annuity contracts except state insurers and residual markets; authorizes national insurance agencies	Property-Casualty insurance; no provision for agents	Life Insurance, Annuities, Disability Income and Long Term Care Insurance; Chartering of National Insurers; Licensing of federal producers; Market Conduct	Similar to ABIA	All insurance except health insurance; producers licensed by state but subject to federal market conduct regulation when selling products of national insurers
Solvency	Examinations, minimum capital requirements, risk-based capital requirements, investment limitations, rehabilitation, liquidation, prompt corrective action	Examinations, minimum capital and risk based capital requirements, investment limitations, rehabilitation and liquidation	Supervision and Regulation of Agencies; Educational and Examination requirements; Risk-Based Capital Standards (based on NAIC models); Audits and Actuarial analysis based on NAIC models; investment limitations; accounting guidelines	Similar to ABIA	Similar to ABIA
Guaranty System	National Insurance Guaranty Corporation for national insurers and, at their option, state insurers; funded by risk-based assessments; generally patterned after federal deposit insurance	Must participate in state guaranty funds	Must participate in state guaranty funds	Must participate in state guaranty funds provided that state's fund meets minimum requirements; national plan will be used if state does not meet standards	Same as Schumer Bill
Rates	No state or federal regulation of rates	Exempt from rate regulation, including rate filing requirements, at state and federal levels		Not subject to state regulation; silent on federal regulation	National and state insurers subject to state regulation
Forms	No prior approval; forms must be filed and meet federal standards or, at the insurer's option, state law in principal place of business	No prior approval by state or federal regulators	Prior approval by director of the Office of National Insurers for national insurers	No prior approval by state or federal regulators	Prior approval of forms for national insurers by Office of National Insurers
Residual Markets	Must participate in state programs	Must participate in state programs	No provision	Must participate in state programs	Must participate in state programs
Trade Practices/Market Conduct	Federal standards and regulation, including prohibition of unfair discrimination	Federal standards and regulation	Both Federal standards and regulation, and regulation set by the Director of the Office of National Insurers	Similar to ABIA	National standards apply to all insurers; enforceable against state insurers by state regulators
Antitrust Exemption	None for national insurers	None for national insurers, except for policy forms and residual markets; FTC Act would not apply to national insurers	No provision, but by implication federal insurers are subject to federal anti-trust law	None for national insurers, except for policy forms and residual markets	Repeals exemption for all insurers, except for historical data and residual markets

APPENDIX E

Resources for Insurance Regulation Project

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Sharon Hermanson, Consumer Issues, Public Policy Institute

ACLI
Gary Hughes
Friar Fitzgerald
Julie Spezio
David Wentworth
Jeffrey Janoska

American Enterprise Institute
Peter Wallison

California Department of Insurance
Norris Clark, Deputy Commissioner, Financial Surveillance
James Johnson, Deputy Commissioner, Consumer Services and Market Conduct
Victoria Sidbury, Assistant Chief Counsel
Patricia Staggs, Assistant Chief Counsel
Keith Kuzmich, Acting Chief, Licensing Services Division
Woody Girion, Chief, Financial Analysis Division
Louis Quan, Chief, Life Bureau, Financial Analysis Division
Ron Rosen, Chief, P/C Bureau, Financial Analysis Division
Chuck DePalma, Supervisor, Field Examination Division
Al Bottalico, Supervisor, Field Examination Division
Jill Jacobi, Senior Staff Counsel, Legal, Corporate Affairs Bureau
Joel Laucher, Chief, Market Conduct Division
Tony Cignarale, Chief, Consumer Services Division

California Health Advocates
Bonnie Burns
Director of Consumer Education

Center for Community Change
Allen Fishbein

Center for Economic Justice
Birnie Birnbaum

Citizens for a Sound Economy
Wayne Brough

Columbia University
Charles Calomiris, Professor of Finance and Economics

Consumer Federation of America
Robert Hunter

Conference of State Bank Supervisors
Neil Milner
Alan Cox, Vice-President, Regulatory Affairs

Department of Labor
Ann Combs, Assistant Secretary

Equitable Life Assurance Society of the United States
Stanley B Tulin, Vice Chairman and Chief Financial Officer
Wendy E. Cooper, Senior Vice President and General Counsel

Federal Deposit Insurance Corporation
Arthur Murton, Director, Division of Insurance and Research
Donna Gambrell, Deputy Director, Compliance and Consumer Protection
April Breslaw, Chief, Compliance Section
Susan Boenau, Chief, Consumer Affairs
David Lafleur, Policy Analyst, Compliance

Federal Reserve Board
Rich Spillenkothen, Director, Supervision
Jessica Martin, System Planning, Budgeting and Evaluation
Yvonne Cooper
Lanette Meister

Florida Department of Financial Services
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Hazel Muhammad, Senior Management Analyst Supervisor, Bureau of Agent and Agency Services, DFS
Gwen Chick, Applications Coordinator, OIR
Paul Johns, Financial Examiner/ Analyst Supervisor, Bureau of Life and Health Insurer Solvency, OIR
Jovita Ashton, Bureau Chief, Bureau of Life and Health Insurer Solvency, OIR
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Tom Terfinko, Division of Consumer Services, DFS
Frank Dino, Administrator, Bureau of Life & Health Forms & Rates, OIR
Don Dillard, Administrator, Bureau of Life & Health Forms & Rates, OIR

The Foundation for Taxpayer and Consumer Rights
Doug Heller

GAO
Larry Cluff

GE Capital Assurance
Sam Morgante, Vice-President, Government Relations

House Committee on Financial Services
Robert Gordon, Counsel

Iowa Insurance Division
Therese Vaughan, Commissioner
Susan Voss, Deputy Insurance Commissioner
Kim Cross, Financial Regulation Bureau
Angela Burke Boston, Producer and Product Regulation Bureau
Ann Outka, Consumer Affairs Bureau

Lincoln National
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Vice President and Associate General Counsel
Director State Relations

Mass Mutual
Robert J. O'Connell, President and Chief Executive Officer
Kenneth S. Cohen, Senior Vice President and Deputy General Counsel
William B. Fisher, Vice President and Associate General Counsel

NAIC
Jeffrey Johnston, Director Financial Regulatory Services
Eric Nordman, Director of Research
Andrew Beal, General Counsel
Tim Mullen, Senior Regulatory and Consumer Services Manager
David Vacca, Accreditation Manager
David Wetmore
Thomas Kliman
Natalai Hughes

NASDR
Larry Kosciulek

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Gale Simon, Assistant Commissioner, Life & Health
Lynda Klebold, Chief, Life Bureau

Nancy Hritz, Chief, Valuation Bureau
Karen Mitchell, Assistant Commissioner, Financial Surveillance
Robert Kasinow, Assistant Chief Insurance Examiner, Field Operations
Lee Barry, Assistant Commissioner, Consumer Protection Services
Anne Marie Narcini, Manager, Consumer Protection Services

New York State Insurance Department
Greg Serio, Superintendent
Peter J. Molinaro, Senior Deputy Superintendent
Salvatore Castiglione, Assistant Deputy Superintendent and Bureau Chief, Consumer Services & Licensing Bureau
Kashyap Saraiya, NYC Office
Clark J. Williams, Assistant Director, Licensing Services Bureau
Melissa Pingel

Northwestern Mutual
Michael Youngman
Kathleen Rivera

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Daniel Stipano, Deputy Chief Counsel
Tony Bland, Senior Advisor to Deputy Comptroller for Mid-Size and Community Banks
Karen Kwilosz, Director, Core Policy Development
Jim Vivenzio, Special Assistant to the Deputy Chief Counsel
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Prudential Insurance Company
George Coleman, Vice President

Reinsurance Association of America
Frank Nutter

Securities and Exchange Commission
Susan Nash

Social Security Administration
Ed De Marco, Associate Commissioner

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José Montemayor, Commissioner
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Jack Evins, Director, Advertising Unit
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APPENDIX F

Reference

Ahart, Tom, 2003 Statement of the Independent Insurance Agents and Brokers of America, Before Committee on Commerce, Science and Transportation, United States Senate. October 22

American Banker, 2004 Mixed View on Impact of Panel's Preemption Vote

Birnbaum, Birny, 2003 Insurance Credit Scoring, Testimony Before the New York Assembly Committee on Insurance. October 22

CRA, 2002 Consumer Credit Insurance, Report to Congress

Csiszar, Ernst, 2003 Testimony of the NAIC before the Committee on Commerce, Science and Transportation, United States Senate

EBRI, 2003 Can Americans Afford Tomorrow's Retirees: Results from the EBRI-ERF Retirement Security Projection Model, Issue Brief Number 263, November

EBRI, 2003 Employment Based Retirement and Pension Plan Participation: Declining Levels and Geographic Differences, Issue Brief Number 262, October

Employee Retirement Income Security Act of 1974 (ERISA)

Federal Insurance Act of 1976, S. 3884

Franks , J.R., Shaefer, S.M., and Staunton , M.D., 1998 The Direct and Compliance Costs of Financial Regulation, Journal of Banking and Finance. December. Vol. 21, 1547-1572

GAO, 2003 Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation

Gasper, Joseph J, 2002 Testimony before the Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises of the Committee on Financial Services of the United States House

Gramm-Leach-Bliley Act of 1999 (GLBA)

GLBA Conference Report 1999 November 1

Grace and Klein, 2000 Efficiency Implications of Alternative Regulatory Structures for Insurance, in Peter J. Wallison, ed., (2000) Optional Federal Chartering and Regulation of Insurance Companies. Washington, D.C.: The AEI Press.

Greve, Michael, 2001 Federalism and Insurance Regulation, Remarks presented to the Federalist Society. November 15

Harrington, Scott, 2000 The History of Federal Involvement in Insurance Regulation, in Peter J. Wallison, ed., 2000 Optional Federal Chartering and Regulation of Insurance Companies. Washington, D.C.: The AEI Press

Harrington, Scott, 2002 Optional Federal Chartering of Property-Casualty Insurance Companies

Hawke, John D., 2003 Letter from John D. Hawke, Jr. Comptroller of the Currency to the Honorable Paul S. Sarbanes. December 9

Health Care Financing Review. Medigap Reform Legislation of 1990: A 10 year Review. Spring

Hennosy, Kevin, 2003 Waist Deep in the Big Muddy, Rough Notes Magazine

Hillman, Richard, 2002 State Insurance Regulation: Efforts to Streamline Key Licensing and Approval Processes Face Challenges, GAO

Home Owners Loan Act (HOLA) of 1933 48 St. 134.

House Financial Services Committee, http://financialservices.house.gov/

Hunter, Robert, 2003 Testimony of the Consumer Federation of America before the Committee on Commerce, Science and Transportation, United States Senate

Hunter, Robert, 2003 State of Insurance Regulation

Hunter, Robert, 2004 Insurers Weigh in on Market Conduct, National Underwriter

Insurance Legislator's Foundation, 2003 The Path to Reform –The Evolution of Market Conduct Surveillance Regulation

Jackson, Howell, 1999 Regulation of Financial Institutions, Westlaw 1999

Kandarian, Steven, 2003 Testimony before the Special Committee on Aging, United States Senate. Executive Director, Pension Benefit Guarantee Corporation. October 14

Klein, Robert W., 1999 A Regulator's Introduction to the Insurance Industry, National Association of Insurance Commissioners Educational and Research Foundation

Lane, John, 2003 Statement of the Deputy Director, Division of Supervision and Consumer Protection, FDIC Banking Policy Advisory Committee, November 19

LaSalle, Lavada, 2003 Written Statement of Lavada E. Desalles, Member, AARP Board of Directors, Before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises of the Committee on Financial Services, U.S. House of Representatives. May 15

McCarran-Ferguson Act of 1945

M'Culloch v. Maryland, 17 US 316 (1819)

Moriarty, Michael, 2004 Presentation to the NAIC Symposium on State Insurance Regulation, Washington, DC February 24, 2004

National Association of Attorneys General, 2003 Letter to Office of the Comptroller of the Currency Regarding Docket No. 03-16, 12 CFR Parts 7 and 34. October 6

NAIC, 2002 Nation's Top Insurance Regulators Support Interstate Compact, Press Release December 8

NAIC, 2003 A Reinforced Commitment: Insurance Regulatory Modernization Action Plan

NAIC, 2003 Market Conduct Examiners Handbook, 2003 Edition. Kansas City: NAIC

NAIC, 2003, 2002 Insurance Department Resources Report

NAIC, 2003 Staff Document. December 3

NAIC, Memorandum from Julie Gann, NAIC Financial Examination Manger, to University of Massachusetts Isenberg School of Management (August 6, 2003)

NAIC, www.naic.org

OCC, 2003 National Banks and the Dual Banking System

OCC, 2004 Advisory Letter, March 1

Rajnes, David, 2002 An Evolving Pension System: Trends in Defined Benefit and Defined Contribution Plans, Issue Brief Number 249, September

Rejda, George E., 2001 Principles of Risk Management and Insurance. Seventh Edition., Boston: Addison, Wesley, Longman

Rice, Graham and Fox, 1997 Impact of Policy Standardization on the Medigap Market, Inquiry. Vol 34, Summer

Scott, Ken, 1978 The Dual Banking System: A Model of Competition in Regulation, Issues in Financial Regulation McGraw-Hill 1978

Terrorism Risk Insurance Act of 2002, P.L.107-297

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

U.S. House, Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, 1990 Failed Promises: Insurance Company Insolvencies

12 USC Section 24

517 US 25 (1996)

Vaughan, Terri, 2003 Remarks before the NAIC by Iowa Insurance Commissioner

Wallison, Peter J., 2000 Optional Federal Chartering and Regulation of Insurance Companies, Washington, D.C.: The AEI Press

Williams, Julie L., 2003 Remarks by Julie L. Williams, Chief Counsel and Senior Deputy Comptroller, Office of the Comptroller of the Currency, Before the Consumer Federation of America. December 5

Sheila C. Bair

Sheila Bair has over 20 years experience working in the nation's capital in senior positions in government and financial services. The National Journal has described her as "an experienced Washington hand who has forged a career at the intersection of politics and policy."

A 1978 graduate of Kansas University Law School, she began her career in the General Counsel's office of the former US Department of Health, Education and Welfare. In 1981, she joined the staff of Senator Robert Dole (R KS), working for him on both his senate leadership staff and his 1988 presidential campaign. In 1990, she was a candidate for Congress in the Kansas 5th District. From 1991 – 1995, she served as a Commissioner on the Commodity Futures Trading Commission, being appointed by President George Bush in 1991 then re-appointed by President Bill Clinton in 1994. Following her tenure on the CFTC, she spent five years as Senior Vice President of Government Relations for the New York Stock Exchange.

Ms. Bair was President George W. Bush's first pick to serve as the Treasury Department's Assistant Secretary for Financial Institutions in his new Administration. During her tenure at Treasury, she was responsible for a wide range of policies affecting financial institutions related to safety and soundness, consumer protection, and national security. In the aftermath of the September 11 attacks, Secretary Paul O'Neill cited her for her tireless work on the enactment of terrorism insurance legislation and for her integral involvement in Treasury's development of the USA Patriot Act regulations. The Wall Street Journal, among other publications, recognized her as playing "a lead role for the Bush Administration in negotiations over terrorism insurance, bank deposit insurance reform, and numerous other financial issues" and as "knowledgeable and dedicated in her approach to legislative issues."

While at Treasury, Ms. Bair also served as Secretary O'Neill's representative on the Board of the Pension Benefit Guarantee Corporation and was a key staff player in the development of the Administration's post-Enron proposals for strengthening retirement security protections. Her large, diverse portfolio also included the Chairmanship of the Financial and Banking Information Infrastructure Committee of the President's Critical Infrastructure Protection Board, which had lead responsibility of strengthening the financial services infrastructure post- 9/11.

Due to family obligations, Bair resigned her position with Treasury in the summer of 2002. She, her husband Scott Cooper, and their two children, Preston, 11 and Colleen, 4, now live in Amherst, MA, where Bair serves as Dean's Professor of Financial Regulatory Policy at the University of Massachusetts Isenberg School of Management, and associate professor at the University's Center for Public Policy and Administration. She also serves on the FDIC's Banking Policy Advisory Committee and on the Board of the Center for Responsible Lending. At the University, her research has focused on financial services regulatory structure, particularly with regard to insurance and government-sponsored enterprises (GSEs). She is actively involved in efforts to improve access to financial services among low and moderate income Americans. She has led a major research project to examine the consumer ramifications of an optional federal charter for life insurers, and has recently published papers on the Federal Home Loan Bank System and Latino immigrant access to the US banking system. A passionate advocate of financial education, she also writes articles for children about financial matters, most recently publishing "How Banks Work" in the June, 2003 edition of Highlights for Children "How To Grow Your Own Money Tree" with former Secretary O'Neill in the January 2004 edition.