Edited Excerpt on Executive Life Failure and its Aftermath from Howell E. Jackson & Edward L. Symonds, Jr., Regulation of Financial Institutions 479-506 (West 1999)

Section 3. The Regulation Of Insurance Company Solvency

Perhaps the most striking characteristic of the insurance regulation in the United States is the fact that the states retain primary responsibility for regulating most facets of the industry. In the previous chapter, we explored the historical origins of this regulatory structure. Now, we consider the practical significance of the structure. Here we focus our attention on two areas where the primacy of local regulation presents special problems. The first involves the disposition of failed insurance companies that operate on a national basis. The second concerns the coordinating role of the National Association of Insurance Commissioners (NAIC). As you read through these materials, consider the merits of a decentralized regulatory system in these contexts. Clearly, the structure increases administrative costs, but are there offsetting benefits of regulatory federalism?

A. Executive Life Insurance Company: A Case Study

Twenty years ago, Executive Life Insurance Company (ELIC) was a small and little-noticed life insurance company domiciled in California. In the 1980s, however, new management, led by Fred Carr, transformed ELIC and its New York affiliate:

> As chief executive officer, Mr. Carr used [ELIC] to construct one of the largest insurance organizations in America in just 10 years. The numbers are staggering: Reported assets of Executive Life in California sky-rocked 1,578 percent from 1980 to 1990, and the assets of Executive Life in New York leapt 1,273 percent during the same period. By 1990, First Executive had become the 15th largest life insurer in the United States with combined assets exceeding $19 billion.
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> Mr. Carr and his associates achieved their heady success by turning the Executive Life companies into high-risk investment funds which obtained capital from the public under the guise of insurance policies, annuities, and guaranteed investment contracts. Risky investments in junk bonds and speculative real estate yielded very substantial short-term profits that enabled the Executive Life insurers to beat their competition in the insurance industry. They attracted hordes of policyholders who were delighted to earn generous rates of return equivalent to the investment markets, while maintaining their funds in the secure hands of State-regulated insurance companies. The obvious defect in this happy scenario was that the generous earnings propelling the First Executive empire were produced by businesses with inflated values that would easily falter.

> During its heyday, First Executive amassed more than 60 percent of its insurance assets in the volatile and exceedingly risky junk bonds peddled by Michael Milken through the Drexel Burnham Lambert investment firm. These bonds paid very high interest because they were issued and backed by marginal corporations, which could not qualify for the lower interest capital offered by traditional securities and bank loans. When the junk bond market began to collapse precipitously in late 1989, gigantic write-downs in the investment portfolios at Executive Life in California triggered a policy redemption rush by worried customers. The rush exposed the underlying financial vulnerabilities of First Executive, and sank the Executive Life insurance companies in 1991.

Wishful Thinking: A World View of Insurance Solvency Regulation, A Report by the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce 19 (Oct. 1994).

ELIC's principal operating unit, the one domiciled in California, was placed into conservatorship on April 11, 1991. The California Insurance Commissioner, who had statutory responsibility for overseeing rehabilitation of the firm, faced an immediate and daunting task. The unit's accounts showed some $9.0 billion of policy and contract claims. Of these liabilities, $1.8 billion were in the form of an innovative product known as municipal guaranteed investment contracts (or Muni-GIC's), and the balance were more traditional insurance products, including standard guarantee investment contracts (GICs) held by pension plans and individuals. (We will examine litigation involving both of these liabilities shortly). One of the Commissioner's primary problems was that the ELIC's remaining assets were worth much less than $9.0 billion when the firm failed. Although many of the company's assets were hard to value -- particularly the junk bonds which were highly volatile at the time -- it appeared in the spring of 1991, that all of the firm's assets would be in the range of $5.0 to $6.0 billion.

By the fall of 1991, the Insurance Commissioner had developed a plan for resolving the ELIC conservatorship. He explained the plan in the following correspondence:

September 6, 1991

TO: POLICYHOLDERS, ANNUITANTS, CONTRACT HOLDERS, OTHER CREDITORS AND INTERESTED PERSONS OF EXECUTIVE LIFE INSURANCE COMPANY, OF LOS ANGELES, CALIFORNIA

I wanted to let you know the status of our efforts to rehabilitate Executive Life Insurance Company (ELIC) . . . .

After a long series of negotiations, the first official bid from the company came from a group of French investors on August 8, 1991. They agreed to purchase most of ELIC's assets and assume most of the policyholder and contract obligations which will provide approximately 81% of the ELIC contract value. . . . .

In an historic agreement of cooperation, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) decided on August 27, 1991, that state guaranty associations would fund the remaining 19% to most contract values. This means over 95% of the ELIC policyholders and contract holders will receive 100% of their original contract values. . . .

This agreement must be ratified by the individual guarantee associations. The California Life Guaranty Association has become the first to approve the agreement. This agreement would restore covered, allocated policyholders and contract holders (other than the Municipal-GICs) benefits to 100% of the ELIC contract account values for contracts up to the first $100,000. Contracts in excess of $100,0000 would also receive enhanced participations, including payments from a liquidating trust which will be created to carry out certain activities, including litigation designed to increase benefits to policyholders and contract holders. . . . .

Sincerely,
John Garamendi
California Insurance Commissioner
Conservator of ELIC

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January 29, 1992

TO: POLICYHOLDERS, ANNUITANTS, CONTRACT HOLDERS, OTHER CREDITORS AND INTERESTED PERSONS OF EXECUTIVE LIFE INSURANCE COMPANY, OF LOS ANGELES, CALIFORNIA

I am very happy to report that since my last communication with you we have made tremendous progress towards completing the sale of Executive Life. Last month, the Superior Court in Los Angeles approved my recommendation of [the French consortium] Altus/MAAF as the winning bidder in a vigorous competitive bidding process that saw eight different investor groups vying for the insurance company. . . . .As part of the sale Altus will pay $3.25 billion for the junk bond portfolio and other investors will contribute an additional $300 million to the new company, bringing the total infusion of capital to $3.55 billion. . . . .

The enclosed Rehabilitation/Liquidation Plan (the "Rehabilitation Plan") is the legal mechanism to accomplish the transition of Executive Life contracts to the new company established by Altus/MAAF, Aurora Natonal Life Assurance Corporation ("Aurora"). . . .

An important provision in the Rehabilitation Plan details how holders of Municipal Guaranteed Investment Contracts (Muni-GICs) should be paid. In our original proposal, we considered Muni-GICs to be Class 6 contracts, the same as general creditors under Insurance Code Section 1033. A higher priority, Class 5, was given to all other Executive Life policies and contracts. The Muni-GICs filed suit to challenge the position. The Superior Court held on November 15, 1991 that the bondholders [who benefit from the Muni-GICs] should receive the same treatment as other policyholders. We immediately appealed the decision and are awaiting a hearing date.

In the Rehabilitation Plan, we have recommended the if Muni-GICs are classified the same as insurance products, the account values of the Muni-GICs should be based on the purchase price of the bonds rather than their face value, which totals almost $2 billion. In order to provide equity and to avoid windfall profits, the account value of the Muni-Gics will reflect the price paid for the bonds purchased before the April 11, 1991 conservation proceedings, and the market price of the bonds on April 11, 1991 for bonds purchased after that date. It is our strong belief that bondholders should not receive a greater percentage of their actual investments than the insurance policyholders and annuitants.

If the Court of Appeal reverses the lower court and determines that Muni-GICs should be considered Class 6, insurance policyholder payments will rise from

approximately 72 cents on the dollar to about 89 cents. This will primarily affect those policyholders and contract holders with account values over $100,000. . . . .

I realize this has been a difficult nine months for you, and I appreciate your patience and cooperation as we bring this complex process to a successful conclusion.

Sincerely,
John Garamendi
California Insurance Commissioner
Conservator of ELIC

Litigation over the Muni-GICs mentioned in the Commissioner's second letter lasted for several years. We will examine one opinion from the litigation shortly, but first some background on these instruments. ELIC designed the Muni-GICs for municipalities raising funds for public works projects of various sorts. After raising tax exempt funds through the sale of municipal bonds, the municipalities would place the funds with a trustee that would, in accordance with the provisions of a trust indenture, invest the funds in one of ELIC's customized Muni-GICs. The Muni-GICs typically paid a relatively high rate of interest, and allowed the indenture trustee to withdraw funds to make payments on the indenture's bonds and to cover drawdowns on the projects associated with the bonds. Since bonds financed in this manner were typically not general obligation bonds — that is, they were not guaranteed by the sponsoring municipality — losses on Muni-GICs were borne by holders of the municipal bonds. Thus bond holders were directly affected by the treatment of the Muni-GICs in ELIC's rehabilitation Plan.

The bondholders' most financially significant disagreement with the Commissioner was over the treatment of the Muni-GICs in ELIC's rehabilitation plan. For example, the bondholders claimed the Muni-GICs were entitled to Class 5 priority status, which would put them on a par with ELIC's more traditional insurance obligations. The Commissioner argued for Class 6 status, which would make the Muni-GICs subordinate to ELIC's insurance obligations and therefore unlikely to receive any payments from the conservatorship. In Texas Commerce Bank v. Garamendi, 11 Cal. App. 4th 460, 14 Cal. Rptr. 2d 854 (1992), the California Court of Appeal ruled that the Muni-GICs were entitled to Class 5 status because the instruments fell within the California insurance statute's definition of annuity. The Court rejected the Commissioner's attempts to distinguish Muni-GICs from traditional annuities on the grounds that the instruments were simply fixed-rate funding instruments unconnected to a human life. (Traditional annuity make payments to an individual, typically from retirement until death.) Resolving the priority of Muni-GICs did not, however, end the litigation:

Commercial National Bank v. Superior Court
14 Cal.App.4th 393,17 Cal.Rptr.2d 884 (1993)

EPSTEIN, Judge.

Immediately upon his appointment by the court as conservator of the [Executive Life Insurance Company ("ELIC")] estate on April 11, 1991, the [California Insurance] Commissioner proceeded to sequester and conserve the assets of the insolvent company. . . . Early in the insolvency proceedings, a dispute arose over the priority claim status of the eight [Municipal Bond Guarantee Contracts ("Muni-GIC's")] which had been purchased for

a total sum of $1.8 billion. In Texas Commerce Bank v. Garamendi, [11 Cal.App.4th 460, 14 Cal.Rptr.2d 854 (Nov. 30, 1992)], we held these instruments to be annuities and their holders to be entitled to class-5-priority status.

The Muni-GIC's were issued to banks that acted as indenture trustees for eight municipal entities. Through these annuities, ELIC promised to make guaranteed, periodic accumulated interest payments to the trustee banks. The indenture agreements with the municipal entities required the banks to purchase Muni-GIC's from ELIC with the proceeds of funds raised by the entities through the sale of municipal bonds. The banks were required to transmit a part of the periodic annuity payments and special withdrawals from the Muni-GICs to the municipal entities, and, on their behalf, to pay all debts on a pro rata basis.

The result was that ELIC was the issuer and the trustee banks the policyholders of the Muni-GIC's. The municipal entities were the sole intended third-party beneficiaries of these instruments, and the municipal bond purchasers were creditors of the municipal entities.

During the pendency of the Muni-GIC claim priority dispute, the Commissioner entertained bids for assumption of portions of ELIC's assets and liabilities through a rehabilitation plan. This included sale of substantial portions of ELIC's "junk bond" portfolio, and a negotiated rehabilitation plan. The successful bidder was New California Life Holdings, Inc. (Newco), a California insurance company.

The rehabilitation plan provides for transfer of essentially all liabilities and assets of insolvent ELIC to Aurora National Life Insurance Company (Aurora), a subsidiary that Newco acquired and recapitalized to effect the plan. The present value of ELIC assets to be transferred is estimated at $7.2 billion or more, but no adjudication of the precise value has been made. In addition to the transferred assets of ELIC, Aurora will have access to an additional $300 million capital infusion now held in trust by another Newco subsidiary, Altus.

The plan also incorporates benefits under an Enhancement Agreement negotiated through the National Organization of Life and Health Insurance Guaranty Associations. Under that agreement, the guarantee associations of 43 states will supplement the rehabilitation plan with substantial assets for the benefit of insurance contracts which these associations are otherwise obligated to cover under the laws of their respective states. The plan deems this contribution as fulfilling the statutory obligations of the associations to their respective covered policyholders.

Aurora will assume liability for all ELIC insurance contracts and will issue restructured insurance contracts to owners of ELIC contracts who agree to participate in the plan. Aurora will make lump-sum "liquidation" cash payments to contract holders who elect not to accept a restructured contract. The plan provides all policyholders the right to opt out, but it is designed to discourage that election. . . .

The value of each restructured contract for purposes of fixing its alternative liquidation cash-out payment is obtained by multiplying the account value by the "liquidation percentage." That percentage, in turn, is fixed by dividing the value of ELIC's distributable assets as of the April 11, 1991 insolvency date by the total account values of all contracts. The trial court has adjudicated the value of the distributable assets on April 11, 1991 to be $5,044 million. Based on that, the liquidation value of a restructured contract will be about 72 percent of its value for purposes of benefits as a continuing Aurora restructured contract.

While there was extensive expert opinion testimony about the valuation methods used in the plan, and about alternative methods, there were few significant disputes as to the material facts. The principal dispute is over a legal issue: whether the valuation methods used are arbitrary and improperly discriminatory . . . .

The Two-Tier System

The central issue in this litigation is how policyholder accounts are to be valued for purposes of calculating the terms of restructured policies and the amount of lump-sum payments to be made to those who choose not to accept those policies.

In the case of Muni-GIC's, and for them alone, the plan sets up a valuation system that disregards the actual policyholders and the amounts they paid to purchase their annuities. This is the "two-tier" system, and it is the basis of the first challenge to the plan that we discuss.

The assumption of the two-tier system is that the trustee banks that purchased and that hold the Muni-GIC's, and to which they were issued, are not policyholders. Instead, the system looks through the banks and the municipalities that furnished the funds to buy the policies, to the current owners of the municipal bonds issued to raise funds used to purchase the annuities.[6] The valuation is not based on the amount raised from the sale of municipal bonds for purchase of the annuities or on what ELIC received for the annuities, but on what each bondholder of record actually paid for bonds on the primary or secondary market, if the acquisition was on or before the April 11, 1991 insolvency date. For purchases after that, the plan uses the market value of the bonds on April 11, 1991.

Stated in another way, the system disregards the $1.8 billion actually paid to ELIC for the Muni-GIC annuities, and looks instead to the out-of-pocket amounts paid by persons who were bondholders of record on April 11, 1991, and to the market price on that date for bondholders who purchased bonds thereafter.

The effect of disregarding the premiums actually realized by ELIC is significant. It is undisputed that a large number of the municipal bond owners purchased their positions on the secondary market at prices below, and in some cases substantially below, the par-value issuance price. Devaluing the Muni-GIC's reduces the amount to be paid or credited to their owners, either in benefits or in opt-out payments. The money realized by this devaluation increases the value of other policies relative to the Muni-GIC's.

The Commissioner argues that rehabilitation proceedings are equitable in nature and that the plan is fair because it prevents profit-taking by those who purchased bonds for less than a par consideration. He also asserts that statutory requirements for recognition of consideration and ratable distribution are satisfied by focusing on the out-of-pocket amounts paid by the bondholders.

We cannot accept the two-tier approach as valid. It is based on an unjustified fiction, and it is not supported by law or reason.

Its most obvious infirmity is that it treats the municipal bondholders as "claimants" and "policyholders." They are neither. It also refers to the out- of-pocket payments for the bonds (or the market price on April 11, 1991 for bonds purchased after that date) as the "consideration" for the Muni-GIC's. They are not.

Section 1023 controls what must be shown for a creditor or policyholder claim to be allowed against the estate of the insolvent insurer. The statute requires that a claim based on a contractual obligation declare that the amount claimed is "justly owing from such person [the insolvent insurer] to the claimant" and state "the particulars thereof, and the

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6 For that reason, this aspect of the plan is alternatively called the "look through" system. The plan uses the term "Nominated Account Value" to describe the aggregate account value established by the system, apparently on the theory that the amount paid for the municipal bonds, originally or on the secondary market, "nominates" (i.e., fixes) the amount to be used in the valuation formula.

consideration paid therefor." It is evident that section 1023 means consideration paid by or on behalf of the insured for the insurance contract, not consideration paid in some other transaction by parties not in privity with the insurer.

There can be no serious dispute that the record owners of the municipal bonds issued in 1985 and 1986 to fund the 1986 ELIC Muni-GIC's have no privity of contract with the insolvent insurer and did not pay section 1023 "consideration" to ELIC for the Muni-GIC's.

In Texas Commerce Bank v. Garamendi, supra, 11 Cal.App.4th 460, 14 Cal.Rptr.2d 854, we explained in substantial detail what constitutes an insurance annuity under section 101. We concluded that the 1986 ELIC Muni-GIC's are entitled to class 5 "policyholder" claim status against the ELIC estate because they qualify as insurance annuities under section 101. In arriving at this conclusion we examined the relationship between the Muni-GIC's and the underlying "indenture agreements" between the respective trustee banks and municipal entities.

Under the provisions of the Muni-GIC's, ELIC's only contractual obligations were to the trustee banks, as owners, and to the underlying municipal entities, which were designated in the GICs as the only intended third-party beneficiaries. The very terms of the Muni-GIC's state that the indenture trustees are the legal owners of those annuities. The Muni-GIC's expressly disclaim any intent to create any other third-party beneficiary or contractual obligation on the part of ELIC. While the underlying bonds were offered to the public with the representation that the municipal entities' obligations would be backed by the security of Muni-GIC's, this did not create a policyholder status in the bondholders or a contractual relationship between bond purchasers and ELIC.

The circumstance that the indenture agreements between the municipal entities and the bank indenture trustees require the banks to pay a portion of the Muni-GIC periodic payments to bondholders for accruing interest on the bonds, and generally subject the agreements to insolvency and bankruptcy laws, does not abrogate the legal status of ELIC as insurer, the trustee banks as the sole Muni-GIC policyholders, or the municipal entities as the only third-party beneficiaries under the indentures.

The requirements of section 1023 also are inconsistent with provisions in the plan that municipal bondholders are entitled to share ratably with class 5 priority claimants. Even if bondholders somehow could qualify as claimants on the theory that ELIC owed a debt to the municipal entities that the bondholders could reach, they would be, at best, class 6 general creditors, not entitled to share ratably or at all with the class 5 claimants.[7]

Besides its inconsistency with section 1023, the legal fiction that bondholders are policyholders also is inconsistent with the rationale of equitable distribution required by the controlling statutes and by the Carpenter rationale.

Sections 1025, 1033 and 1057, read together, manifest the principle that the insolvency trustee has a fiduciary duty to effect a pro rata distribution to all allowed policyholder claimants. Section 1025 controls the allowance of unliquidated claims, but requires that

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[7] We note, also, that the Commissioner's position that bondholders are policyholders is inconsistent with the position taken by the Commissioner in Texas Commerce Bank v. Garamendi, supra, 11 Cal.App.4th at p. 482, 14 Cal.Rptr.2d 854. In that litigation, which was pending during the briefing in this case, the Commissioner put forward the rationale that Muni-GIC's did not qualify as annuities under section 101 because they were sold to banks and had no human annuitants. That position is inconsistent with the argument he now makes that the banks and the municipalities should be "looked through" to find the true annuitants--the bondholders--many of whom the Commissioner acknowledges to be individual persons.

such claims, once proved and allowed, "... shall share ratably with other claims of the same class in all subsequent distributions." Section 1033 controls liquidation preferences of allowed claims. Its subdivision (a)(5) gives the same claim priority to "all claims of policyholders of an insolvent insurer that are not covered claims." Section 1057 provides that in insurance insolvency proceedings the Commissioner is deemed to be the trustee for the benefit of all creditors and other persons interested in the estate.

The principle embodied in sections 1023, 1033 and 1057 precludes the Commissioner from disregarding insurance contracts or the policyholders who filed claims based on those contracts. It also precludes him from reducing the value of those contracts in order to achieve objectives extraneous to the entitlements of the policy owners.

In fact and in law, the Muni-GIC's, not the municipal bonds, are the policies; the trustee banks, not the bondholders, are the claimants; and the $1.8 billion paid to ELIC by the banks, not the prices paid by bondholders for their bonds, is the "consideration paid" within the meaning of section 1023.

The discrimination against Muni-GIC policyholders by the two-tier system is manifest. They are the only group as to whom the actual purchase price paid for an insurance product is disregarded. We have pointed out that the use of this system seriously disadvantages Muni-GIC policyholders relative to other policyholders.

What is left is the claim that the authority to impose a "two-tier" system may be implied from the equitable nature of insurance insolvency proceedings.

It is not disputed that insurance insolvency proceedings are special proceedings controlled by statutory provisions requiring fairness with respect to allowed claims within the same claim priority class. But no authority has been cited and none has been found conferring discretion to the superior court to approve a valuation scheme that disregards the very insurance policies upon which claims were filed and approved, and disregards the legal owners of the policies who actually paid consideration for their contracts to the insolvent insurer and filed timely claims against the insolvent insurer. . . .

The "equity" argument is based in large part, if not entirely, on the notion that speculators who purchased municipal bonds at prices less than their par issuance value should not be allowed to profit. There is no showing or even an argument that any of the bond transactions are voidable or illegal in any way. The usual rule is that the buyer of a bond or similar instrument of debt is at least entitled to exercise the right of the seller, into whose shoes the buyer has stepped. There is nothing to suggest that this rule does not apply to bondholders who purchased bonds on the secondary market. Indeed, if it did not, there would scarcely be a secondary market.

The two-tier system vitiates the legal ownership rights of the trustee banks and diminishes by millions of dollars the account values of the Muni-GIC's. This indirectly diminishes the amount of ELIC funds that might ultimately be distributed to the legal owners of the Muni-GIC's and transmitted by them to the issuing municipal entities and their creditors, the current bondholders (including those who bought at par-value issuance prices or higher). Moreover, it does nothing to reimburse an original bond purchaser who sold at a distressed price.

We find nothing equitable in a system that disregards the very insurance policies upon which claims were filed and approved, disregards the legal owners of the policies who paid for them, and simply redirects a part of their entitlement for reasons unrelated to effectuation of the rehabilitation plan. . . . .

The Liquidation Valuation Date

The final issue we determine is whether the date ELIC conservatorship proceedings were commenced (April 11, 1991) is an appropriate date for setting the value of the distributable assets of the insolvent insurer that opting-out policyholders will share.

The selection of the April 11, 1991 conservatorship date, rather than a date closer to the effective date of the rehabilitation plan, relegates opting-out policyholders to share a fund acknowledged by all parties to be billions of dollars less than the value of the ELIC assets when the rehabilitation plan was approved, on July 31, 1992. The value of ELIC's assets as of April 11, 1991 was adjudicated by respondent to be $5,044 million. The parties dispute the value of the assets at present, but it is agreed that the estate has substantially appreciated (partly due to cessation of payments to most general creditors and reduced interim benefit payments to policyholders) and may amount to $7.6 billion.

The liquidation valuation date is important because it determines the amount of ELIC assets available for pro rata distribution among opting-out policyholders. Consequently, it also determines the amount of ELIC assets available to Aurora for purposes of carrying on the business of ELIC through the restructured policies of the opting-in policyholders. A calculation based on the liquidation value of the insolvent estate as of the date of implementation of the rehabilitation plan would increase the portion of ELIC assets available to opt-out policyholders and decrease the portion transferred to Aurora.

The Commissioner and Aurora contend that the April 11, 1991 date set by the plan is authorized by section 1019 and supported by equitable considerations. They also contend that setting the valuation date is a matter within the broad discretion conferred upon the Commissioner, acting as rehabilitator, and upon the superior court by section 1043 and the police power of the state.

We conclude that the valuation date selected cannot be supported.

Section 1019 provides: "Upon the issuance of an order of liquidation under section 1016, the *rights and liabilities* of any such person [the insurer in liquidation] and of creditors, policyholders, shareholders and members, and all other persons interested in its assets ... shall, *unless otherwise directed by the court*, be fixed as of the date of the entry of the order...." (Emphasis added.)

The Commissioner and Aurora read the section 1019 reference to "rights and liabilities" as including the determination of the total value of the distributable assets of the insolvent insurer for purposes of liquidation distribution. They urge that the statute's reference to a court order ("unless otherwise directed by court") confers discretion on the court to select either the date of the liquidation or any other date for the valuation. They conclude that section 1019 authorizes a rehabilitator under section 1043 to select any liquidation valuation date for purposes of determining how much is available for distribution to policyholders opting-out of the rehabilitation. . . . .

Use of the insolvency date provides an unrealistic result because, in most situations, significant time will pass from the date of the conservation order to the actual liquidation or rehabilitation distribution. If the estate appreciates after the conservation order and straight liquidation is ultimately necessary (when a rehabilitation plan fails or when rehabilitation is not a viable alternative), valuing the estate as of the conservation date will not yield the total net value of the estate available for distribution to claimants. Conversely, if the estate value decreases after entry of the conservation order, valuation of the estate assets as of the date of the conservation order yields a value in excess of that actually available to claimants upon liquidation or rehabilitation distribution. In either case, a second valuation as of the distribution date would be required.

Calculation of the "liquidation" value of assets as of the distribution date of a rehabilitation plan is more functional. It pragmatically fixes total distributable asset value

as of the very date the liquidation distribution is actually to occur. No second calculation is required to account for interim fluctuation in the value of the distributable assets. . . . .

The Commissioner and Aurora also contend that April 11, 1991, is the appropriate "liquidation" valuation date for the insolvent insurer's assets because, since that date, the efforts of the Commissioner have been directed toward effecting a rehabilitation plan providing continuation of policy benefits to ELIC policyholders and greater recovery than could have been realized in a straight liquidation pursuant to section 1016.

From this they argue that policyholders who elect not to participate in the section 1043 rehabilitation plan, which was formulated by the Commissioner and approved by respondent approximately 14 months after commencement of the conservation proceedings, are not entitled to share in the accumulated value of the insolvency estate during that period. Instead, the plan would treat policyholders who elect not to accept restructured insurance contracts as if no rehabilitation plan were ever effected. They are not permitted to share in either the benefits or the burdens of the rehabilitation.

In contrast, it is argued, policyholders who agree to accept restructured policies under the plan deserve to have their restructured policy benefits calculated on the basis of the total value of the estate as of the effective date of the rehabilitation plan (estimated to be approximately $2 to $3 billion greater than the April 11, 1991, value).

The problem with this rationale is that it assumes that policyholders had a choice at the time the assets of ELIC were taken over on April 11, 1991. The fact is that, with very limited exceptions, all ELIC policyholders were compelled to wait over 14 months while the rehabilitation plan was being formulated and offered for court approval. They are still waiting. It is only when the plan is known that policyholders can intelligently determine whether to opt in or opt out. In the meantime, all policyholders were subjected to the same risk that the ELIC estate would depreciate in value by the time a plan was formulated and approved. There is no rational basis to penalize policyholders who are dissatisfied with the eventual plan on the theory that they are ungrateful dissidents who bore no risk of depreciation of the estate and deserve no share of the accumulations.

Comments and Questions

1. The Commissioner's proposed valuation technique was intended to prevent holders of municipal bond from receiving windfall profits on their investments. Was this a legitimate concern? Would you recommend the California insurance statutes be amended to incorporate the Commissioner's position? What effect would such an amendment have on future insolvencies? The second issue considered in this case — the valuation date of ELIC's assets — also had implications for bondholders, as well as any other claimant of the conservatorship that was not fully protected by state guarantee funds. As a matter of public policy, should these claimants participate in the performance of conservatorship assets after the receivership has been declared? Or should the state agencies charged with supervising the receivership bear the risks from any increase or decrease in asset values? How is this issue resolved in the disposition of failed banks?

2. In certain respects, the rehabilitation proceedings of insolvent insurance companies such as ELIC resemble those we studied for depository institutions. Once again, the provisions of the federal bankruptcy code do not apply; rather specialized government agencies are responsible for the rehabilitation or liquidation of the entity. In addition, government guaranty funds, analogous to the FDIC, protect eligible

claimants from loss. (In ELIC's case, these guarantees typically did not extend to Muni-GICs.) Moreover, as the ELIC case illustrates, the preferred disposition technique for failed insurance companies is to transfer the failed entity's assets and liabilities to an existing or newly created firm to ensure continuity of operations. (This is similar to the purchase and assumption transaction in the failed bank context.)

Where insurance company resolution procedures differ from the depository institution practices is in the number of organizations involved. For banks and thrifts, the FDIC serves as both receiver and guaranty fund. In the insurance context, these functions are divided. In ELIC's case, for example, the California Insurance Commissioner served as conservator of the failed entity, but a collection of state guaranty funds indemnified eligible claimants for their coverage shortfalls. The California insurance fund would typically cover policyholders resident in that state, but out-of-state policyholders would ordinarily have seek indemnification from their own jurisdiction's guaranty fund. This network of guarantees considerably complicates insurance company insolvencies. As the ELIC case illustrates, all affected guaranty funds typically must sign off on final rehabilitation plans. Often there is uncertainty as to which state's guarantee fund covers a particular policy. (For example, which state covers a life insurance for a person who was a Minnesota resident when the policy was purchased ten years ago, but for the last five years has been living in Florida?) There is also considerable variation in the amount of guarantees offered in different states. For example, whereas California covers life insurance contracts up to $100,000, Pennsylvania guarantees comparable policies up to $300,000. See Unisys Corp. v. Pennsylvania Life & Health Insurance Guaranty Ass'n, 667 A.2d 1199 (Pa. Commonw. Ct. 1995). States even take different positions with respect to what kind of policies are covered, as the following case illustrates:

Arizona Life & Disability Insurance Guaranty Fund v. Honeywell, Inc.

927 P.2d 806 (Ariz. Ct. App. Div. 1996), *rev'd*, 945 P.2d 805 (Ariz. 1997)

The Arizona Life and Disability Insurance Guaranty Fund ("the Fund") filed an action for declaratory relief in superior court seeking a declaration that it was not obligated to cover losses suffered by an employee retirement plan operated by Honeywell, Inc. . . . The issue presented is whether the Fund must assure payments by an insurer which had entered into Guaranteed Investment Contracts ("GIC's")[1] with the plan trustee.

I.

Honeywell is a Delaware corporation with its principal place of business in Minnesota. It operates manufacturing and research facilities in various locations in Arizona. Honeywell sponsors employee retirement plans for its employees. The assets of Honeywell's employee retirement plan are held in trust and are managed by the trustee.

Honeywell's employees voluntarily participated in the retirement plan. Employees elected to deduct a designated percentage from their pay to be invested on their behalf. Employees could select from among several different investment programs.

More than 7,000 of Honeywell's Arizona employees selected what was designated the "fixed income" or "protected interest" option. For those employees who selected this option, the trustee invested approximately 21 million dollars with the Executive Life Insurance Company ("ELIC"). ELIC was a California insurance corporation authorized to do business in Arizona.

The trustee purchased four GIC's from ELIC in January and April of 1988. The four contracts were substantially similar. Each named the trustee as the owner of the contract. As owner, the trustee was entitled to "exercise every contract right and enjoy every contract provision without the consent of any [Honeywell employee retirement plan] participant."

The trustee deposited a specified amount, either in a lump sum or in installments, with ELIC. Each GIC issued by ELIC provided a guaranteed interest rate on the deposit. Each GIC had a set maturity date at which time ELIC was obligated to pay the full "fund value." "Fund value" was defined in the contracts as "the sum of all deposits, less any withdrawals and scheduled payments, plus interest earned at the guaranteed rate...." Each GIC provided for annual payments of accrued interest to the trustee. Each GIC also provided that the full fund value was to be paid not in one installment but in a specified number of yearly installments.

Deductions from the fund value of the GIC's were allowed without penalty under specified conditions. Each GIC contained what we will refer to as "payout provisions":

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[1] The definition of a GIC varies. Recent Arizona legislation defined the term "Guaranteed Investment Contract" as

> an investment contract, funding agreement or guaranteed interest contract in which an insurance company agrees to guarantee a fixed or variable rate of interest or a future payment that is based on an index or any other similar criteria and that is payable at a predetermined date on monies that are deposited with the insurance company without regard to the continuance of human life.

A.R.S. § 20-208 (Supp.1995).

> The Owner may direct [ELIC] to purchase an individual annuity contract for a participant before the retirement date. [ELIC] will withdraw the cost of annuity benefits for the participant on the date it withdraws the amount. The owner may also withdraw all or part of the fund value to provide for plan benefits, in accordance with the [Honeywell employee retirement plan's] provisions.[5]

If funds were withdrawn before the contract maturity date, interest payments on the amounts withdrawn ceased. Although the trustee could have withdrawn funds from the ELIC GIC's to purchase annuities on behalf of Honeywell's employees, it is undisputed that it made no such withdrawals.

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[5] Honeywell's retirement plan allowed for distribution of retirement benefits upon retirement, disability, death or termination of employment.

Upon retirement, a plan participant could select three types of annuities: a life annuity, an annuity covering the participant for life with the remainder to a beneficiary, or a joint and survivor annuity.[6] When the trustee purchased annuities for retiring employees, it purchased the annuities from other insurance companies.[7] However, if a retiring employee did not wish to select an annuity, Honeywell's retirement plan allowed several other options, including a lump-sum distribution, a deferred lump-sum distribution, and payment over a term of years.

When an employee died, Honeywell's retirement plan provided three options for the surviving beneficiary. The survivor could request full payment of the dollar value of the deceased employee's accrued benefits in a lump sum, payment over a term of years, or payment in the form of an annuity to provide retirement income for the life of the beneficiary.

II.

Because the issue in this case depends on whether Arizona's guaranty fund statute covers guaranteed investment contracts, we begin with an analysis of the relevant statutory provisions.

In 1977, the Arizona Legislature established the Life and Disability Guaranty Fund. The legislation was patterned after a model act developed by the National Association of Insurance Commissioners.

Although no statement of intent was adopted by the Arizona Legislature, the drafters of the model act wrote that the purpose of such a guaranty fund is "to protect policy-owners, insureds, beneficiaries, annuitants, payees and assignees against losses . . . which might otherwise occur due to an impairment or insolvency of an insurer."

Under the Arizona statutes, all member insurers are required to be members of the Fund as a condition of their authority to transact insurance in Arizona. A.R.S. § 20-683(A) (1990). All costs, expenses and liabilities of the Fund are paid from assessments levied against the member insurers. A.R.S. § 20-683(C) (1990).

When a non-Arizona insurer becomes impaired, the Fund is obligated to

1. Guarantee, assume or reinsure . . . the covered policies of residents.
2. Assure payment of the contractual obligations of the impaired insurer to residents [and]
3. Provide such monies, pledges, notes, guarantees or other means as are reasonably necessary to discharge such duties . . . .

A.R.S. § 20-685(D) (Supp.1995).

However, the Fund's obligations are limited to certain kinds of insurance, namely:

> to direct life insurance policies, disability insurance policies, annuity contracts and contracts supplemental to life and disability insurance policies and annuity contracts issued to residents of this state by persons authorized to transact insurance in this state. . . .

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[6] The GIC's contracts provided that, once the trustee applied for "an individual retirement annuity contract ... [t]he contract will be owned by the [employee retirement plan] participant, and will specify the dates and amounts of payments...."

[7] If the retiring employee selected the annuity option, the retirement plan provided that the trustee would select the insurance company from which the annuity would be purchased.

A.R.S. § 20-682(A) (Supp.1995). The question of the Fund's obligation to cover the losses suffered by Honeywell's employee retirement plan after ELIC's liquidation depends on whether the GIC's are included in section 20-682 as "annuity contracts ... issued to residents of this state. . . ."

The first question is whether the GIC's were "issued to residents of this state." The Fund argues that they were issued to the non-resident trustee. While the trustee was legal owner of the GIC's, the equitable owners were the beneficiaries of the retirement plan trust. Many of the beneficiaries were Arizona employees of Honeywell. The contracts were "issued to" Arizona residents even though the trustee held legal title. See Unisys Corp. v. Pennsylvania Life and Health Ins. Guar. Ass'n, 667 A.2d 1199, 1204 (Pa.Commw.Ct.1995) (resident employees protected under Pennsylvania's Guaranty Fund even if owner of GIC's was the trustee of the employee benefit plan). But see Bennet v. Virginia Life, Accident and Sickness Ins. Guar. Ass'n, 251Va. 382, 468 S.E.2d 910, 913 (1996) (GIC's were issued to plan trustee, not plan participants, and were owned by trustee).

We agree with Honeywell that the Fund's interpretation of the phrase "issued to residents" leads to anomalous results. It would be possible under the Fund's construction for employees who are residents of other states to invoke the protection of Arizona's fund merely because an Arizona resident was trustee of their retirement plan. That would expose the Fund to coverage of benefits owed to unknown numbers of non-Arizonans, based merely on the selection of an Arizonan as trustee. On the other hand, the Fund's interpretation would deny coverage to Arizona employees merely because their trustee was not a resident of this State. That result would disserve the legislative purpose, which is to protect the interests of resident policyholders and insureds from the consequences of insurers' impairment.

[The next question is whether the ELIC GIC's are "annuity contracts."] The Fund statutes do not define the term, but elsewhere the term "Annuities" is defined. That term

> encompasses all agreements to make periodic payments ... where the making or continuance of all or some of a series of such payments, or the amount of such payment, is dependent upon the continuance of human life.

A.R.S. § 20-254.01 (1990).

Honeywell contends that the GIC's were annuities for two reasons. First, it argues that the GIC's themselves are annuities because they provided that ELIC would make life-contingent periodic payments. Second, Honeywell argues that the payout provisions requiring ELIC to issue an annuity to a Honeywell employee on the trustee's request satisfies the definition of annuity. We disagree with both contentions.

The GIC's themselves are not annuities because payments under the GIC's are not life-contingent. Under the terms of the GIC's, the trustee deposited specified sums with ELIC. ELIC then agreed to pay the fund value -- accrued interest and principal -- in yearly installments. Honeywell argues that these yearly installments constituted "periodic payments" as contemplated by A.R.S. section 20-254.01. Honeywell also contends that these payments were "dependent upon the continuance of human life" because the GIC's provided that amounts could be withdrawn from the fund value if a Honeywell employee died.

Honeywell's claim that the GIC's were life-contingent rests on a part of the retirement plan. The plan allowed for distribution of benefits upon the death of the employee. The GIC's in turn accommodated the plan provision by allowing the trustee to withdraw all or part of the fund value to provide for plan benefits, including the distribution upon death. Honeywell argues that the periodic payments of the fund value to the trustee were life contingent because -- if an employee died -- the trustee could make withdrawals to pay plan benefits.

If this occurred, then some of ELIC's payments to the trustee would depend on the continuance of a human life.

The death benefit payout provision does not make the GIC's themselves annuities. Arizona's definition of annuities requires that some or all of the payments from the financial institution to the annuitant "*is* dependent upon the continuance of human life." A.R.S. § 20-254.01 (1990) (emphasis added). Honeywell's interpretation of the statute would require us to hold that a contract is an annuity if the making or amount of the payments "may" depend on the continuance of human life, or if the payments "potentially" depend upon the continuance of human life. ELIC's payments were not affected by the death of an employee alone, but were affected only if the trustee also elected to pay the employee's benefits by a withdrawal from the GIC. This further condition means that payments under the GIC's did not depend on the continuance of human life.

Because the GIC's themselves were not life-contingent, they resembled bank certificates of deposit more than annuities. Indeed, Honeywell's description of the GIC's to its employees represented that the GIC's were similar to bank investments at a guaranteed interest rate. In explaining the fixed income fund, Honeywell wrote that "[t]he Fixed Income Fund invests in insurance company investment contracts, bank investment contracts, and money market investments." It also noted:

> The Fund assets are invested primarily in insurance company investment contracts, which are issued by insurance companies and are usually for substantial amounts of money.... The Plan agrees to invest money with the insurance company for a fixed time, usually one to five years. In return, *the insurance company agrees to pay a fixed rate of interest and return the principal upon maturity of the contract.*
>
> *Bank investment contracts are similar to insurance company investment contracts except they are offered by banks rather than insurance companies.*

(Emphasis added). Although Honeywell's characterization of the trustee's investments in GIC's is not dispositive, it does suggest that GIC's are analogous to bank certificates of deposit, not to annuities.

Honeywell cites Board of Trustees of the Maryland Teachers & State Employees Supplemental Retirement Plans v. Life & Health Ins. Guar. Corp., 335 Md. 176, 642 A.2d 856 (1994) for its argument. The issue in Board of Trustees was whether GIC's sold by ELIC to the trustee of the state employee retirement plan were covered policies under Maryland's guaranty fund provisions.

Under Maryland law, the provisions of the guaranty fund law were applicable to "direct life insurance policies, health insurance policies, annuity contracts, and contracts supplemental to ... annuity contracts issued by persons authorized to transact insurance in this State." 642 A.2d at 858 (quoting Md.Code. Ann. Ins. § 522(1) (1957)). The Maryland Fund's obligations when a foreign insurer became impaired were the same as the obligations of the Arizona Fund when a foreign insurer is impaired. See A.R.S. § 20- 685(D) (Supp.1995). Maryland law further defined annuity as

> all agreements to make periodical payments where the making or continuance of all or some of a series of such payments, or the amount of any such payment, is dependent upon the continuance of human life.

Board of Trustees, 642 A.2d at 859 (quoting Md.Code Ann. Ins. § 65 (1957)).

The court in Board of Trustees addressed the Guaranty Fund's argument that the payout provisions in the GIC's were not life-contingent. In rejecting this argument, the court wrote:

> ELIC could be called upon, whenever a participant died, to pay its pro rata share of that participant's account in the Plan. This amount would be the initial value of the share together with interest at the guaranteed rate, compounded daily. The actual return which ELIC might have

> realized on its investment of the premium deposits . . . as of the times of demands for payments generated by death or illness of participants, could have been below the amount which ELIC had promised to pay the Board. Thus, ELIC's assumption of the economic risk was life-contingent. Indeed, ELIC's contractual assumption also included the risk, however remote, that a catastrophe or epidemic would result in the deaths of large numbers of participants in a relatively brief span of time.

Board of Trustees, 642 A.2d at 861.

We disagree with the conclusion in Board of Trustees that the death benefit payout provision makes the GIC's themselves life-contingent. The court in Board of Trustees noted that ELIC could be called upon to pay sums out of the fund value of the GIC's if an employee died. The very rationale in that case was that it was sufficient that ELIC's payments were potentially life- contingent. We do not agree that the definition of annuity under Arizona law can be read to include an arrangement that makes the life-contingent nature of the periodic payments speculative.

The court in Board of Trustees also relied heavily on considerations not present in this case. First, the court relied on administrative treatment of GIC's as covered annuities.[12] Maryland's Insurance Commissioner had approved GIC policy forms, evidencing an administrative interpretation in favor of coverage. Id. at 863. Also, administrative regulations adopted pursuant to Maryland's guaranty fund law defined group annuities as contracts "*purporting* to provide annuity benefits to more than one person." Id. at 865 (emphasis in original). Second, the court cited evidence of legislative acquiescence to the administrative decision to include GIC's in Maryland's guaranty fund law. Maryland law provided a specific method for evaluating GIC's, and the court concluded from this fact that the Legislature knew that GIC's were being written by life insurance companies in Maryland at a time when the Insurance Commissioner had determined that GIC's were covered under the guaranty fund law. Id. at 864. The court also noted that the Maryland legislature had rejected four bills that would have excluded GIC's from coverage under the guaranty fund. Id. at 865-66. The court held that the failed amendments to the guaranty fund laws evidenced legislative acquiescence to the administrative practice of treating GIC's as covered annuities. Id. at 866.

We are not under any similar compulsion to follow an administrative practice to include GIC's as covered annuities. No administrative body in Arizona has determined that GIC's are covered under Arizona's guaranty fund provisions.[13] We interpret the statutes without any prior administrative practice of accepting these contracts for coverage or of making fund assessments based on these contracts.[14] Because we are not constrained by

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12 The same is true of the decisions in Unisys Corp. v. Pennsylvania Life and Health Ins. Guar. Ass'n, 667 A.2d 1199 (Pa.Commw.Ct.1995) and Minnesota Life & Health Ins. Guar. Ass'n v. Dep't of Commerce, 400 N.W.2d 769 (Minn.App.1987). . . .

13 Honeywell claims that an opinion of the Arizona Attorney General favors a finding of coverage. In an opinion written in 1983, the Attorney General wrote that the guaranty fund "covers individual lives insured under a group policy." Op. Ariz. Att'y Gen. I83-053 (R83-036) (May 11, 1983). This opinion is not helpful because it lacks any factual context. At best, the opinion demonstrates that coverage will not be denied to "a master plan encompassing many individual lives." Id. Even if group insurance policies or annuities are covered, this does not answer the question of what constitutes an annuity.

14 The Fund argues that the insurance department has by inaction determined that GIC's are not covered under the guaranty fund law. It notes that the insurance department has never applied

administrative interpretations in favor of coverage, we can interpret the definition of annuity according to its plain meaning: payments which depend in whole or in part on the continuance of human life rather than payments which might be contingent on the continuance of human life.

Honeywell's second argument is that the GIC's are annuities because the payout provisions provide for the purchase of an annuity from the fund value of the GIC's upon the retirement of a Honeywell employee. We also reject this argument. The possibility that an annuity would be purchased is even more speculative than the possibility of a withdrawal to pay the benefits upon death.

The provision allowing the purchase of an annuity is not itself an annuity. Rather, it is a clause accommodating a provision of the pension plan for purchase of an annuity. ELIC's contract accommodated this plan provision by allowing withdrawals to pay for the annuity.[15] The annuity entitled the employee to payments of retirement income for his or her life. After the employee exercised this option, the employee was designated as the owner of the annuity.

Whether an annuity would be purchased was entirely speculative. First, an employee who invested in the fixed income fund must have retired. Second, the employee would had to have selected the annuity option from the number of options available under Honeywell's retirement plan. Third, the trustee must have elected to direct ELIC to purchase the annuity by withdrawing money from the fund value of the GIC's, as opposed to purchasing an annuity from other funding sources. Given the contingencies that stood in the way of a purchase of an annuity under ELIC's contracts with the trustee, we cannot hold that the payout provisions mean that the GIC's are "annuity contracts."

Comments and Questions

1. On appeal, the Supreme Court of Arizona held that "[t]he ELIC GICs are annuity contracts as defined under [Arizona statute] and therefore eligible for Fund coverage" and "vacate[d] that part of the court of appeals opinion holding that the ELIC GICs are not annuity contracts." 945 P.2d 805, 817 (Ariz. 1997) The majority opinion explained: "GICs in and of themselves are not life-contingent, . . . [but] the GICs are part of [Investment Plus Plan] . . . [and] therefore . . . incorporat[e] the Plan, subject to all the Plan's provisions." *Id.* at 812. The dissented countered that "[i]n deciding whether GICs are annuities, [he] would look at the GICs alone without reference to the employer's Plan." *Id.* at 817.

2. As the divergent decisions in the Arizona courts reveal, there has been considerable variation in the way state guarantee funds have treated ELIC GICs issued

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the "form filing" requirements to GIC's and that ELIC was never required to pay premium taxes on the GIC's. . . . . The parties have not briefed the applicability of the form filing requirements or of the premium tax to annuity contracts. Assuming that an annuity contract is subject to these two requirements, we do not agree with the Fund that administrative inaction is evidence of an administrative interpretation to the effect that GIC's are not covered annuities.

15 It was only when an employee retired that the trustee could direct ELIC to withdraw money from the fund value of the GIC's to purchase an annuity. When an employee was otherwise entitled to benefits--upon death, disability and termination--the contract with ELIC provided that the trustee could withdraw funds to pay the employee's benefits. In the latter situation, there was no requirement that ELIC purchase an annuity for the employee.

to pension plans. Since the decisions typically involve interpretations of state law, the U.S. Supreme Court will not likely resolve these conflicts. Is the result is a healthy illustration of the states' serving as laboratories for regulatory experimentation? Or is it is simply inefficient and inequitable? Could you design a system that did a better job of dealing with insurance company insolvencies without moving to a national system comparable to what exists in the depository institution field?

3. Both the Arizona decisions and the preceding case arose from ELIC's insolvency: the earlier decision dealt with the conservatorship in California and this one involves guaranty fund coverage in Arizona. How would you compare the two decisions? Do they approach ELIC's failure in a consistent manner? Note in particular the ways in which these decisions treat the beneficiaries of ELIC's contracts: municipal bondholders in the first decision and Honeywell's employees in this case. Are the respective decisions consistent in their willingness to look beyond the nominal contract holders?

4. Another distinctive feature of our insurance insolvency procedures is the use of industry assessments to cover costs the guaranty funds incur when a company fails. Typically, these costs are assessed on insurance companies in the same line of business in that state. Assessments are also typically pro-rated based on amount of premiums written, and most states have an annual cap on the level of assessments each year (typically two percent of total premium income). In almost all U.S. jurisdictions, assessments are made only after an insolvency takes place. In many jurisdictions, insurance companies are permitted to deduct all or a portion of these assessments from state taxes.

4. This post-funded assessment system has been criticized in recent years. Some have questioned whether the system has the capacity to handle the simultaneous failure of one or more large insurance firms. See U.S. General Accounting Office, Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guarantee Funds (1992) (GAO-GGD-92-44). Statutory limits on the amount of annual assets, in particular, restricts the ability of insurance regulators to raise funds quickly, and one of the lessons of the thrift crisis of the 1980's is that undercapitalized guarantee funds can make costly mistakes by postponing closures in order to preserve resources. An alternative approach would be for insurance regulators to move towards the FDIC's deposit insurance system which entails pre-funding on a national basis. Would you favor such a change? Why or why not?

B. The NAIC and Its Accreditation Project

The failure of ELIC and several other large insurance companies in the late 1980s and early 1990s prompted congressional leaders and other experts to question the efficacy of our state-based system of regulating an industry that often operates on a national basis. Of particular concern was the perceived inability on the part of state insurance commissions to coordinate their efforts. Rogue companies domiciled in one jurisdiction posed a threat to the entire system. In the case of ELIC, for example, subsequent congressional investigation reached the following conclusions:

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> The regulators in other States relied entirely upon California and New York to supervise the Executive Life companies, rather than having many separate checks by different

commissions on the company's excesses. Nobody else took any action until the insurers' collapse was imminent.

- There was minimal communication and cooperation among State agencies. Dating back to 1980, New York had found . . . serious management wrongdoing. In February 1987, the department finally ordered a $250,000 fine and a $151 million capital infusion, and also banished the California company and the offending officers from New York. The California commission did not discover these regulatory actions until 3 months later, after the $151 million was paid without notice in violation of California law. . . . [T]he new California commissioner said the First Executive holding company basically "raided Executive Life of California to protect the New York Company." . . . .
- State regulators did not share important information. The Minnesota commission became deeply concerned about the condition of Executive life in early 1990, and sought to obtain current information from California. The California commission would not provide such data or agree to an immediate examination. . . .
- The NAIC's Securities Valuation Office, which is supposed to catch improper investments, allowed First Executive to create the illusion of investment grade securities by transferring $789 million of junk bonds to affiliated companies in exchange for new securities that were collateralized by the junk bonds . . . .
- Although State regulatory agencies have existing general powers to order an insurer to halt any practice which might result in a hazardous financial condition, no agency used these powers against the Executive Life companies. . . .

Wishful Thinking: A World View of Insurance Solvency Regulation, A Report by the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce 21-22 (Oct. 1994). At the time, parallels to the still unfolding thrift crisis were common:

> The need to adapt to the increasingly competitive environment has presented problems for many types of financial institutions--commercial banks, savings and loans, securities firms, and insurers. We see these stresses in the insurance industry in increasing insolvencies among both the property/casualty and life/health insurers. For property/casualty insurers, the average number of liquidations from 1970 to 1983 was about six per year. However, from 1984 to 1989, the average number of property/casualty liquidations increased to 24 per year, with a high of 36 in 1989. For life/health insurers, the average number of liquidations from 1975 to 1983 was about five per year. However, from 1984 to 1990, the average number of life /health liquidations was about 19 per year, with a high of 43 in 1989.

Insurance Regulation: Assessment of the NAIC, Statement of Richard L. Fogel**,** Assistant Comptroller General of the General Accounting Office Before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce (May 22, 1991).

Increasingly, Representative John Dingell (D-Mich.) and other influential congressional leaders were calling for a federal role in the regulation of the insurance industry. In response to these developments, the NAIC instituted an accreditation program which is the subject of the following testimony from an official of the U.S. General Accounting Office. As you review this testimony, consider the extent to which the NAIC's program offers a viable response to the problems of the prior regime.

Statement of Richard L. Fogel
Assistant Comptroller General of the General Accounting Office
Before the Subcommittee on Oversight and Investigations
House Committee on Energy and Commerce
(June 9, 1993)

NAIC's financial regulation standards were adopted in June 1989 and fall into three categories:

- First, there are twenty-seven Part A standards covering laws and regulations, seven of which were added by NAIC in March 1993. State insurance departments have until January 1, 1996 to comply with these new standards. According to NAIC, the Part A standards address whether the state insurance department has the needed authority to regulate an insurer's corporate and financial affairs. These standards cover such things as regulatory authority to examine firms, minimum required capital levels, prescribed accounting practices, and appropriate corrective actions for troubled companies.
- Second, there are twelve Part B standards covering regulatory practices and procedures. According to NAIC, these standards address whether the state insurance department has the necessary resources and capabilities to conduct financial analysis and examinations of firms operating within the state.
- The third part of the program consists of six Part C standards covering organizational and personnel practices. According to NAIC, these standards address whether a state insurance department has professional development and minimum educational requirements for its staff that will promote effective regulatory practices.

In June 1990, NAIC adopted its accreditation program to encourage states to implement the standards. In a full accreditation review, an independent on-site team of about five individuals assesses the state insurance department's compliance with these standards. The on-site visits generally last about 5 days. Subsequent on-site re-accreditation reviews are to be scheduled every 5 years with annual off-site evaluations by NAIC in the interim. To attain accreditation, a state insurance department must

- have authorities through laws, regulations, or administrative practices that substantially comply with Part A standards;
- have sufficient resources and appropriate procedures and practices to comply with each of the part B and part C standards, as measured by a rating of at least "acceptable" on a rating scale of "excellent," "good," "acceptable," and "unacceptable"; and
- receive an average score of "good" or better for the Part B standards taken together and for the Part C standards taken together.

To date, there is no penalty, other than peer pressure, for being an unaccredited state. However, beginning in January 1994 accredited states, except under certain circumstances, will not accept examination reports prepared by nonaccredited states on those states' domiciled insurance companies. This could require companies domiciled in nonaccredited states to get a second examination performed by an accredited state insurance department. This still does not penalize the unaccredited state directly. NAIC expects this sanction to lead insurers to lobby their home states to become accredited in order to avoid the expense of multiple examinations under differing state rules.

We continue to support NAIC's objective of improving the quality and consistency of solvency regulation and believe its accreditation program has helped to improve the overall quality of state regulation. We also recognize that a new program will inevitably experience

unanticipated problems and that a learning curve can be expected as changes are adopted to improve the program.

While NAIC's standards have been a catalyst in some states to make improvements in insurance regulation, our concern with the process is the speed with which NAIC is moving and its willingness to develop clear standards and apply them rigorously. NAIC's accreditation program still does not convincingly demonstrate that accredited states can effectively regulate. . ..

STANDARDS ARE NOT SPECIFIC, ALLOWING PERMISSIVE INTERPRETATION

For the accreditation program to be credible, it must establish consistent minimum standards that apply to each accredited state. NAIC and its review teams, however, continue to interpret the Financial Regulation Standards permissively. Therefore, states with weak regulatory authorities and practices are being accredited.

For example, most of the standards on laws and regulations require the state insurance department to have a particular NAIC model or authorities that are "substantially similar." In most instances, NAIC has not specified criteria for determining whether state variations from NAIC models actually provide the minimum level of solvency regulation intended by the standard. NAIC has said that these determinations are left primarily to the judgment of the review teams and ultimately the Financial Regulation Standards and Accreditation Committee. NAIC's President has said that this creates a problem for the review teams as well as for the committee. We are concerned that liberal interpretation of what is "substantially similar" to the NAIC models specified in the standards allows inconsistent or inadequate regulation.

Our review of the accreditation documentation revealed that all of the accredited states had variations from the NAIC models. Sometimes the states lacked model provisions, and sometimes the language of provisions was simply different from that of the NAIC models. In other cases, states had provisions not found in NAIC models; sometimes these provisions were stricter than the models but other times appeared to negate the intent of the models. Without specific criteria defining "substantially similar," we could not assess whether the teams' or the committee's determinations were appropriate or consistent. In light of the many variations cited by the review teams, we question whether the accreditation program will result in uniform, or even consistent, solvency regulation as NAIC envisions.

NAIC is trying to make several of the accreditation standards more specific. These include the standard for minimum capital requirements and the standard requiring that a state have a guaranty fund. We do not know when or if these changes will be adopted. However, in our view, NAIC failed in its much publicized attempt to clarify one of the financial regulation standards. In October 1991, NAIC ruled that, to become accredited, states had to have a particular provision of the Model Insurance Holding Company System Regulatory Act precisely as it was stated in the model. This particular language, setting regulatory approval, was added to the model law in 1986. This provision was added following the failure of Baldwin-United where, according to regulators, the parent holding company milked the insurance subsidiaries to service its own debt. By the time that NAIC made its decision to require the specific model language, several states with weaker thresholds than the model had already been accredited. Subsequently, NAIC reversed its ruling requiring the stricter threshold and approved a number of alternative provisions that it will accept as "substantially similar." According to NAIC, this action was taken because it believed that requiring only the model provision was "too rigid". However, some industry analysts have characterized NAIC's acceptance of the alternatives as weakening the standard.

We are concerned that liberal interpretation of what is accepted in the accreditation program as "substantially similar" may allow significant variation among states and

potentially weak regulatory performance rather than a consistent and definable floor in state systems . . . .

GROWING RESISTANCE TO DEMANDS OF ACCREDITATION PROGRAM MAY LIMIT ITS SUSTAINABILITY

According to NAIC, the accreditation program is dynamic, and standards will be added or amended to keep pace with changing industry practices. The evolutionary nature of NAIC's accreditation program will require states to periodically adopt new authorities or amend their regulatory programs to maintain their accredited status. For example, states have until January 1, 1996, to comply with seven new standards recently adopted by NAIC. Given the nature of the state-based insurance regulatory system, changes in the accreditation program require each state to revisit issues already addressed and considered resolved by its state legislature. We continue to question whether NAIC can sustain its program over time because it lacks authority to require states to adopt and use its standards.

Many state insurance departments are still working to adopt the original standards and may not be able to keep pace with NAIC's ever evolving standards. In March of this year, New York--one of the first states to be accredited--had its accreditation suspended by NAIC for failing to adopt several model laws or regulations added to the original standards. Recently, a number of regulators, industry representatives and state legislators have expressed resistance to NAIC's efforts to clarify vague standards and add new ones. Opposition from these participants in the regulatory process raises further doubts about the long-term viability of the program.

LACK OF FOCUS ON PERFORMANCE ALLOWS STATES WITH WEAK EXAMINATION QUALITY TO BE ACCREDITED

Insurance regulators have two tools that they routinely use to monitor insurers' financial condition and identify solvency problems. These are on-site examinations and off-site analyses of insurer-reported financial information. The accreditation documentation we reviewed revealed a disturbing pattern of weaknesses in the way states do insurance company examinations--a fundamental regulatory function. We found that NAIC's review teams consistently identified deficiencies in states' examination systems. This is troubling because examinations, which are generally required only every 3 to 5 years, are the principal means that state regulators have to verify insurer-reported data and to detect financial problems.

In our review of states accredited in 1991, we found numerous instances in which the review teams' workpapers appeared to indicate clear noncompliance with the regulatory practices and procedures standards on examinations. For example, some state insurance departments did not examine insurers in a timely fashion, and some did not have the necessary and required specialists available to assist examiners. Several states also did not comply with the accreditation requirement that they follow the policies and procedures of NAIC's Examiners Handbook. Nevertheless, the review teams certified departmental compliance with NAIC's standards as acceptable for accreditation, despite these noted deficiencies.

Again this year, the review teams' documentation suggested that minimum capabilities and procedures necessary for effective examination processes were not truly in place in all accredited states. In 7 of the 10 states accredited during 1992, the documentation indicated that examinations did not generally follow the Examiners Handbook in areas crucial for solvency monitoring. While the extent of the problems varied among the states, the accreditation review teams found inadequate testing of policy and loss reserves, lack of comprehensive internal control assessments, and reliance on unverified insurer-produced data and on the work of insurers' external auditors without assessing the quality and reliability of the auditors' work.

With these documented weaknesses in insurance company examinations, we question the state regulators' abilities to effectively detect solvency problems. Without proper assessment of insurance reserves, examiners have no reliable basis to understand an insurer's primary business operation. Without comprehensive assessments of internal controls, regulators have little assurance that examinations will detect all major control weaknesses. As a result, regulators could fail to find problems before they seriously erode an insurer's financial condition. Using unverified data and the work of external auditors without reviewing the scope and quality of that work also increases the risk that examiners will not detect potential problems.

Summary of States' Adoption of NAIC Models Related to Accreditation

(NAIC Data as of May 12, 1993)

---- Number of States With ---- NAIC Model	Date Model Adopted by NAIC	Changes to Legislation or Regulation Pending	Initial Legislation or Regulation Pending
	1991	2	6
Examination Authority			
Regulation to Define		Standards and	Commissioner's Authority for
Holding Company Act			
Holding Company Regulation			
Credit for Reinsurance Act		0	3
Credit for Reinsurance	1985	13	0
Regulation (1)	1969	4	1
Regulation for Life and Health	1971	Reinsurance Agreements (2)	2
Standard Valuation Law (1)	1984		
Actuarial Opinion and		0 Memorandum Regulation (1)	4
CPA Audit Regulation (1)	1991		
Rehabilitation and Liquidation		Model Act	
IRIS Model Act	1986	1	3
Risk Retention Act	1943	4	0
Business Transacted w/Producer		Controlled P/C Insurer Act (3)	
Managing General Agent Act	1991	0	4
Reinsurance Intermediaries Act	1980	2	0
Life and Health Insurance		Guaranty Association Act	
Post-Assessment Property and	1978	Liability Insurance Guaranty	2 Association Act
	1985	1	3
	1983	4	2
	1991	2	7
	1989	2	5
	1990	2	9
	1971	7	0
	1970	3	0

Legend:

(1) States have until January 1996 to adopt.
(2) California is the only state to enact a more comprehensive version of this model adopted by NAIC in 1992. States have until January 1996 to adopt the new version.
(3) States have until June 1993 to adopt.

CRITERIA ARE INADEQUATE FOR ASSESSING THE QUALITY OF FINANCIAL ANALYSIS

Insurance departments also assess an insurance company's financial condition through analysis of insurer-provided financial information. Like examinations, financial analysis is a component of NAIC's standards and the accreditation review process. However, whereas NAIC's Examiners Handbook contains specific work procedures and guidelines for planning,

supervising, and conducting examinations, similar procedures or guidelines that could be used as criteria in assessing how well a state insurance department analyzes insurer financial statements do not exist. As a result, we are unable to determine what constitutes an acceptable level of performance for the financial analysis process.

Because the scoring for each of the regulatory practices and procedures standards is not independent, the limited criteria for financial analysis is a significant concern. That is, although the program specifies that a state must receive a passing score on each standard, NAIC told us that weaknesses in one area can be offset by perceived strengths in other areas. In fact, as we reported last year, NAIC said that examination weaknesses in one accredited state were not a problem because the state had a good financial analysis system.

CONCLUSIONS

We support state efforts to improve the quality and effectiveness of insurance regulation through adoption of the Financial Regulation Standards set forth in NAIC's accreditation program. We believe that NAIC's standards have been a catalyst encouraging state insurance departments to regulate better.

So far, however, the program still does not credibly distinguish effective from ineffective solvency regulation. The standards are applied permissively. Thus, accreditation does not establish a meaningful minimum level of performance. Nevertheless, NAIC's accreditation review teams' efforts reveal a troubling pattern--poor quality of examinations in accredited states. These examinations are critical for effective solvency regulation. As long as the standards for accreditation of state insurance departments are vague and liberally interpreted, NAIC will not achieve uniformity, or even consistency, in state-by-state regulation. Moreover, we continue to question NAIC's ability to successfully sustain the program over the long term without the inherent authority to enforce its standards.

Comments and Questions

1. Since Mr. Fogel presented this testimony, the NAIC accreditation program has continued to evolve. By June 1995, 46 states and the District of Columbia had been accredited. In addition, the NAIC adopted several new mandatory statutes, including a Risk-Based Capital for Insurers Model Act that accredited states are supposed to have adopted by January 1, 1997. Does the continued accreditation of states suggest that Mr. Fogel was unduly skeptical of the NAIC's efforts with this initiative?

2. One of the GAO's concerns about the NAIC's accreditation program has been the ability of the organization to force states to comply with the standards. And, indeed, there has been some resistance at the state level to the NAIC's intiatives. In particular, the National Conference of Insurance Legislators ("NCOIL"), a voluntary organization representing 33 jurisdictions, has been a vocal critic of the NAIC's efforts. NCOIL's principal objections have concerned the large number of bills that state legislators are required to adopt even when the bills address problems that do not exist in all jurisdictions and the fact that the NAIC often insists that the model statutes be adopted verbatim, without amendment or modification to reflect local circumstances. Are these legimate complaints? The NOILC and other critics of NAIC accreditation have proposed that the system be amended to make mandatory only those model statutes that have already been adopted by a certain number of jurisdictions, perhaps a majority. Would you favor such an amendment?

3. As originally envisioned, the NAIC accreditation program was supposed to be self-enforcing. After January 1, 1994, accredited states were supposed to refuse to accept examinations from unaccredited states, thereby forcing insurance companies from unaccredited states to submit to additional examinations. This mechanism, however, has proven ineffective. For one thing, unaccredited states, such as New York, adopted retaliatory legislation threatening to reject regulatory examinations of insurance companies domiciled in states that rejected examinations from the legislating state. Threats of this sort dissuaded most jurisdictions from enforcing the accreditation sanctions. In addition, insurance companies from unaccredited states discovered a loophole in the original sanctioning mechanism. By submitting themselves to "zone" examinations, in which regulatory authorities from several states participated, a company domiciled in an unaccredited jurisdiction could claim that it was examined by an accredited jurisdiction if at least one accredited jurisdiction participated in the examination. Should the NAIC have amended its accreditation program to close this loophole?

4. The problem of multi-jurisdictional regulation reasserts itself in almost all areas of regulation in the international context. Many large financial institutions operate on a global basis. How are the problems of multi-jurisdictional operations solved in this context? Should there be a multi-national analog to the NAIC to coordinate regulation of the financial services industry around the world? What powers should it (or could it) have over sovereign nations?

These procedural weaknesses are exacerbated by a lack of quality controls over the consistency and reliability of examiners' work. The review teams often found inadequate documentation of what examination work was performed. They also found little explanation about why certain work was not performed. Both findings indicated to the teams that supervisory review was lacking or inadequate. Without proper documentation and supervisory review of work performed, there is a high likelihood that errors in examiner judgment could go unchallenged and that incorrect conclusions could result.

In testimony before this Subcommittee last year, NAIC said that it does not accredit states on a conditional basis. But, in reality, it had already done so. In 1991, Iowa was accredited on the condition that it was to demonstrate compliance with the regulatory practices and procedures standards during the year following its accreditation. In 1992, 3 of the 10 newly accredited states — Texas, North Dakota, and Minnesota — received accreditation contingent once again upon a full on-site reevaluation of their compliance with the regulatory practices and procedures standards in 1 year.

Texas was recommended for accreditation by the review team, and the committee accredited the state on the condition that Texas improve how it did financial analysis and financial examinations. Specifically, Texas was told to conduct its financial analysis on a more timely basis and implement more comprehensive examination procedures. North Dakota received accreditation but the review team believed it was only "minimally acceptable" with respect to its use of specialists and its compliance with the Examiners handbook. The review team in Minnesota recommended accreditation but also characterized the state's compliance with the examiners Handbook and supervisory review standards as "minimally acceptable." The review team further recommended that Minnesota's accreditation be withdrawn in 1 year unless it could demonstrate "significant improvement" in its compliance with those standards.

Under NAIC's scoring system, the need for significant improvement to comply with a standard is the definition of a failing score. Furthermore, according to the accreditation procedures, a state can become accredited only if it successfully meets or exceeds all minimum accreditation standards. A state failing to meet any minimum accreditation standard cannot be accredited.

If these three states met the requirements for accreditation, why were they accredited for only 1 year? If they did not meet the requirements, why were they accredited at all? Given the review teams' documentation, the stated criteria of the accreditation program, and NAIC's own recognition that these states did not comply fully with the requirements for accreditation, we question the NAIC's decision to accredit these states.

Last year, we suggested that NAIC consider recognizing publicly a qualified or conditional accreditation status for states which are found not to be in full compliance on all standards and, thus, are not prepared for full accreditation. NAIC's current policy is to publicly announce full accreditation for each state, but NAIC did not publicly disclose that four states' accreditations were contingent on passing another full on-site review in 1 year after their accreditations. The difference between these two alternatives may appear to some to be merely semantic. However, if NAIC is to hold up its program as a basis for assuring the public that the states are doing a good job of regulating the industry, it should be willing to share publicly the results of its assessments of state efforts. Public sharing of this information also could be a catalyst for making improvements.

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