Managing Insurer Insolvency 2003

Updating the 1988 Report

Prepared for the Foundation for Agency Management Excellence

by

Stewart Economics, Inc.

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MANAGING INSURER INSOLVENCY 2003

Updating the 1988 Report

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INTRODUCTION

In 1988, Stewart Economics published a report called *Managing Insurer Insolvency*.[1] The report was commissioned by the leading organization of insurance brokers. The report discussed the then-recent increase in insurance company insolvencies, the nature of the problem, and how regulators were dealing with it and should have been dealing with it.

We have been asked by a successor to the 1988 sponsor – the Foundation for Agency Management Excellence – to update that report. So we start with a reprise of the 1988 report, then describe what has happened in the 15 years from 1988 to 2003, and finally assess the present situation and the prospects for the future. Our focus is on commercial property-casualty insurance and, especially, on its regulation. As before, the views are entirely our own.

The 1988 report was written by the three principals of Stewart Economics – Richard S. L. Roddis, former California Insurance Commissioner, CEO of Unigard Insurance, and Dean of the University of Washington Law School; Barbara D. Stewart, former Corporate Economist of the Chubb Group of Insurance Companies and an Insurance Woman of the Year; and Richard E. Stewart, former New York Superintendent of Insurance, President of the National Association of Insurance Commissioners, General Counsel of Citibank, and Chief Financial Officer of the Chubb Group of Insurance Companies.

In 1998, Dick Roddis died, and this update is written by Barbara Stewart and Dick Stewart in his memory.

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[1] Stewart Economics, Inc., *Managing Insurer Insolvency*, (Washington, DC: National Association of Insurance Brokers, 1988). The report is also available at www.stewarteconomics.com/publications.

EXECUTIVE SUMMARY

The reliability of the insurance promise is an important objective of public policy in the United States and every other developed economy. The main focus has been on the ability to pay claims – regulation for solvency.

Two fundamental changes in the insurance business since the 1940s have increased the likelihood of insolvency. The first was the shift in the mix of business from property and marine insurance, with short intervals between sale and claim, to liability insurance, with long intervals. The second change was from cartelized markets and regulated pricing to price competition and chronic overcapacity.

The usual reason insurers go broke is that they do not charge enough for their product. That is obvious, but fixing it is not easy. Charging enough involves two difficult tasks – forecasting costs accurately and obtaining a price that will cover those costs. Both tasks are now far more difficult than they used to be.

The change from property to liability means a longer interval between sale and claim payment, often stretching more than a decade. Insurance companies have to forecast the cost of claims over that long interval in order to know what an adequate price is and what their financial condition is – both critical to success and even survival. Many will forecast too low.

Even when the forecast is accurate, collecting a price to cover the predicted costs has become harder too. In the new, competitive insurance world, insurance tends to be a commodity – an item whose buyers don't care about source and who regard sellers as interchangeable. Commodity markets are mainly competitive on price.

Price competition favors low-cost providers. Overheads vary widely among insurers. Most companies with high costs will never be able to get them down far enough.

The other way out of the squeeze of commodity competition is to be different, so as to escape comparison on price alone. Differentiating is not impossible for a few insurance companies in a few situations, but it is exceedingly difficult to establish and maintain.

So a lot of exits are coming. They will not come all at once, but they will come sooner or later. They will not all be by acknowledged insolvency. Some will be called restructuring or merger or strategic repositioning or discontinued operations or outsourcing of claims administration. But by any name they will be exits in the face of impending failure.

For decades, we have tended to blame insolvencies on mismanagement and fraud. Seeing it that way fits the characteristically American view that the natural state of affairs is good and getting better. So when something really awful happens, there must be a villain behind it.

Contemplating an insolvent insurance company, we search for fools, wastrels and criminal masterminds. Sometimes we find them. More often we do not. Then sometimes we invent them out of people who simply failed.

Competitive decline is the big cause of insolvency. It is true that some company failures are due to incompetence alone, some to fraud alone, and some to the two combined. But even villainy is most destructive when conjoined with competitive decline. It is possible for management to be both incompetent and dishonest, and also to be in an impossible competitive position. That synergy can produce disaster in a trice.

The problem with the villain theory – mismanagement and fraud as the causes of insolvency – is that it ignores the economics of a mature, overcrowded and price-driven business. A company with high costs and no advantages will either go out of business or be absorbed by a competitor. A management that cannot figure out how to survive such a situation is not necessarily incompetent or dishonest, even if in terminal desperation it takes foolish chances or fudges some numbers. And it is a short step from blaming the management for causing an insolvency to blaming the regulator for letting it happen.

The objective of solvency regulation has always been preventing company insolvency. For a long time, the property-casualty market was cartelized, which kept prices up. The way regulators helped prevent insolvency was by using rate regulation, agent licensing and other government powers to reinforce the cartels. That kept prices high enough to preserve the financial health of the entire market.

After World War II, the market changed in the most fundamental way imaginable. It became competitive on price. Regulators wanting to prevent insolvency had to do it one company at a time. Rescuing individual companies became more and more difficult as competition intensified.

Regulators are painfully aware that the villain theory of insolvency can extend to them, and that taking over a company against its will is difficult, disagreeable and uncertain. So they postpone public recognition of, and decisive action upon, financial weakness and insolvency. Delay has become even more tempting as the techniques for delay disguised as rescue have become more sophisticated and meretricious.

The regulators would benefit from stating the systemic truths – that insolvencies are an inevitable accompaniment of competition, that competition is both desirable and inevitable, and that focusing regulatory energy on preventing insolvencies is futile and a bad idea anyway.

The goal is protecting the public, not the companies. Saving failed companies is an inefficient way of protecting the public, and one with bad odds and bad side-effects.

Nor is time any longer on the side of the regulator who delays the recognition of insolvency, for two reasons.

One reason is that, with so many devices at hand for taking the conservatism out of statutory accounting, the chances increase that by the time the regulator acts, the company's financial cushions will have been used up.

The second reason is that a regulator is no longer alone with a failing company. Now the rating agencies and plaintiff's lawyers are watching. Each has the ability to finish off the failing company and expose the dithering regulator.

So regulatory delay is an even worse approach today than 15 years ago. The problems are worse and the chances of a good outcome are worse. Techniques for delaying action on insolvency have become more sophisticated and superficially attractive. And the techniques have influential economic constituencies – businesses that make money by selling them.

The declared purpose of insurance regulation is to have a sound industry and to protect policyholders. What has happened recently is an inversion of those regulatory priorities.

Failed companies are being kept alive, so the industry is less sound. Policyholders are unpaid and hustled off into impecunious, surly and combative run-off vehicles. Under official auspices, money is shifted from policyholders to

failed companies and failed managements that should have been taken out of the market. That doesn't sound like protection.

We are now emerging from an interlude when external forces, not management or regulation, reduced the incidence of insurance company insolvency.

Government and business people who want better insurance regulation ought to use what remains of that respite. They can use it to make the situation better for policyholders, insurers and everyone else who depends on a reliable insurance business. It is by no means impossible, but it will call for overcoming some powerful and quite natural forces of financial ambition, regulatory habit and human nature.

THE 1988 REPORT

The 1988 report, *Managing Insurer Insolvency*, addressed the role of solvency regulation in insurance and the regulatory response to an anticipated increase in the number and severity of insurer insolvencies.

The report reached two major conclusions. First, the regulatory mission is not to prevent insolvencies – they are inevitable – but to minimize the public harm from insolvencies. Second, minimizing harm means taking troubled companies out of the market promptly. Doing so is not a technical or legal challenge, but one of regulatory will to act.

This first section of the 2003 update briefly reviews the reasoning and conclusions of the 1988 report. Subsequent sections of this report will bring the 1988 report forward to reflect developments during the last fifteen years.

The Importance of Solvency Regulation

Insurance eliminates or reduces the risk of the financial consequences of external events for its customers, the policyholders. Insurance performs that role by accepting the risks defined in policy contracts, in return for the payment by the customer of a price, the premium. Insurance is essential to many kinds of commerce and finance.

Unlike most other kinds of commerce, in insurance the price or premium is paid long before the delivery of the product, the payment of a claim. If in the interval between premium payment and claim payment, the insurance company becomes unable or unwilling to pay claims, then the policyholder has received less than nothing, having parted with premium dollars for no performance in return.

Non-performance of a property-casualty insurance company is perhaps more damaging than that of any other kind of private company. The benefit a policyholder buys is compensation for an event which may or may not occur. The amount of protection is usually many times the premium – often hundreds of times. For the policyholder who cannot collect a valid claim, bad insurance just makes misfortune worse.

Hence the reliability of the insurance promise is an important objective of public policy in the United States and every other developed economy. The main focus has been on the ability to pay claims – regulation for solvency.[2]

The Chances of Insolvency

Two fundamental changes in the insurance business since the 1940s have increased the likelihood of insolvency.[3] The first was the shift in the mix of business from property and marine insurance, with short intervals between sale and claim, to liability insurance, with long intervals.[4] The second change was from cartelized markets and regulated pricing to price competition and chronic overcapacity.[5]

The usual reason insurers go broke is that they do not charge enough for their product. That is obvious, but fixing it is not easy. Charging an adequate price calls for two difficult tasks – forecasting costs accurately and getting a price that will cover those costs. Both tasks are now far more difficult than in the past.

The change from property to liability means a longer interval between sale and claim, often stretching more than a decade. Insurance companies have to forecast the cost of claims over that long interval in order to perform two

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[2] In 1927, the leading legal scholar of insurance regulation wrote:

> The chief object in view in creating separate insurance departments and in delegating to them extensive powers of regulation and investigation was to protect the public against financially unsound enterprises; and this remains the chief *raison d'être* of the insurance commissioner.

Edwin W. Patterson, *The Insurance Commissioner in the United States, A Study in Administrative Law and Practice* (Cambridge, MA: Harvard University Press, 1927), p. 192.

[3] Dating the fundamental shifts from the late 1940s stems in large part from the 1944 Supreme Court decision (in *U.S. v. South-Eastern Underwriters Assn*), that insurance was interstate commerce and hence subject to the federal antitrust laws. That meant the end of the cartel system, an end that was slowed but not stopped by the 1945 enactment of a partial exemption (the McCarran-Ferguson Act). In the years that followed, Congress and most of the states became convinced that price competition was both inevitable and desirable.

[4] In 1950, liability coverages accounted for 28% of total premiums. In 1988, the year of the prior report, and more recently, in 2001, they accounted for over 50%. *Aggregates & Averages*, A. M. Best Company, 1951, 1989 and 2002 editions.

[5] Jon S. Hanson, Robert E. Dineen and Michael B. Johnson, *Monitoring Competition* (Milwaukee: National Association of Insurance Commissioners, 1974), pp 35-53.

functions that are critical to success and even survival – setting prices and ascertaining their own financial condition.

To make those loss cost[6] forecasts, insurance companies deploy highly sophisticated mathematical and actuarial techniques, applied to huge amounts of detailed data, using advanced computing power. So do weather forecasters and interest rate forecasters, but nobody would expect a five-year weather forecast or interest rate forecast to be of much use.

Yet insurers have to make the forecasts. They have to develop rates to price their product. They have to set loss reserves to comply with law. Throwing up their hands is not an option. But consider the components of a loss cost forecast – economic activity, inflation, interest rates, technology, law, public attitudes toward various insured businesses, public attitudes toward insurance itself.

Insurance company managements are not so arrogant or unworldly as to believe they can really forecast such matters five or ten years out. If they end up simply extrapolating the past, it is because they cannot think of any better approach, and because price competition would not let them act on more conservative assumptions anyway.

The second change – from cartelized to competitive markets – confronts insurers that have high costs and no competitive advantages with a dilemma. If they charge the same price as more efficient companies, they lose money on every unit and eventually go under. If they charge a price that covers their own costs, they lose their best customers to competitors with lower prices, leaving them with the worse risks, which drives their prices even higher until the spiral of adverse selection takes them under too.

Decades of cartelization and price regulation brought high and predictable prices for insurance. That long history of stability and well-being invited the creation of hundreds of companies with high costs and no advantages.[7] They did

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[6] "Loss costs" is the actuarial term for claims costs, including claims that have been (a) paid, (b) reported to the insurance company but not yet paid, and (c) incurred (as predicted statistically) but not yet reported. Loss costs also include the cost of adjusting claims, such as investigation and legal expenses.

[7] There were 1,000 property-casualty insurance companies in 1950 and 2,000 at the end of 1988. After combining affiliated companies, the number of distinct organizations was 350 in 1950 and 940 in 1988. In 2001, there were 2,400 companies and 950 organizations. *Aggregates & Averages*, A. M. Best Company, 1951, 1989 and 2002 editions. Figures are rounded. Note that

not just have to compete with each other. More deadly competition came from insurers with different distribution systems and hence lower costs, and from substitutes for insurance from the risk management movement.

In the new, competitive insurance world, the exit of many insurance companies has become inevitable.[8] For many of them, exit will be by insolvency.

Competitive Decline vs. Mismanagement and Fraud

The market described in the preceding section is one in which a large number of companies – those with high costs and no advantages – cannot survive in the long run. Unless the management of such a company can differentiate its offerings or its ties to customers, or can get its overhead costs down significantly, the company is doomed in the long run.

Very few companies that start out with high costs and no advantages will be able to make either of the changes. Driving costs down by the amount necessary (a quarter to a half) calls for aggregating risks or replacing distribution systems. Dimming the lights, flying tourist and putting the employees on short rations will not save enough to matter.

Only a very few companies will be able to achieve the expense reductions that are required. For many it is literally impossible, no matter how good the management is.

The same is true for differentiating the product or the customer relationship. Unlike other industries, insurance does not offer meaningful patent or copyright protection. Novel policy forms can be copied. Niche markets can be entered by followers. Imaginative services and sales presentations can be imitated. Innovation buys a head start, but no more.

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the initial response to the decline of the insurance cartel has been an increase in the number of companies and distinct organizations. It is less likely that insurance is exempt from the laws of economics than that the short-term change just means the long-term change has further to go. Post-deregulation airlines behaved much the same way.

[8] The elimination of inefficient and non-progressive insurers through competition is described in Halim Iskandar Bishara, *An Analysis of Insurance Company Financial Insolvencies and The Public Interest* (University of Wisconsin, Ph.D. thesis, 1961), pp. 3-4, 99-100. A general economic model of competitive market behavior with excess capacity is in Alfred E. Kahn, *The Economics of Regulation* (Cambridge, MA: The MIT Press, 1988), pp. 172-178.

Hence insurance tends to be a commodity – whose buyers don't care about source – and commodity markets are mainly competitive on price. Price competition favors sellers with low costs. Differentiating is not impossible for a few insurance companies in a few situations, but it is exceedingly difficult to establish and maintain.[9]

So a lot of exits are coming. They may not come all at once, but they will come sooner or later. They will not necessarily be by acknowledged insolvency. Some will be called restructuring or merger or strategic repositioning or discontinued operations or outsourcing of claims administration. But by any name they will be exits in the face of impending failure.

The specter of numerous insolvencies was raised thirty years ago in a few studies. While those studies noted the theoretical possibility that competition could eliminate some companies, they identified the main causes of insolvency as mismanagement, fraud and natural disasters.[10] Less rigorous reports in the press took the same view, with emphasis on mismanagement and fraud.

Seeing mismanagement and fraud as the causes of insolvency fits the characteristically American view that the natural state of affairs is good and getting better. So when something really awful happens, there must be a villain behind it. Contemplating an insolvent insurance company, we search for fools, wastrels and criminal masterminds. Sometimes we find them.[11] More often we do not. Then sometimes we invent them out of people who simply failed to do a terribly difficult job.

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[9] Protestations by insurance companies that their commercial coverages and services are too specialized to be commodities don't hold up over the underwriting cycle. When the supply of insurance is excessive relative to demand, all insurers' prices and profits fall, and when the supply is inadequate, all insurers' prices and profits rise. If an insurer's products were truly differentiated, its prices would not be dominated by the industry's supply and demand conditions.

[10] New York State Insurance Department, *The Public Interest Now in Property and Liability Insurance Regulation* (January 7, 1969), p 56. McKinsey & Company, Inc., "Strengthening the Surveillance System," *National Association of Insurance Commissioners Proceedings – 1974*, *Volume II*, pp. 225-346.

[11] The founder of bankrupt Guarantee Security Life Insurance Company bought a small island with company funds and struck as its official currency a silver coin bearing the bikinied figure of his girlfriend. The bankrupt Home Insurance Company served for years as the captive source of huge fees for the Finley Kumble law firm, one of whose founding partners was CEO. Fugitive financier and thief Martin Frankel bled a series of now-bankrupt life insurance companies he controlled to support a lavish life-style for himself and numerous girlfriends.

The villain theory is not entirely wrong. Some company failures are due to incompetence alone, some to fraud alone, and some to the two combined.[12]

But mismanagement and fraud are most destructive when conjoined with competitive decline. It is possible for an insurance management to be both incompetent and dishonest, and also to be in an impossible competitive position. That synergy can produce disaster in a trice.

At the time of the 1988 report, the most recent example of such wicked synergy was the wave of insolvencies of small auto insurers in the mid-1960s. What happened was this. Large, national insurance companies with high costs (from independent agency distribution) and no advantages (auto insurance being a commodity) had dominated personal auto insurance for a long time. But they were being driven from the market by a different kind of company – one with structural and hence inimitable lower costs (due to exclusive agency or direct response distribution).

Because the independent agency companies were losing the competition on expenses, they tried to lower their total costs by getting tougher on underwriting, by refining rating classifications and by refusing to write drivers who didn't fit into strict templates. Many people who had good driving records but who did not satisfy the new requirements could not get insurance. They were mostly people from inner city areas.[13]

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[12] A respected study of property-casualty insurer insolvencies from 1969 through 1990 listed eight primary causes of insolvency. Causes related to mismanagement (deficient loss reserves/ inadequate pricing, rapid growth, significant change in business and reinsurance failure) accounted for two-thirds of the insolvencies during that period. Causes related to fraud (alleged fraud and overstated assets) accounted for one-fifth. Causes related to natural disasters (catastrophe losses) accounted for one-tenth. A.M. Best Company, *Best's Insolvency Study, Property-Casualty Insurers 1969-1990* (Oldwick, NJ: A.M. Best Company, June 1991), pp. 45-46. For a vivid description of how gross mismanagement or fraud or both led to four large insolvencies in the 1980s, see United States House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Failed Promises – Insurance Company Insolvencies*, February 1990.

[13] The market situation is described in *Insurance Accessibility for the Hard-to-Place Driver* (Washington, DC: U.S. Department of Transportation, May, 1970). This study and several others were prompted by U.S. Senate hearings into the automobile insurance business and specifically into the failures of high-risk auto companies in the early 1960s. See United States Senate Subcommittee on Antitrust and Monopoly, *Hearings on the Insurance Industry before the United States Senate Subcommittee on Antitrust and Monopoly*, S. Res. 40, 89th Cong., 1st Sess. (Part 12, 1965)

To meet the need of the inner cities at that time, a number of new insurers sprang up. They used the general agency system of distribution, for that was where the creators got their profits. That system, with its two layers of intermediation, led to even higher costs than the costs of the large companies that had left. The two layers also filtered out more of the information needed for good underwriting.

Once the national companies, especially the low-cost ones that were beating everybody everywhere, saw good risks in the abandoned market, they came in. The new, high-cost companies were finished. Their exits were helped along by widespread mismanagement and fraud. The fundamentals would have killed them anyway, but the post-mortems concentrated on bad behavior.[14]

The problem with the villain theory – mismanagement and fraud as the causes of insolvency – is that it ignores the economics of a mature, overcrowded and price-driven business. A company with high costs and no advantages will either go out of business or be absorbed by a competitor. A management that cannot figure out how to survive such competition is not necessarily incompetent or dishonest, even if in terminal desperation it takes foolish chances or fudges some numbers.

The grind of competition by itself will eliminate a large number of property-casualty insurers. The process may take decades for some companies. Those with slimmer resources, larger obligations or worse market position will go sooner. Regulators cannot prevent it, nor should they wish to. Regulators can, however, do a great deal to protect the public.

Solvency Regulation

A Perspective on Solvency Regulation

The goal of regulating the financial condition of insurance companies has at all times been stated to be the prevention of insolvency. It sounds like a constant goal, and at the highest level of abstraction perhaps it is. But over its long history it has fundamentally changed in both objective and methodology.

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[14] At the time, the failure of these high-risk auto companies was attributed to management ineptness and fraud, not to impersonal market forces. See Douglas G. Olson, *Insolvencies Among Automobile Insurers* (Washington, DC: U.S. Department of Transportation, 1970), pp. 43-77.

The objective and approach of solvency regulation have not changed often. They really have only changed once. But that one change was from acting in a cartelized and regulated market environment to acting in a competitive and deregulated one. In all business and regulation, no greater change exists. Ask the airlines, bankers, truckers, securities dealers and even the doctors and lawyers.

Widespread failure to appreciate that fundamental change in the setting for solvency regulation, and thus in regulation itself, is causing confusion and trouble today. Like much else in insurance, it is highly path-dependent. Where we are now and where we are going depend greatly on where we have been. So the best way to straighten things out is to look at how solvency regulation started out and at how it evolved.

Early Solvency Regulation

In the early days of insurance regulation (1850-1900), regulatory efforts to maintain solvency were directed at all companies rather than at individual ones – statutory accounting, minimum capital, licensing and security deposits. When a company went under, the cause was usually a catastrophe, like a great fire in its home city.[15] Usually there was not much the insurance regulators could have done about it in advance.

From as early as the 1830s, fire insurance companies had from time to time entered into agreements to fix rates. The agreements were administered by insurer-owned "rating bureaus," which collected loss data and promulgated the rates for all companies to charge.

The bureaus set rates with profit provisions and catastrophe loadings designed to assure good profits and to encourage accumulation of funds against future catastrophes.[16] But as with other cartels, the agreements broke down after a few years, as individual companies cheated in order to get more business. The

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[15] After the great Chicago fire of 1871, of the 202 insurance companies involved, 68 failed. After the San Francisco earthquake and fire of 1906, of the 243 companies involved, 20 failed. Hawthorne Daniel, *The Hartford of Hartford* (NY: Random House, 1960), p. 187. See generally Alfred M. Best Company, *San Francisco Losses and Settlements* (New York: Alfred M. Best Company, 1907).

[16] The usual calculation of fire insurance rates called for an underwriting profit of 5% of the rate, plus a catastrophe loading of 2%, or a target combined ratio of 93%. Investment income was not counted at all, and while the duration of loss reserves was short, the duration of unearned premium reserves was long. Policies were for 5 years, with all the premium paid at inception, giving insurers between two and five years of free, investable float.

cushion in the pricing would be competed away and catastrophe reserves dissipated.

Then the state regulators gave a powerful boost to the practice of using price maintenance to preserve the solvency of the insurance industry as a whole. Late in the 19th century, they began to reinforce the price-fixing agreements of the rating bureaus and to regulate the bureaus to make sure they were doing their job.[17]

If an agent placed coverage at non-agreed rates or with companies outside the rating bureaus, the bureau companies would pull out of his office and the insurance department might revoke his license. Despite the general anti-trust fervor in the United States at the turn of the century, the insurance compacts were valid under federal law (which didn't apply) and under the laws of most states. After a careful study, New York concluded that cartel costs were less disruptive than insolvency costs and that, therefore, supporting the rating bureaus was sound public policy.[18]

As a result, until the 1940s, the insurance business operated as a legalized cartel. The rating bureaus were the cartel offices, like OPEC but more pervasive, ruthless and effective.[19] Insurance rates were uniform and made in concert. Rates tended to cover the costs of the least efficient companies, like a convoy steaming at the speed of the slowest ship. From 1922 to 1948, the New York Insurance

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[17] See Francis R. Stoddard, Jr. (NY Superintendent of Insurance), *The State Supervision and Regulation of Insurance Rates*, address delivered at the 53rd Session of the National Convention of Insurance Commissioners, September 5, 1922, and *Insurance Rate Making*, (Albany: J.B. Lyon, 1923); Louis H. Pink (NY Superintendent of Insurance), *The Problem of Fire Rates* (no publisher given, 1942); and Walter Martineau (NY Deputy Superintendent of Insurance), *The Revision of Fire Insurance Rates* (no publisher given, 1947).

[18] Under *Paul v. Virginia*, 8 Wall 168 (1869), insurance was not interstate commerce and hence was not subject to the federal anti-trust laws. The New York State study was the *Report of the Joint Committee of the Senate and Assembly of the State of New York Appointed to Investigate Corrupt Practices in Connection with Legislation, and the Affairs of Insurance Companies, Other Than Those Doing Life Insurance Business* (Albany, NY: J.B. Lyon Company, 1911), known as the Merritt Report. A few states thought otherwise and passed "anti-compact" laws.

[19] William Hamlin Wandel, *The Control of Competition in Fire Insurance* (Lancaster, PA: The Art Printing Company, 1935), pp. 125-139.

Department even tried the cartel approach to controlling agent commissions – the acquisition cost conferences.[20]

During the years of rating bureau dominance, the prevailing regulatory view of the way to prevent insolvency was to protect the finances of the whole insurance industry by suppressing price competition. The mission went under names like "responsible behavior," "orderly markets," "avoiding cut-throat competition," "conservative accounting," "adequate surplus" and, best of all, "statesmanship." But it worked.

Not only was it hard to run a company into the ground in those days. When it did happen, regulators forced mergers of weak companies into strong ones, which was not difficult when insolvencies were small and pricing redundant. Companies would often fail safely, that is, while they still had net assets on the balance sheet, and while they had even better assets, such as agency forces and books of good business, that were not on the statutory accounts at all.

The regulators rightly saw their mission as helping maintain the market structure and conduct that made failure difficult and rescue easy. With the regulatory focus on the whole industry, not on individual companies, when a company went under, its regulators were unlikely to be blamed.[21] Nor should they have been.

The Decline of the Cartel System

Then, starting in the late 1940s, the road to ruin turned. Instead of by catastrophe, companies failed by the erosion of their good business and their

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[20] See papers by three New York Superintendents of Insurance: James A. Beha, *Acquisition Cost Control* (New York: Herbert-Spencer, 1922); Francis R. Stoddard, *The History of Acquisition Cost in New York* (no publisher given, 1944); and Robert E. Dineen, *Commissions: New Developments in a Continuing Problem* (New York: Insurance Department, 1949).

[21] One exception was after the collapse of an entire industry – mortgage guaranty insurance in the 1930s. During the Depression, widespread defaults caused the mortgage guarantors to go broke, taking many lending banks with them. The New York Legislature investigated whether Superintendent of Insurance George Van Schaick should be removed from office for nonfeasance. But it exonerated him, recognizing that the Great Depression was a catastrophe like a great fire. New York State Insurance Department, *Examination of Insurance Companies*, *Volume 6* (New York: 1955), p. 7. See also *Report to his Excellency Herbert H. Lehman, Governor of the State of New York, by George W. Alger, Appointed under the Executive Law to Examine and Investigate the Management and Affairs of the Insurance Department with Respect to the Operation, Conduct, and Management of Title and Mortgage Guarantee Corporations under its Supervision* (New York, 1934), known as the Alger Report.

inability to charge an adequate premium for the costlier business that remained.[22] Their predicament was made worse by the substantial exemption from rate regulation of the low-cost companies that were most effectively attacking the bureau companies.[23]

It was a gradual shift. The rating bureaus and other industry-wide cooperative structures and beliefs still held sway, though losing their grip. Companies went under slowly and not for large amounts of money, and often they were worth something if absorbed by a stronger one. Policyholders usually did not suffer much.

But the causes of failure had turned from institutional ones like catastrophic fires to individual ones like competitive inadequacy. It looked more like bad management. In the cartel period, mismanagement or dishonesty had to be on a heroic scale to put a company under. As price competition intensified, less and less fraud and mismanagement sufficed.

Unless one understood that the prevailing cause of insolvency had changed from catastrophe to competitive decline, it was easy to say almost all insolvencies were due to fraud and mismanagement.

The Rise of Price Competition

By the 1970s, the competitive landscape had changed beyond recognition. The cartel system had dissolved. The leading cause of insurer insolvency came to be competitive decline, and declining companies were increasingly on their own.

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[22] United States Senate Subcommittee on Antitrust and Monopoly, *The Insurance Industry: Aviation, Ocean Marine and State Regulation*, S. Rep. No. 1834, 86th Cong., 2nd Sess. 1 (1960); and United States Senate Subcommittee on Antitrust and Monopoly, *The Insurance Industry: Rates, Rating Organizations and State Rate Regulation*, S. Rep. No. 831, 87th Cong., 1st Sess. 1 (1961).

[23] Many of the attackers were mutual companies, whose price competition was in the form of dividends to policyholders after the end of the policy year. Rates for mutuals were made by their own rating bureau, which exempted dividends. The state rate regulatory laws exempted dividends as well. Other attackers were independent of the bureaus, and fought with increasing success to avoid being bound by bureau practices or rates. But the key event in this period was the Supreme Court's reversal of its century-old position that insurance was not interstate commerce. See United States v. South-Eastern Underwriters Assn., 322 U.S. 533 (1944). Congress thereupon granted insurers a limited anti-trust exemption, with passage of the McCarran-Ferguson Act, also known as Public Law 15 (59 Stat. 33-34 (1945), 15 U.S.C.A. Secs. 1011-1015).

The commissioners had no way to regulate the industry as a whole so as to prevent individual companies from failing competitively. Solvency regulation was now company-by-company, with emphasis on close analysis of each company's financial statements and on periodic, on-site examination of every company.

The mix of business had shifted toward casualty, with the attendant risk of large errors in pricing and reserving. Insolvency was no longer a fate reserved for small companies. Large, national, widely-recognized companies could go under too. Insolvencies could be for a lot of money. Policyholders could get hurt badly.

Yet to the eyes of regulators, legislators, insurance executives and the press, insurer insolvency remained culpable, due to villains committing mismanagement and fraud. Price-cutting was considered irresponsible by many in industry and regulation, and running an insurance company into the ground was almost universally regarded as management malpractice.[24]

Even the tradition of industry solidarity and regulatory rescue lingered on. As late as the mid-1970s – when almost all traces of the cartel system had disappeared – nearly every sizeable insurer and nearly every regulator joined together to rescue the most aggressive, efficient and dangerous competitor, after years of lax underwriting, inadequate pricing and under-reserving had brought it to the brink of insolvency.[25]

If a company went broke, the conventional reasoning went, somebody had to be to blame. The most likely culprits were management. But whatever the sins of management, they were usually committed over a long period. And just where, during all those years, was the insurance commissioner? So it was easy for everyone – legislators, other governments, other agencies, politicians, consumer

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[24] The New York Insurance Department was so concerned with "cut-throat" competition in the 1980s that it set up a Cash Flow Task Force to investigate insurers' pricing. Of the twenty-some insurers it investigated, all were fined for violations of the rating law. Martin Minkowitz, "The Regulator's View of Insolvency" in Thomas A. Harnett, chairman, *Insolvency and Solidity of Insurance Companies* (New York: Practicing Law Institute, 1987), pp. 39-50. See also *Annual Report of the Superintendent of Insurance to the New York Legislature*, 1989, pp. 1, 82.

[25] The story of the rise, near collapse and rescue of GEICO is told by John J. Byrne, former chairman and president of the company, in *Government Employees Insurance Company, The First Forty Years* (New York: Newcomen Society in North America, 1981).

advocates, journalists and the public – to follow the villain theory wherever it led, and it led right to the commissioner's door.[26]

As human beings in a political spotlight, commissioners did not like to pronounce a company dead and then be blamed for it. So they put off doing so. During the interval between objective bankruptcy and official recognition of it, the typical desperate company would chase whatever business it could get, to keep itself going and its agents quiescent. It would resist claims, to hold onto the dwindling cash it had.

During that interval, the typical failed company would do a lot of damage and its insolvency would deepen. Among those in public or private authority, practically no one stood up and explained that competitive markets lead to failures, that competitive markets need to have competitors free to fail, and that regulators should not be blamed every time they do so.

The Regulatory Mission

Preventing Insolvency

As the rating cartels faded in the 1950s and 1960s, and competition became the rule of the market, the regulatory mission changed by staying ostensibly the same. The propitious market structure was going away, but the goal was still preventing insolvency. The only way left was to try even harder to save a company once it was seen to be in trouble.

Preventing individual insolvencies was a constructive-sounding mission, and if the insurer failed anyway, it was a workable explanation for apparent regulatory inaction and delay. A regulatory mission to prevent insolvency at the individual company level was also congenial to the industry. Like support for cartel pricing, preventing insolvency continued to align regulatory goals with business goals – the financial well-being of insurance companies.

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[26] United States Senate Subcommittee on Antitrust and Monopoly, *Hearings on the Insurance Industry before the United States Senate Subcommittee on Antitrust and Monopoly*, S. Res. 40, 89th Cong., 1st Sess. (1965) and 91st Cong., 1st Sess. (1969), and S. Res 233, 90th Cong., 2nd Sess. (1968); United States House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Insurance Company Failures, Hearings before the Subcommittee on Oversight and Investigations*, 101st Cong., 2nd Sess. (1990); United States House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Failed Promises – Insurance Company Insolvencies*, February 1990.

The mission statement did, however, carry a tacit affirmation that regulators could still prevent insolvencies. Without the framework of cartel pricing, saving individual companies became a lot harder. But the commissioners were held responsible, and they felt they had to try.

Competitive decline was widely labeled management failure, and for the commissioner not to save the company was labeled regulatory failure.[27] That was still true in 1988, when *Managing Insurer Insolvency* was written. It is still true today.

Minimizing Public Harm

In 2003, even more than in 1988, commercial property-casualty markets are fiercely competitive, both among insurers and with substitutes from the risk management movement. Geographic and functional barriers are down. The US market is overpopulated, and companies are aware of the implications. They are no longer collegial in spirit, but ready to pounce upon a competitor who stumbles.

In such an environment, preventing insolvency is an unrealistic goal. Regulators should not hold themselves to it. The public should not hold them to it. When competition is working, there will be failures. The regulators are not to blame, provided only that they do their best to stop the company from doing needless harm to the public.

Nor is preventing insolvency a desirable goal. The belief in a duty to prevent insolvency is not merely a harmless anachronism. It is a dangerous anachronism. It leads regulators to delay acting on a company's financial

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[27] For example, when referring to the increase in insolvencies in 1984-1986, a well-known actuary stated:

> …the current situation reflects very poorly on the industry and its regulators. Perfection, or the absence of any insolvencies, would be utopia, but the occurrence of an insolvency should be so infrequent that it would truly be news and not leave the policyholder and/or shareholders of well managed companies paying the bill.

Thomas E. Murrin, "Insolvency and Solidity of Insurance Companies" in Thomas A. Harnett, chairman, *Insolvency and Solidity of Insurance Companies* (New York: Practicing Law Institute, 1987), pp. 13-25.

difficulties. It leads regulators to go along with management's own efforts to delay, while both wait for something good to happen.[28]

The period of delaying the official recognition of insolvency or imminent insolvency is the time when desperate management takes on greater and greater risk in an attempt to gamble its way out. Seeing the company in a hole, management just digs faster. Desperate gambles from weak positions almost never work out.[29]

The failures of solvency regulation are not the insolvencies themselves. The failures are partly in the conception of the problem, seeing insolvencies as culpable rather than inevitable. The failures are even more in the conception of the regulatory mission and in the adequacy of regulatory will.

The 1988 report put it this way.

> …[R]egulators and the business continue to look upon insolvency as a regulatory failure and upon the regulator as sort of a doctor, with an oath to save the patient, rather than as a public safety officer with an oath to protect the public against dangerous individuals. This meretricious medical analogy exalts heroic life-saving efforts, and concentrates attention and sympathy on the individual company rather than on those who have trusted it or on society or on the insurance system as a whole.[30]

The regulatory mission is not to save companies; it is to minimize public harm. That may involve rescuing a company here and there, but in the usual case it involves the opposite – taking the dying company out of the market before it can do more damage.

So the 1988 report said to the commissioners: Don't be afraid or ashamed of putting failed companies under. And put them under faster.

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[28] New York Insurance Department, *Regulation of Financial Condition of Insurance Companies* (March 1974), pp. 50-51, 87-88, 91-92.

[29] Such gambling, with government permission and encouragement, accounted for the massiveness of the public losses in the Savings & Loan crisis. National Commission on Financial Institution Reform, Recovery and Enforcement, *Origins and Causes of the S&L Debacle: A Blueprint for Reform* (Washington, DC: U.S. Government Printing Office, 1993), pp. 43-55.

[30] p. 19.

THE 15 YEARS AFTER 1988

The Recent Record

When *Managing Insurer Insolvency* was published in 1988, the property-casualty insurance business was experiencing a modern record number of insolvencies. The number and percentage of failing companies continued at historically high levels through 1993.

After that they came down significantly. Even so, some prominent companies, such as The Home and Reliance, have gone broke in a big way since 1993. And starting in 2000, the failure rate has moved up again.[31]

Several factors contributed to a lower failure rate during the second half of the 1990's.

First was the bull market in equities and declining interest rates, which increased the value of insurers' invested assets. Second, competitively weak companies that were headed for extinction were acquired by stronger companies for top-line growth and in the hope that greater size would equate to economies of scale.

Third, the unexpected magnitude of natural catastrophe losses in the earlier period had shocked insurers into better modeling of potential losses, spreading of risk and buying more adequate reinsurance.[32] Fourth, for a few years industry profitability improved.

Fifth was the popularity of new devices for putting off recognition of insolvency even more, so that the apparent decline in the failure rate may not have been entirely in insolvency itself. More is said about these new devices later in the report.

Nobody has claimed that improved regulation was among the reasons for the smaller number of insolvencies. Nor should it have been. Regulation improved in some ways, got worse in others, but nobody thinks it was a factor

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[31] A. M. Best Company, *Rising Number of P/C Company Impairments Continues Trend*, Special Report, March 10, 2003.

[32] Catastrophe losses from Hurricane Hugo (1989) of $4.2 billion and Hurricane Andrew (1992) of $15.5 billion were unprecedented for that time.

either way. Nor were improvements in management, if any, a factor in the smaller number of insolvencies. The forces that made insolvencies come down in the later 1990s were external, fortuitous and very favorable.

Today's Prospects for Insolvency

Now is a time to expect reported insolvencies to increase.[33] Most of the propitious post-1993 factors listed above have stopped, and a few have gone into reverse.

Old practices are being questioned, managements are turning over, and accounting tricks are out of fashion. Time is running out for the best vehicles for under-reserving (asbestos and pollution liability), as coverage disputes wind down and reserve dollars have to be converted into cash dollars to pay verdicts and settlements.

On the liability side of insurer balance sheets, loss reserves for other than asbestos and pollution claims are deficient by almost a third of the industry's capital.[34] And who can say how deficient are reserves for asbestos and pollution liability?[35]

Financial reinsurance has discounted reserve liabilities at many companies from ultimate settlement value to present value. During the price war of the

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[33] It is not at all clear that the state guaranty funds could handle a sharp increase in insolvencies. Today's failed companies are far larger and more complex than the simple, local, auto insurers the funds were designed for. Stewart Economics, Inc., *Insurance Insolvency Guarantees* (October 1990), pp. 35-40, available at www.stewarteconomics.com/publications. A current example is the California workers' compensation guaranty fund which is facing bankruptcy due to a record number of insolvencies. The State and the insurance industry are making up the shortfall between claims on the WC fund and what it can assess insurers by having it borrow from California's guaranty funds for automobile and homeowners insurance. A.M. Best Company, "California Approves Stopgap for Workers' Compensation Crisis," *BestWeek*, May 26, 2003, p. 10.

[34] The Insurance Services Office has estimated that the industry's loss reserves (excluding asbestos and pollution liability) were deficient by 17% to 32% of the industry's surplus as of year end 2001. Insurance Services Office, *Loss and Loss Adjustment Expense Reserves at year-End 2001*, December 2002.

[35] A. M. Best has estimated that at year end 2001 insurers had not yet funded (accounted for in reserves or loss payments) 43% of their potential liabilities for asbestos and environmental (pollution) liability of $121 billion. That deficiency is 18% of the industry's surplus, but since most of the liability is held by only 30 companies, the deficiency for them is a far greater percentage of surplus. A. M. Best Company, *Largest Increase in A&E Losses to Date Seen in 2001,* Special Report, October 28, 2002.

1990s, it was common knowledge that managements were suppressing reserves in order to show better profits.

On the asset side of insurer balance sheets, reinsurance recoverable from non-US entities looks shaky. Lloyd's reinsured its open syndicates' pre-1993 losses into an under-funded runoff vehicle, which pays only after a fight and at deep discounts. Ominous news comes daily from European and Asian reinsurers, which are traditionally more exposed than US reinsurers to stock market, real estate market and affiliate valuation risks.

Reinsurers everywhere are more disposed than in the past to contest collections. Yet ceding companies do not hurry to write dubious reinsurance recoverables off their balance sheets.

As the comments above suggest, the clouds of insolvency do not hang over only America. Insurers and reinsurers all over the world have the same problems.[36] They are lashed to one another and to US companies by reinsurance. In today's interlocked insurance world, there is only one boat.

A New Paradigm of Insolvency

In 1988 the implications of the shift from a cartelized insurance market to a competitive one were apparent, as were the implications of a shift in the mix of business from property to liability. Both shifts suggested that exits from the market were on the way.

In the ensuing years, the exits by insolvency began. Among the larger ones were American Mutual, Home, Ideal Mutual, Integrity, Midland, Mission, Reliance, Texas Employers, Transit Casualty and Union Indemnity.

Other exits were by merger and acquisition. Among the formerly leading property-casualty insurers whose identity disappeared through merger after 1988 are Aetna, American General, Commercial Union, Continental, Crum & Forster, Orion, Sentry, Transamerica, and USF&G.

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[36] A spectacular example (especially relative to the size of its host economy) is the recent insolvency of HIH in Australia. It had competitive decline and mismanagement in abundance. The report of The HIH Royal Commission (April 4, 2003) is an instructive post-mortem. The HIH report is in the admirable British tradition of commissioning analytical studies after something affecting the public interest goes seriously wrong. It is available at www.hihroyalcom.gov.au.

Many of those exits – by both insolvency and merger – were the result of competitive failure on the familiar model. A company with no special advantages and high costs gradually lost out in competition to companies with advantages or lower costs or both.

But another pattern of failure was emerging as well. It was the company that was exposed to catastrophic risks that it did not fully appreciate or provide for. It resembled the problem of urban conflagrations in the 19th century. A large number of risks on a company's books would be correlated, that is, an event that hit one policyholder would hit many. If it hit enough, a single event could destroy the company all at once.

A company could get away with subjecting itself to catastrophic risk for a while, but when the catastrophe hit, the insolvency was quick, surprising and for a lot of money.[37] It could also look like bad luck, which tends to ward off criticism.

Sometimes the second kind of insolvency (invited catastrophe) would be a result of efforts to head off the first (competitive decline). A company struggling with competition and seeing its margins squeezed would try to stay alive by "writing its way out."[38] In the process it would take on a disproportionate amount of risk, often unfamiliar risk, and often without charging, reserving or reinsuring enough for it.

Invited Catastrophe

Invited catastrophe can take many forms. The most familiar is natural disasters for property insurers, which have a concentration of risks in areas that are susceptible to windstorms, hurricanes and earthquakes.[39] Another way is to

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[37] An example of how this can happen from a natural disaster is 20th Century (now 21st Century), an innovative and successful California auto insurer. After years of outstanding automobile results, in the 1980s it started writing homeowners insurance. Then the Northridge earthquake of 1994 wiped out the company's surplus. The company was rescued and eventually bought by American International Group.

[38] The expression "writing its way out" refers to growing the business faster than the need to recognize deficient loss reserves. The idea is that the new business, either because it is priced higher than the old or because it is less likely to generate claims than the old, will give the company a cushion of several years over which to recognize the losses on the old business.

[39] Ever since Hurricane Andrew, rating agencies have become more attuned to the insolvency threat of natural disasters and have incorporated catastrophe modeling and reinsurance protection into their analyses. To the extent overexposure to natural catastrophe could cause a rating downgrade, the rating agencies might be able to police this kind of invited catastrophe.

write a lot of liability insurance on broad forms like comprehensive general liability.[40] That invites disaster, especially in times of economic inflation or legal change, as happened with asbestos, pollution and medical products.[41]

Yet another way is to reinsure large amounts of business that is new to and not understood by the assuming company, particularly when the business is brought by intermediaries and managers who are compensated by commission. Examples occur every decade or so, after the market has forgotten the previous one.

An episode still smoldering involved "carving out" the medical and disability portions of workers compensation and then reinsuring and retroceding them to life insurers.[42] At each successive retrocession, the participants took some money for themselves and then passed the risk along, and the relationship of premium received to risk assumed got worse and worse. Such a "spiral" can be catastrophic for both ceding companies (if the reinsurers refuse to pay) and assuming companies (if they do pay).[43]

The next illustration of invited catastrophe may be right around the corner. It involves credit derivative instruments, especially credit default swaps. The swaps are the equivalent of credit guarantees – a form of suretyship or financial guarantee that through the years has broken dozens of insurance companies that

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[40] The Lloyd's "Broad Form Excess Comprehensive Liability" policy, nicknamed the umbrella, was a famous example of inviting catastrophe with exceptionally broad liability coverage, few exclusions and no aggregate limits. Despite warnings from within the Lloyd's community, for many brokers and underwriters the premiums and commissions were irresistible. Lloyd's started to restrict the form in 1960, and then pulled back. The liability catastrophes of asbestos, pollution and medical products liability – hitting the umbrella – were leading causes of the near-collapse of Lloyd's in the 1990s. See Randolph M. Fields, *The Underwriting of Unlimited Risk*, 5 Coverage 36 (1995).

[41] While surviving commercial insurers today struggle to fund enormous losses from asbestos, pollution and medical product claims on general liability policies written years ago, for many years they saw general liability as an especially profitable growth opportunity, up to and including when unexpected losses began to emerge. A reason for the relative attractiveness of commercial general liability business was that those same companies were losing money and market share in personal lines, which accounted for almost half of the insurance market.

[42] See Report of the United States General Accounting Office on *Reinsurance Activities and Rating Actions Tied to Selected Insurers Involved in the Failed "Unicover" Venture*, August 24, 2001 (GAO-01-977R).

[43] The Unicover carve-out spiral helped precipitate the regulatory takeovers of Reliance, Fremont and Paula, required a heavy capital infusion into Cologne Life Re, and resulted in charges against earnings of $100+ million each by several prominent life insurers.

didn't understand how correlated the risks could be.[44] Of late, insurance companies, insurance holding companies and their affiliates have been using them to guarantee the credit of others at a rapid pace.[45]

Although swaps are characterized as "risk remote" in the financial circles where they trade, the face amounts of credit risk assumed are staggering – over $100 billion. The market for credit default swaps is immature, unregulated and untested by a major financial crisis. It has transferred significant risk on commercial and industrial loans from commercial banks to insurance companies.[46] In all likelihood the originating lenders (banks) know more about the credit risks in those loans than the insurers do.[47]

With invited catastrophe of any kind, insolvency can be a surprise. An insurance company that yesterday was a picture of good health, with all its financial measures above standard, suddenly crashes today. The crash appears to have been beyond prevention, even imagination, and to have been terribly bad luck.

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[44] In the early 1930s, the entire mortgage guarantee insurance industry was destroyed by a single event – the Great Depression. Unemployed people could not pay their home loans. The mortgage guarantors could not cover such widespread defaults. See the Alger Report, at note 21 above.

[45] If the non-insurance affiliate sells the protection, the guarantee has to be by the holding company, because multi-line insurers cannot legally write pure financial guarantees. But a credit default swap can be linked to a note which can then be bought by an insurer and carried as an invested, admitted asset, with the gain and loss for the insurance company itself. See Shanique Hall-Barber, "Introduction to Credit Linked Notes," NAIC Securities Valuation Office, *SVO Research*, Volume 1, Issue 4, May 21, 2001, pp. 1-4. See also Shanique Hall-Barber, "Credit Derivatives," *SVO Research*, Volume 1, Issue 2, February 15, 2001, pp. 3-5; and Dimitris Karapiperis, "Insurer Investment in Structured Securities," *SVO Research*, Volume II, Issue II, 2002, pp. 6-8.

[46] The participation of insurance companies in the credit derivatives market is described in Fitch Ratings, *Global Credit Derivatives: Risk Management or Risk?*, Special Report, March 10, 2003, pp. 2, 6-8, available at www.fitchratings.com. See also Warren E. Buffett, *Chairman's Letter, 2002 Annual Report of Berkshire Hathaway Inc.*, pp. 13-15, in which Mr. Buffett characterizes derivatives as "financial weapons of mass destruction."

[47] In economics, the situation of a seller with better information than the buyer (or *vice versa*) is called "asymmetric information." In insurance, it turns up as "moral hazard" and "adverse selection." The possibility of adverse selection when banks lay off with others (especially others in a different industry) the credit risks in their own loans is described in *Credit Derivatives in Banking: Useful Tools for Managing Risk?*, University of California at Berkeley, Research Program in Finance Working Paper RPF-289, November 1999.

But management could have headed it off by not taking on so much correlated risk, and regulators could have warned against it or even stopped it. Needless to say, the extra risk in the correlation was not reported so as to weaken the balance sheet and reduce reported earnings.

All the ways of inviting catastrophe have the characteristic of loading large amounts of risk, especially correlated risk, onto the company without reflecting it on the financial accounts, perhaps without management's even realizing it. If and when the catastrophe occurs – whether in the physical, economic, legal or financial world – it runs right across the company's accounts and throughout its financial foundations.

All the ways of inviting catastrophe are tempting because they seem to offer easy growth and extra profits. They require only managements and regulators who naively underestimate or willfully ignore the risks to weigh against the rewards.

Risk and Capital Adequacy

At the amounts of leverage customary in insurance, capital may not even be an appropriate measure of financial strength for dealing with catastrophes.

Usually we measure capital adequacy by comparing equity with premiums and loss reserves. But that is a logical shortcut with a lot of elisions.

Premiums are revenues, not losses, and reserves are for what has happened, not what could. In a competitive market with a heavy emphasis on annually reported earnings, premiums and reserves may not be the good proxies for risk they were in the days of cartel pricing, private ownership and unlisted stock.

But if premiums and reserves don't represent catastrophe risk, what does? Consider leverage "on line," that is, as a function of policy limits. That exposure is, conservatively, 100 times premium (a 1% rate on line). If premium is two times capital, then capital is one-half of one percent of exposure to loss. Banks are expected to hold four percent – eight times as much.[48]

[48] Comparisons of insurer and bank capital requirements are difficult and imprecise. But under the standards set by the Bank for International Settlements, which the U.S. has adopted, banks are required to hold Tier One capital (stock at par plus retained earnings) of 4% of risk assets. The requirement for Total Capital is 8% of risk assets.

The point is not that insurers are generally under-capitalized. It is that with so little capital supporting so much exposure, a big increase in capital (say, doubling it to 1% of exposures) does practically nothing about catastrophes. By definition, catastrophes defy probability and hit a lot of limits. Capital would be gone in a minute.

Insurance companies and their regulators might do well to look at the potential hit as well as at the cushion against it – at the top line (exposure) rather than the bottom (capital). That is the perspective with other catastrophes, such as riot and terrorism, where government reinsurance limits net exposure. It is reminiscent of the old rule of fire insurance and surety bonding that an insurer cannot write limits on any one risk that exceed 10% of its surplus.

A century has passed since we thought about solvency that way. Today's focus on capital adequacy, while not incorrect, may pose the problem – or at least the invited catastrophe component of the problem – the wrong way around. When you look in the wrong end of a telescope, you still see what you were looking at, but you don't see it in a particularly useful way.

Post-1988 Techniques for Delaying Recognition of Insolvency

As insurance companies got into financial trouble in the late 1980s and early 1990s – whether by competitive decline or by invited catastrophe – many of them did not want, or did not know how, to deal with the fundamental problems. Instead they turned to two kinds of technique for putting off the day of reckoning. One was changes in corporate structure or strategy. The other was changes in accounting.

Neither technique was exactly new. Precedents existed, at least in a general way, for everything that was tried. But they were different and new in two significant respects.

First, remedies became concealments. Actions traditionally taken to deal with acknowledged trouble were used to put off the acknowledgment of trouble.

Second, control shifted from government to private vendors. Managements seeking to postpone recognition of incipient insolvency turned to outside firms for cosmetic transactions.

Troubled Company Restructuring

The most conspicuous change was the use by managements of an old regulatory technique – splitting the company's book of business into two parts, the profitable and the unprofitable, and placing the two parts in two separate companies.

When a company was known to be failing, regulators sometimes used the technique – famously by the California Department of Insurance in the 1930s with Pacific Mutual Life.[49] That effort was a success. But it was a government effort utilizing the powers of the state.

In the 1990s, what looked like the same technique was used by private company managements and investment bankers. It was done to conceal insolvency, to let regulators delay facing the facts, to let managements take compensation more appropriate to a live company than to a dead one. Examples were Crum & Forster, Home, Republic, INA and Lloyd's of London.

Called "restructurings" by the managements and bankers who advocated and sold them, these changes could save the "good company" but shortchanged the policyholders at the "bad" one.[50] They bring to mind the Islip Barge, with Islip's garbage loaded on it.[51] The Barge was pushed out to sea to find a harbor that would accept the garbage. Provisioned with fuel and crew said to be adequate, its mission was never to return to Islip.

In the insurance restructurings, the "good" insurer, relieved of its worst liabilities, is intended to survive and continue in the market. The "bad" one is closed for new or renewal business. It is given funds said (by actuaries hired by management) to be sufficient for the claims against it, and its executives and contract managers are similarly certified as up to the task.

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[49] The story is told in *Carpenter v. Pacific Mutual Life*, 10 Cal 2d 307, 74 P. 2d 761 (1937); *Carpenter v. Pacific Mutual Life*, 13 Cal 2d 306, 89 P. 2d 637 (1939); and *Caminetti v. Pacific Mutual Life*, 22 Cal 2d 344; 139 P. 2d 908 (1943).

[50] Restructuring is to be distinguished from a company's exiting a market and continuing to place its own assets and reputation at risk for paying claims on the discontinued business.

[51] In 1987, the village of Islip, Long Island, loaded a barge with garbage to be dumped far away from Islip. The goal was the same as for the insurance restructurings: separate the garbage from the village and lose it. The tactic did not work for Islip. Its Barge was turned away everywhere it went – six states and three countries – with extensive, entertaining media coverage. Finally the Barge limped back to New York City, where the trash was burned and the ash dumped in Islip.

For these purposes "bad" is defined as having outstanding claims. So policyholders with claims are put at risk of under-funding of their run-off insurer. They are also put at risk of having their claims outsourced to people compensated for not paying. One run-off insurer failed badly soon after it was created.[52] The jury is still out on the others.

The main problem with Islip Barge restructurings is that the run-off or Barge company has to be managed so as to preserve the limited assets it was given in the split. The only way to do that is to get rid of claims as late and cheaply as possible. If the run-off company settles claims over their reserved amounts, its meager capital will get used up.[53] If that happens, it will not have the money to pay the contingent compensation common under run-off management contracts.

Give a person such strong incentives, and he or she will follow them. Islip Barge restructurings must lead, and seem already to have led, to unusually cheap policy buy-outs from policyholders, exceptionally stubborn coverage litigation, and settlements at the deepest of discounts.

With such a record, Islip Barge restructurings should be seen not as regulatory solutions for troubled companies. Instead they should be seen as what they are – elaborate and expensive postponements and evasions of official recognition of insolvency. Who pays in the end? The policyholders, claimants and guaranty funds – all three innocent of the debacle.

Islip Barge restructurings require regulatory approval, under the holding company laws and sometimes under the licensing laws, the managing agent laws and the bulk reinsurance laws as well. The record does not reveal a single

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[52] Just two years after its "good" business was sold to another insurer, The Home Insurance Company (consisting of the run-off "bad" business) was taken over by the New Hampshire Insurance Department for lack of sufficient capital. In May, 2003, the Department filed to liquidate the company.

[53] Equitas, the Lloyd's run-off company for pre-1993 business, has established a public record for running off claims as late and as cheaply as possible. Although a UK company, the majority of its claims are on US business. Equitas has stated that it will only pay asbestos claims if the policyholder provides specific, medical evidence of injury and demonstrates that the injury was related to the policyholder's asbestos products or operations. *Equitas Holdings Limited Reports & Accounts for the year ended March 31, 2002*, pp. 12-13. For many claims, the requirement cannot be met. Its effect is to delay payment or to force the policyholder into a deeply discounted settlement. Equitas' claims director has stated publicly that deep discounts are justified because of the time value of money and the expense of litigation. Scott Moser, *Address regarding Equitas Claim Settlements*, Insurance Institute of London, January 14, 1999.

proposed Islip Barge transaction that has been turned down by the company's domiciliary regulator. Objections that they were bankruptcy preferences, evasions of liquidation statutes, and fraudulent transfers have not prevailed so far.

Islip Barge restructurings are unmistakable and potentially embarrassing examples of regulators favoring the interests of the regulated businesses, their managements and their stockholders over the interests of policyholders. That is not the order of priorities proclaimed in the textbooks and the speeches.

Troubled Company Market Strategy

An older, simpler and cheaper, though no more reliable, corporate change is to shift the troubled company's book of business toward new markets where losses are slow to emerge and develop. Excess levels of product liability and malpractice liability are favorites.

Such marketing shifts prolong the possession of cash. They leave loss reserves to management's discretion for years. They confuse the company's books and make them harder to audit and examine. They give management an upbeat story to tell. They delay recognition of insolvency or even trouble.

Distressed markets are especially attractive for this maneuver. Desperate buyers will rush to any insurance company that will take them. Growth is assured. But frequently distressed markets are that way for good reason. The troubled insurer may pile on distressed business for years before finding out.

Such marketing shifts do buy time, but they also give the troubled company a chance to ensnare more policyholders, write more bad business (because it is no longer offered the good) and set itself up for a far larger insolvency.

Such shifts in marketing and the illusions they create do not require regulatory approval. Yet they are apparent to examiners, auditors, agents and brokers, and readers of company advertising. Sometimes the illusions continue for years, in full view of everyone, before anyone cries out that the company has no clothes.

Troubled Company Claims Practices

That a troubled insurance company will get tougher on claims is not new or surprising. As long as a claim is in dispute, there is cash on hand and a loss reserve to manipulate. Indeed, this natural response is one reason for taking such

companies out of the market promptly. Years ago, undue resistance to claims was even used by regulators as an early warning sign of financial trouble.

What is new since 1988 is how widespread claims resistance has become, by healthy insurers as well as by troubled ones. Faced with what looked like black holes of asbestos and pollution liability, many companies put up a blanket refusal to pay without a fight.[54]

Individual claims are very large. So delayed payment means substantial additional investment income, and payment reductions through litigation and compromise can be in the tens, even hundreds, of millions of dollars. With such big financial benefits in view, an insurer can afford excellent counsel and a tenacious defense.

As one would expect, such claims practices have spread to reinsurers. Substantial reinsurance claims end up in arbitration and litigation, which renders payment uncertain and delays it for years. Yet primary insurers continue to carry disputed reinsurance recoverable as an asset – and might forever if allowed.[55]

One asks how long such a curious asset should remain on the ceding company's books, and one has the same question about reinsurance recoverable from an assuming company manifestly unable to pay though not yet declared insolvent.

Such claims practices at both the primary and reinsurance (and retrocessional) levels, amount to insurance failure all by themselves. From a policyholder's point of view, an insurer that will not pay what it should is as useless as one that can not.

Worst of all is the run-off insurer that emerges from an Islip Barge restructuring. Such insurers have no concern about customer relations since they do not write business. For the same reason, they have no restraining concerns about reputation. Their managements are sometimes awarded compensation

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[54] Developments in the insurance business that have led to widespread claims resistance are described in Richard E. Stewart and Barbara D. Stewart, "The Loss of the Certainty Effect," *Risk Management and Insurance Review*, Vol. 4, No. 2, pp. 30-34. The article is also available at www.stewarteconomics.com/publications.

[55] Reinsurance recoverables that are in dispute or more than 90 days overdue are subject to a 20% penalty on an insurer's balance sheet, that is, assets are reduced and liabilities increased by that amount.

contingent on financial results or on there being money left when all the claims have run off. Either way, it is compensation contingent on not paying claims.

With such claims practices so widespread, the fact that a company resists large claims is no disgrace among its peers. Nor is it an early warning sign anymore. But it undercuts the basic value of all insurance, the certainty that valid claims will be paid.

Subversion of Statutory Accounting

Insurance statutory accounting is more or less liquidation accounting. It differs from generally accepted accounting principles, which are going-concern accounting. The original, and still main, purpose of statutory accounting is regulation for solvency. Hence in many respects it is more conservative, in that it accelerates and enlarges liabilities and postpones and shrinks assets.

The idea behind the statutory rules was that a company that was insolvent on its statutory balance sheet would still, at cash or market values, be worth something. It might be attractive to another insurer and, if not, its policy obligations could be met in full as it was wound up.

But the conservatism of statutory accounting has stimulated the invention of ways to undercut it – to increase assets and reduce liabilities. Financial advisers, intermediaries and capitalized institutions like banks and reinsurers have found value in making an insurance company look stronger than it normally would.

An influential cottage industry has grown up whose counseling and products are aimed at increasing present income and surplus on an insurance company's statutory books. To proponents it is "GAAPing the statutory accounts" or truing them up with "the real world." To critics it is "cooking the books."

Whatever one calls it, the effect of the various techniques is to borrow future income for present display and to take the cushions out of the balance sheet. Sometimes it does so without disclosing that the technique has been employed.

The specific examples that follow are of techniques for putting off formal recognition of insolvency or hazardous condition on the financial accounts of a failing company. Some were invented in the last 15 years. Some are older but have blossomed in that period.

They should be taken as illustrative only, not as current reports of specific maneuvers to be dealt with. For to the extent they are exposed or prohibited, new ones will take their places, just as long as regulators want to postpone recognition of insolvency and welcome clever ways of doing so.

Popular techniques for squeezing the conservatism out of statutory accounting fall naturally into three groups.

One, financial reinsurance. The object is to get loss reserve liabilities off the ceding company's balance sheet, with a smaller amount of assets going along to pay for the reinsurance. The effect is to discount loss reserves to present value, since the assets transferred (the reinsurance premium) are similar to the discounted liabilities.

In a pure case, no risk would be transferred. Because regulators require some risk transfer, the objective is to transfer as little as possible.[56] Many years ago, this sort of transaction was candidly called "surplus relief" reinsurance. Now it is called "financial" or "finite risk" reinsurance. Usually the assuming reinsurer does not record the original, undiscounted amount of the assumed liabilities, but only the smaller amount it received as cash premium to support them.

As the name suggests, finite reinsurance takes on limited risks. Often they are the same ones that are retained in risk management programs – high frequency and low severity. They are predictable enough that one could ask whether they are insurance at all or really banking. When less predictable risks are taken on, the reinsurance contract so limits and spreads out the reinsurer's obligation to pay that once again the transaction looks like banking.

From the sales literature, it is apparent that finite risk reinsurance is oriented toward accounting measures, the statutory balance sheet and the solidity tests like the IRIS ratios and Risk Based Capital. It appeals to managers who emphasize "efficient use of capital," which usually means higher leverage.[57]

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[56] Statutory accounting requires that "significant" underwriting risk as well as timing risk be transferred to the assuming reinsurer for the transaction to be treated as reinsurance. Otherwise, the transaction must be treated as a deposit on the ceding company's balance sheet. Another way to transfer discounted liabilities for an equivalent premium is through a loss portfolio that is considered to be retroactive reinsurance. Retroactive reinsurance must be disclosed and accounted for separately from other reinsurance on the insurer's annual statement.

[57] One provider of these products stated that their "linkage to reinsurance is in the fact that reinsurance is a financial structuring tool that is used to help risk managers and other financial

But if finite reinsurance takes losses off of the primary or ceding company's balance sheet, what is left? A greatly reduced dollar amount of liabilities on its balance sheet. It can then write more business without raising additional capital.

What loss reserves remain represent a less stable overall book of business. The most predictable part has gone to the reinsurer, while the less predictable has stayed. But the liabilities on the balance sheet are just shown as quantities. The sharp decline in their quality, or increase in their susceptibility to being wrong, is not disclosed.

The solvency tests were not designed to cope with such degradations in the quality of assets and liabilities. Insurance accounting treats all assets and liabilities the same.[58] This is a serious weakness of statutory (and other) accounting. Entrepreneurial reinsurers, brokers, investment bankers and consultants are taking advantage of it.

Two, selling future revenues. Pioneered by commercial banks, this technique aims to reduce non-loss reserves, such as those for unearned premiums. The bank lends a bit less than the present value of the future stream of premiums or other revenue. The loan is without recourse against the insurer but is secured by the revenue stream. The insurer does not record the debt, so the result is increased surplus.[59]

While this specific accounting treatment is now disallowed for statutory reporting, some variant could come back any time and, as with many statutory accounting games, it is apt to look like "the real world." Capitalizing a solid revenue stream is one of the pillars of the bond market, and revenue bonds are time-tested and entirely legitimate. With so much skill out there, it is likely to reappear in insurance, perhaps this time securitized.

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managers to unlock hidden values on their balance sheets or to free capital encumbered by economic, regulatory, and accounting constraints." (Peter A. Gentile, President & CEO, Gerling Global Financial Products, "Infinite Possibilities," *1998 Global Reinsurance*, Vol. 7: Issue 4)

[58] An exception is certain invested assets that are not freely traded. The NAIC's Securities Valuation Office sets their carrying value on the statutory annual statement using criteria that include credit quality. *Purposes and Procedures of the Securities Valuation Office of the NAIC* (Kansas City, MO: National Association of Insurance Commissioners, 2001).

[59] Two life insurance companies in 1989 attempted to increase their statutory surplus by "selling" the future premiums on existing blocks of business to a bank and not accounting for the proceeds as a loan. The NAIC subsequently disallowed this accounting treatment. *The Insurance Forum*, March, 1990, pp. 92-93.

Three, asset and liability exchanges. Many versions exist, the simplest being to exchange assets that cannot be counted on the statutory books in return for assets that can. The same sort of thing can be done to take liabilities off the books.

Many of the recent accounting scandals outside insurance have involved such devices – offshore, off-balance-sheet, special purpose entities and so forth. Whether or not the technique is new elsewhere, it is not new in insurance. Sale-and-leaseback of home offices was common practice for years under the old rule that home offices were not admitted assets. Reducing statement liabilities by reinsuring with affiliates was well known in insurance long before Enron used the idea to smuggle debt off its books.

Gaming the Rules

All three of these gimmicks are pure cases of gaming statutory accounting. A sensible counterparty to any of these deals will not take on a less valuable asset. The financial reinsurers take cash. The banks take ample security from premium cash flow. The asset swappers take better (albeit non-admitted) assets.

The three techniques, and their many subsets and variants, have one feature in common. Compared to statutory accounting pure and simple, all of the techniques increase assets or decrease liabilities, accelerate income or postpone expenses, with the effect of adding to surplus.

Since all the devices cost money – counterparties and advisers have to be paid – the effect is to leave the company weaker while making it appear stronger.

For that reason, all of the techniques facilitate delay in facing up to financial trouble and insolvency, because they make the situation look less urgent than it is. All make it easier for management and regulators to delay recognizing insolvency. And all make likely that the insolvency, when it comes, will be worse than it otherwise would have been.

In recent years, the states and the NAIC have sometimes responded to these accounting devices not by prohibiting their use or their recognition on the balance sheet, but by letting the modified numbers stand so long as the modification is disclosed in a note, footnote or interrogatory. That is not enough.

The balance sheet numbers – not the footnotes – drive many of the solvency evaluation measures used by regulators, rating agencies, intermediaries and customers. Balance sheet surplus and the ratio of premiums to surplus are the

numbers that marketers and just about everybody else throw around in everything from sales presentations to news stories to casual descriptions of companies.

Footnotes and interrogatory responses disclosing that the surplus is wantonly overstated are generally left out. Who would countenance a balance sheet that stated assets in thousands and liabilities in millions, no matter how fulsome the footnote?

The new accounting maneuvers add up to this: However tempted regulators have been in the past to postpone the hard and unpleasant work of dealing with insolvency and impending insolvency, today's technical virtuosity makes the temptation stronger and the will to resist weaker.

SOLVENCY REGULATION SINCE 1988

The Picture in 1988

The main conclusion of *Managing Insurer Insolvency* was that the state insurance commissioners needed to act more quickly and forcefully on impending insolvency.

A subsidiary conclusion was that saving companies was one method of minimizing public harm, but that it was no longer the main way and was increasingly likely to fail and to make bad situations worse.

Another subsidiary conclusion was that solvency regulation was not so much a matter of technique as a matter of enforcement and will, and that regulatory delay in recognizing, acknowledging and acting on insolvency was an understandable but serious problem for policyholders, other insurers and regulation itself.

Managing Insurer Insolvency also recommended some changes in the technical area of solvency regulation, though only as subsidiary points. Those recommendations included better information about the management and operation of insurance companies; additional disclosure, particularly with regard to loss reserve discounting, questionable recoverables, and contingent obligations; and giving regulators more powers to intervene.

Purpose, Technique and Recrimination

In the intervening 15 years, the regulators and the NAIC have acted mainly on technique. The technical issues mentioned in *Managing Insurer Insolvency* as well as many others were addressed. Far greater information and more detailed disclosure are found in the statutory annual statement. Early warning tests have been sharpened. Independent audits and actuarial opinions are required. Statutory accounting principles were codified to increase uniformity among the states and to expand disclosure.

The NAIC's adoption of Risk-Based Capital requirements raised, rationalized and standardized minimum capital requirements. It also laid out clear statutory grounds on which a regulator can and must intervene in an insurer's operations. Risk-Based Capital did not, however, address the problem of

incentives to delay recognition of insolvency and the related problem of regulatory will.

Instead, regulators appear to have acquiesced or cooperated in the various steps, described above, whereby managements try to postpone recognition of insolvency or financial trouble. Then, once insolvency is declared, they have sued the company's managers, directors, auditors, actuaries, lawyers and other helpers, for causing the insolvency, concealing it, or wrongfully keeping the insurer in the market.

None of the company gimmicks and regulatory dodges is new. Insurance departments have occasionally approved or permitted or ignored management's efforts to put off the recognition of financial trouble, probably for as long as solvency regulation has existed. But now such a regulatory response is in danger of becoming the norm.

Similarly, regulators have on occasions sued managements and advisers for causing or hiding insolvency. This step too now seems to be becoming the norm. Sometimes it is richly deserved. But sometimes it may serve mainly to turn wrath away from the regulator.

Suing management, directors and advisers after insolvency occurs can be a useful deterrent for such people in other companies in the future. But a deterrent is one thing; letting it lull regulators into passivity before insolvency is another.

The formula of delay-and-sue is dangerous in another way. It is gradual and it is silent. It is never an announced policy and rarely the result of a policy decision at all. It consists of omissions. It can be no more than a series of warnings that go unheeded and opportunities to act that are allowed to pass. Delay-and-sue is just another form of postponement, and one that may lead the failing company to believe it has not a regulator but a partner.

All the new techniques of the investment bankers, the consultants and the lawyers are, at their core, just new ways of acting out the old script of delaying recognition of insolvency. They look promising to the company and regulators precisely because they do what managements and regulators desire at the moment – delay.

The Unpromising Future of Regulatory Delay

In the past, delay was a plausible strategy for insurers that wrote stable, predictable coverages, such as workers compensation. The idea was that the company could write its way out of trouble and accounting manipulations would buy it time to do so.

Enough correctly priced new business would swamp the inherited deficiencies. The new premium cash could be used to pay old claims. Growth would obscure under-reserving, as reserves were gradually stepped up. For an insurance company to write its way out of trouble, the regulators had to give it a chance, without placing a cloud over it by taking visible action.

Such forbearance raised all the familiar dangers of delay. But it once had a rational regulatory purpose, and it could work. Its chances are not so good now, for three reasons.

First, private rating agencies are watching too.

After the rash of insolvencies in the late 1980s and early 1990s, insurance buyers became more concerned with the financial strength of the companies they bought from. Having just been disappointed by regulation (by the insolvencies themselves), the buyers turned instead to private analysts for assurance that their insurers would be able to pay claims.

Prior to that time and for nearly a century, only one specialized firm (A. M. Best) rated the financial condition of insurance companies. It was respected but also widely believed to rate companies too high, especially large, old ones. The general rating agencies (like Fitch's, Moody's and Standard & Poor's) either did not rate insurance companies or did so only when requested for their (rarely issued) publicly traded debt, not for claims-paying ability. The worries about solvency and regulation in the early 1990s offered the rating agencies an opportunity, and they took it.

The result is that today the big rating agencies cover insurers, and Best's has tightened up. They have access to the same information as state regulators, because any insurer that wants to keep its rating will have to give it to them. The private agencies employ financial analysts who are just as able and just as savvy about insurance as those in the insurance departments.

The private rating agencies do not, however, have the same incentives to delay recognition and announcement of trouble as the government regulators do.

The odds now are that the rating agencies will discover trouble as soon as the insurance departments will, and that they will announce it sooner.

Regulatory forbearance is now more likely to be found out, and it is less likely to succeed. A rating downgrade can easily trigger a rating death spiral by scaring away good business, which leads to another downgrade, and so on.[60] That is a process the commissioners cannot control. Their attempts at rescue cannot succeed in that setting.

The second reason delay is no longer likely to work comes from the interplay of competition, under-reserving and ratings. In a highly competitive and increasingly transparent market, a company that appears under-reserved must compete with new entrants unencumbered by a legacy of horrors such as asbestos and pollution liability. These new entrants look like safer alternatives to insurance buyers, particularly if they are sponsored by credible insurance parties.

A new entrant can simply assert that it is free of whatever the hangover liability of the moment happens to be – asbestos, pollution, medical devices today, perhaps financial guarantees, credit default swaps and catastrophe exposures tomorrow. In competitive markets, it is not considered slanderous or even indelicate to point out the failings of one's competitors.

Third, a price competitive market is unforgiving. When it is overpopulated, that is, when it has more competitors than would maximize efficiency, it acts as though it wants to eliminate competitors.

In economic terms, the insurance market has far too many companies. It is dangerous for a company to make a mistake. A marginal insurance company that stumbles may not have a chance to recover. In its pitiless rationality, the market wants it dead.

The dilatory regulator may see the market race to dispose of the company and of any appearance that the regulator was on top of the situation. Delay becomes futile and embarrassing.

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[60] For a current example of how such a death spiral might occur, see "Death Spiral at Lumbermens and Kemper?" in *Schiff's Insurance Observer*, January 9, 2003.

A Role for the Federal Government?

Insurance is a national and international business. It is only natural to ask whether the federal government can play a role in solvency regulation. But first, some background is in order.

In the 19th century, government regulation of business was almost entirely by the states. That was true of insurance, and in 1869 the US Supreme Court gave it a constitutional basis, holding insurance was not interstate commerce.[61]

Regulating insurance at the federal level is a century-old idea.[62] In 1905, President Theodore Roosevelt proposed it in his annual message (today the State of the Union address) to Congress.[63] The possibility of federal regulation was kept alive for another decade by the big, national life insurance companies, and then it faded away.

In 1942, after a bribery scandal involving the Missouri insurance commissioner and his (and Harry Truman's) political patron,[64] the US Department of Justice reopened the question of federal jurisdiction. It caused the indictment of a prominent rate-making bureau and its member insurance companies, which operated in utter disregard of the federal antitrust laws – if they applied.[65]

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[61] *Paul v. Virginia*, 8 Wall 168 (1869).

[62] See Carman F. Randolph, "Federal Supervision of Insurance," *Columbia Law Review*, Vol. 5 (1905), pp. 500-528.

[63] The President said: "There is need of a far stricter and more uniform regulation of the vast insurance interests of this country, commercial interests which are clearly national in character…. That State supervision has proved inadequate is generally conceded…. As a remedy for this evil of conflicting, ineffective, and yet burdensome regulations there has been for many years a widespread demand for Federal supervision." R. Carlyle Buley, The American Life Convention, 1906-1952, Volume I (New York: Appleton-Century-Crofts, 1953), pp. 238-240.

[64] Kansas City political boss, Tom Pendergast, and his choice as insurance commissioner were paid over $500,000 to resolve a fire insurance rate case that had been pending since the 1920s. Pendergast and the commissioner were convicted in 1939 and sentenced to prison. Lawrence H. Larsen and Nancy J. Hulston, *Pendergast!* (Columbia, MO: University of Missouri Press, 1997), pp. 130-151.

[65] Spencer L. Kimball, *Insurance and Public Policy* (Madison, WI: The University of Wisconsin Press, 1960), p. 105.

The government won, and the insurance business was exposed to antitrust attack and to federal regulation.[66] Being in the midst of World War II, Congress enacted a law preserving most of the antitrust exemption and the jurisdiction of the states.[67] State regulation of insurance came to exist at the sufferance of Congress.

One should not, however, underestimate the political roots of state regulation. The governors often dominate the congressional delegations, and the state legislatures redraw congressional district lines every ten years. And in the last few years, state regulators in several other fields (securities, accounting, environment) seem to have shown more independence and pluck than their federal counterparts.

Since the 1950s, the federal government has exercised oversight of insurance regulation, but only fitfully. When the insurance business gets in trouble, such as with insolvencies, the relevant committees of Congress hold hearings. The usual result is embarrassment for the commissioners and recommendations that the commissioners eagerly adopt in order to make Congress go away.[68] Which it does … until the next crisis.

Another kind of intermittent federal intervention is aimed at specific problems one at a time. Examples are ERISA, the Risk Retention Act, the Insurance Fraud Prevention Act and federal reinsurance for riot and terrorism coverage.

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[66] *United States v. South-Eastern Underwriters Assn.,* 322 U.S. 533 (1944).

[67] McCarran-Ferguson Act (59 Stat. 33-34 (1945), 15 U.S.C.A. Secs. 1011-1015).

[68] Congressional hearings in the 1960s into insolvencies of automobile insurance companies led to the introduction of legislation for a federal guaranty fund. Shortly thereafter the NAIC adopted a Model Guaranty Fund Law. Within two years, every state but one adopted a guaranty law.

Congressional hearings in 1990 into insurance company failures faulted state regulation for the unprecedented losses. The NAIC quickly put in place a solvency policing agenda which included reforms that had been languishing in committees for several years. In order to head off calls for federal regulation, the NAIC adopted a formal accreditation program in which state insurance departments had to meet minimum standards of solvency regulation. Although the process took some time, by the end of the decade all but two states were accredited.

More recently, in 1999, the Gramm-Leach-Bliley Financial Services Modernization Act prompted the NAIC to develop model reciprocal agent licensing legislation. Enough states adopted the model to head off the creation of a national licensing agency under the Act.

The relationship between the national government and the state regulators has been productive, but not nearly as productive as it could be. The reason is that it is not systematic. Congress only sees state regulation when it fails, when it asks for help, or when someone wants an exemption from it. Congress does not gain knowledge of how state regulation works as a system. By exercising oversight only in times of distress or in response to special pleas, Congress focuses too narrowly and the states react too much, both in defense and in deference.

That may be changing. The federal Financial Services Modernization Act of 1999 deals with regulation of all kinds of financial services, including insurance. Early indications are that the Act is prompting committees of Congress to look at state insurance regulation more systemically than before. Congressional hearings have drawn broad testimony about state insurance regulation, federal regulation, the differences between insurance risk and banking risk, and the danger of overlooking insurance in what is widely seen as a banking bill.[69]

[69] Examples are American Academy of Actuaries, *Statement of the Task Force on Banking and Financial Services*, March 11, 1999; Ronald A. Wirtz, "Financial Evolution, Not Revolution," *The Region*, Special Issue 2000 (Minneapolis: Federal Reserve Bank of Minneapolis: 2000); and Robert Mendelsohn, *Testimony on behalf of American Insurance Association* before House Commerce Subcommittee on Finance and Hazardous Materials, Sept. 19, 2000.

THE COURTS AS REGULATORS

Social Control over Essential Industries

Within our overall economic system of private enterprise, free choice and market allocation of resources, the United States has two major public institutions for social control of crucial industries like insurance.

Both implement law created by the three branches of government, but they do so in very different ways. One institution is the administrative or regulatory agencies. The other is the courts.

The state insurance regulators operate under an inquisitorial (or inquiring) model of making decisions.[70] Congress and state legislatures take that approach to topics that may call for legislation. Federal agencies use it for formal and informal rulemaking and information gathering.[71]

In insurance regulation, within legal and due process requirements, the commissioner is supposed to be a self-starter. He or she surveys a situation and, once satisfied it is illegal, improper or hazardous, orders a subject company or the whole industry to do whatever the commissioner thinks best.

Regulatory discretion is wide. When the regulator acts after investigation, courts tend to defer. When a regulatory agency does not want to act, courts are not disposed to mandate it. Judicial review is under the restrictive standards of the old prerogative writs, granted only after a finding that the regulator's action or inaction was arbitrary, capricious and unreasonable, or words to that effect.

The inquisitorial model is well suited to developing policy and to balancing many interests and many costs and benefits. It is not well suited to resolving individual disputes between two parties and, in those situations, the regulators themselves have moved toward the judicial (or adversarial) model.

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[70] Edwin W. Patterson, *The Insurance Commissioner in the United States, A Study in Administrative Law and Practice* (Cambridge, MA: Harvard University Press, 1927) pp. 332-372.

[71] See Peter L. Strauss, Todd L. Rakoff and Cynthia R. Farina, *Gellhorn & Byse's Administrative Law*, (New York: Foundation Press, 2003) pp. 276-77, 557-705.

By contrast, the courts respond to controversies brought to them by others. They are not self-starters and, in theory, they do not make policy or balance a multitude of interests not present before them.

The courts are well suited for resolving disputes between two parties or two points of view. Indeed, for that purpose the judiciary is the strongest decision-making institution in our society. In that role the courts enjoy very wide and deep respect and support from the public.

The courts and the judicial or adversarial model are not, however, well suited for creating policy or for balancing many interests or complex costs and benefits.

Agencies and Courts as Alternatives

On the historical record in this country, sensitive businesses like insurance, once government has decided to regulate them, are generally regulated by both regulatory agencies and by courts. The balance of activity swings back and forth between them.

In the early 19th century, regulation was entirely by the courts. After the Civil War, the states gave responsibility to specialized agencies, the insurance departments and their commissioners. The courts kept contract disputes over coverage.

As to the rest, they generally deferred to the presumed expertise of the agencies. But even so, up until 1938 the federal courts had developed a substantial federal common law of insurance, and much of it extended beyond contract interpretation.[72]

With that history, courts do not see themselves as interlopers or as having no legitimate role to play. When the administrative agencies appear unable or unwilling to deal with something that is widely seen as a problem, the courts will sooner or later step in. They do not do so because they want to, but because they conclude they have to if anything is going to get done.

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[72] In *Erie R.R. v. Tompkins*, 304 U.S. 64 (1938), the U.S. Supreme Court required the federal courts to look to state law in deciding civil disputes. The ruling effectively ended the development of a federal common law of insurance.

That was true at a momentous level, and involving not mere agencies but the legislative and executive branches of both federal and state government, with school integration, legislative reapportionment, Watergate, abortion and tobacco.

So also in insurance regulation, if the agencies do not keep control of the field, and maybe even if they do or try to, the courts can be expected to step in if parties to litigation convince them something important is not being attended to.

Causes of the Growing Role of Courts – Disaffection with Government

Since 1980 or so, two large economic and governmental shifts have made judicial intervention in insurance regulation more likely.

One is popular disaffection with government in general. It weakens the political foundations of state regulation as it weakens them in other areas of governmental activity. The disaffection seems mainly directed at the executive and legislative branches, at both the federal and state level, and in many fields specifically at regulatory agencies such as the S.E.C. and the state and federal energy regulators.

Insurance regulators have not been singled out, but neither have they been exempted. Deficits and revenue shortfalls are likely to cut the material resources of the state regulators and can be expected to make the disaffection worse.

A by-product of the general disaffection was California's revolutionizing of insurance rate regulation by a popular initiative, Proposition 103. During the implementation process, nominally by the California Department of Insurance, insurance companies and their adversaries repeatedly turned to the courts in the hope of getting more favorable results.

While the Prop 103 litigation was far from the first time insurance rates have ended up in court, the California battles had two qualities that built up their impact on how people view regulation and the courts.

They were at the policy-making level, not the transactional or simple adversarial level, and they were used by insurance companies more than by their opponents. And they were highly visible. Up close they were dramatic and at a distance they were novel reforms advanced by the trend-setting state.

One message the California lawsuits sent was that if you don't like your insurance rates or your insurance commissioner, the place to go is the courthouse.

Causes of the Growing Role of Courts – Deregulation

The second big shift in policy and opinion since 1988 was deregulation. On the merits, the shift of state rate regulation, in the late 1960s and early 1970s, from prior approval to open competition was sound as economic theory and practice. It followed years of study and debate in individual states and the NAIC. It was almost certainly this country's first deregulation of a major industry. Airlines, trucking, railroads, energy, banking and securities came later.

But the insurance rating law changes of 35 years ago were not presented as deregulation. Instead they were proposed and understood as methods of harnessing the discipline of competition under regulatory scrutiny, and of sloughing off obsolete and counterproductive regulatory rituals. The stated goal was not to get rid of regulation but to make regulation better.

Starting in the late 1970s, deregulation in name as well as in fact became fashionable and in some settings demonstrably beneficial. Some of it was after careful and documented analysis of costs, benefits and alternatives. Regulation, at least as much as other government activities, tends to become rigid and unable to keep up with changes in business practices and public needs. Deregulation can mean simply keeping up to date.

But some of the deregulation was not a matter of policy study and scholarly debate. Instead it was ideological, arising from a belief that regulation was bad, almost bad in principle, and from an annoyed urge to "get government off the back of business."

The difference between deregulation after study and debate, on the one hand, and deregulation pursuant to ideology or fashion, on the other, is that the first is a reasoned case presented to the public and the other is not. In a democracy, that distinction matters. If supported only by ideology or fashion, deregulation hangs politically on whether the ideology lasts and the change is seen to be working at the moment.

After the fashion has died or subsided, if the public sees an industry that has undergone ideological or fashionable deregulation behaving badly, the public is apt to blame deregulation. Ideological or fashionable deregulation has little reasoned or publicly-examined underpinning, and hence little independent defense against attack.

Americans are famously pragmatic about business institutions (like insurance) and government institutions (like regulation). What is good is what

works. When rates go up, the public is disposed to think something isn't working and that leaving insurance companies free to charge what they want is a perfectly horrible idea.

For one reason or another – analysis, ideology or fashion – the insurance commissioners got on the deregulation bandwagon, with "commercial lines deregulation" and other initiatives. At the same time, much commercial insurance capacity moved offshore, where the US commissioners could not regulate, and moved into risk retention devices which, at the moment, nobody can regulate.

In the last 15 years, the commissioners have evinced no interest in the epic coverage disputes between many of the world's largest business corporations and their insurers, over such matters as liability for asbestos, pollution and medical products. Whether or not such abstention was correct, it left many of the world's biggest corporations with the impression that state insurance regulation was irrelevant, even inimical, to their interests, and that their only recourse was to the courts.

The Courts – Pro and Con

Disaffection with government undermines insurance regulation along with a lot else, and deregulation is a deliberate pullback from what used to be considered regulatory responsibilities.

Deregulation of rates and forms, wider opportunities for unlicensed insurers, abstention from coverage disputes, and acquiescence in the devices for keeping failed insurers in business – all these recent actions may or may not be sound on the merits, but they can all look like regulators siding with the regulated industry.

As one might have predicted, and as a few did, it was only a matter of time before the courts and the bar stepped in. That has happened with automobile crash parts and with life insurance sales misrepresentations. It is surely only a matter of time before their attention turns to rates and forms generally – and to solvency regulation.

In a class action for losses due to an insurer's insolvency, the commissioners and the guarantee funds could expect to be defendants, not plaintiffs. They would not be alone, but would be joined by the reinsurers, reinsurance brokers, investment and commercial bankers, lawyers, accountants, actuaries and consultants who would be accused of aiding and abetting their

dereliction of duty or even of being principals and co-conspirators in the fraud. Needless to say, delay in recognizing insolvency would be subjected to extensive discovery and savage attack.

The problems with courts in these areas are two. One is settled jurisdiction and expertise. The commissioners were given jurisdiction over this kind of thing a long time ago.

The good agencies are good at it, and policy form review (as with crash parts and life misrepresentation), market conduct supervision (as with harsh claims practices) and financial analysis (as with solvency) are matters squarely within their special expertise.

State insurance regulation has its share of problems, but they pale in comparison with trying to regulate the national insurance business from one state (or federal) court through its threat of unendurable penalties. Decisions of this sort are better suited to the inquisitorial model of the agencies than to the adversarial model of the courts.

The second reason for concern about the courts' expanded role is fairness and certainty. What are insurers to do if one state court hits them with prohibitively large punitive damages for doing something on a national basis that other states, through their regulatory agencies, permit or even require? Is it fair in such circumstances to penalize insurers after the fact?

Generally, how are insurers to make product, price and marketing plans and decisions in the face of such uncertainty? It is well known that rational businesses abhor uncertainty and function worst in an uncertain setting. It is also well known that hard cases make bad law.

Were the Courts Invited?

One reason the courts are moving in on traditional regulatory turf is that the commissioners seem to have (inadvertently) invited them.

The apparent invitation was partly by something the commissioners did and partly by something they did not do.

What they did was go to court repeatedly to place responsibility for a particular insolvency on someone other than the insurance department – directors, auditors, actuaries and the like. Having turned to the courts for so complicated a question as blame for a company's failure, the commissioners are in a weakened

position to assert that the courts should not look at insolvency when someone else petitions them to do so.

What the commissioners did not do was to address some significant regulatory questions that had been around for years. More aggressive regulation might have headed off both the crash parts and the life insurance marketing litigation and done so on a thoroughly sound basis from the public standpoint.[73]

Take crash parts as an example. It comes down to two questions. What does the phrase "like kind and quality" in the auto physical damage policy mean about the kind of repair parts an insurer is obliged to pay for? And are third-party or generic parts, rather than OEM parts (*i.e.*, those from the auto manufacturers), of like kind and quality?

These are not new questions. The question of the meaning of identical language in the standard fire insurance policy came up a century ago, and the auto body shops and OEMs have been complaining about generic parts for decades.

At any time in the last 20 years or more, any state insurance department in the country could have conducted a study and held hearings on those two questions, either in general or in relation to a particular rate and form filing. It could have confirmed that the contract correctly described the insurance companies' view of their obligation, or that the contract did not; that the auto policy needed to be changed or that two policies with two rates were appropriate – or whatever.

In life insurance, the class action issues were even simpler – did agents describe one product (whole life) as another (annuity) and should their companies be held responsible? Those are classic regulatory questions. Life agent misbehavior is an old regulatory concern, first officially castigated in 1877, and abundant laws deal with it.

Yet over the years, the enforcement of rules of life agent behavior has been left largely to the life insurance companies. Government enforcement has

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[73] Disability insurance claims practices are on the way to being yet another example. The courts, including federal appellate courts, have been active in response to class actions. The NAIC has now taken it up, but for a long time only one state (Georgia) was even looking into the problem. See Joseph M. Belth, "The National Media Spotlight Focuses Attention on UnumProvident's Disability Insurance Claims Practices," *The Insurance Forum*, February, 2003, pp. 169-175. Disability insurance has just as large and politically positioned a constituency as auto physical damage and life marketing – probably more if the impact on the elderly is taken into account.

been directed at preventing agents from exploiting companies – the licensing, twisting, rebating and premium trust fund rules and so forth. In the misrepresentation cases, the regulators did not lead but followed the plaintiff's lawyers.

The key to keeping the crash parts and life misrepresentation questions within the regulatory purview and out of the courts was not the substance of what the departments should have decided, but that, on a reasoned basis, they should have decided something. Chances are there would then have been no lawsuits or, if they had come anyway, they would have been less intrusive, less expensive and less likely to succeed.

The story has a simple moral. If state insurance regulators are seen to be uninterested or passive or incompetent or captured or dependent on courts for the tough decisions, the courts will be more likely to step forward – in their own way and on their own terms – to fill what will look to them like abdication by the primary public agencies.

THE FUTURE AFTER 15 YEARS OF CHANGE

Progress and Retreat since 1988

The business and regulatory pattern that has emerged in the last 15 years has all the defects and dangers of the old one, with some additions that make it more complex and probably worse.

Insolvency now has more than one face. It can be through competitive decline, as before. Much more of that is probably coming.

The working of inexorable economic forces to squeeze high-cost providers with no advantages should be distinguished from mismanagement and fraud. But mismanagement and fraud will always be with us, and they can combine with competitive decline to truly destructive effect. More of that is probably coming too.

What is new, or returned after sleeping a century, is insolvency through catastrophe. Often it is likely to be a catastrophe that a company invited, reaching for profit or market position with not much going for it.

The overexposure can be on the part of personal lines companies, obliging their agents by over-writing in areas susceptible to natural disasters. It can be commercial insurers over-writing in long-tailed casualty lines, relying on shaky reinsurance, or selling credit derivatives without fully appreciating the risk.

Claims and Solvency

The new strategy of not paying large claims without a fight relates to failure in several ways.

Non-payment is failure in itself. Unwillingness to pay is at least as harmful to policyholders and the insurance business as inability to pay. It also affects a company's finances.

Resisting claims keeps loss reserves on the balance sheet (and manipulable) for many years, until a step as routine as bringing them up where they ought to be will amount to a catastrophe. Eventually paying them through litigation or settlement can have the same impact, as it establishes what the

reserve should have been. As the non-payment strategy spreads to reinsurance, the primary companies have an increasingly dubious asset on their books.

A final thought on claims. This report focuses on commercial property-casualty insurance and on company solvency rather than claims practices. But solvency and claims are interrelated, because claims are where most of the money goes, and reserves for unpaid claims are where most of the accounting manipulations take place. Right now, resisting commercial claims is buying some shaky companies time to suppress reserves so as to defer acknowledging insolvency, all in the hope that during that time they can write or merge their way out of trouble.

But time may be running out due to developments elsewhere. In long-term disability insurance, the largest insurer is accused of systematic, unfair denial of benefits to disabled people.[74] In individual accident and health insurance, several leading insurers are accused of forcing sick policyholders out of coverage either directly or through rates that spiral ever upward.

The techniques go by such names as "claims management," "closing blocks," "tier rating" and "underwriting at renewal," but the effect is the same – insurance is there until you need it.

If the alienated big corporate buyers and the alienated sick and disabled individuals ever see how much they have in common, claims practices could become a real public issue.

As the regulators have not done much about disability and accident and health insurance claims practices, and nothing about large commercial claims, they have probably lost control of both issues. The changes will likely be by Congress or the courts.

For present purposes, the point is that such changes could well end the short-term usefulness of restrictive claims practices, and the concomitant under-reserving and financial reinsurance, as a way of putting off the recognition of insolvency.

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[74] See Joseph M. Belth, "The National Media Spotlight Focuses Attention on UnumProvident's Disability Insurance Claims Practices," *The Insurance Forum*, February, 2003, pp. 169-175; and Joseph M. Belth, "Transferring Claims Administration for Disability Insurance Policies" and "Other Agreements for Transferring Disability Insurance Claims Administration," *The Insurance Forum*, April/May, 2003, pp. 191-196.

Techniques of Delay

The techniques for delay disguised as rescue also have become more sophisticated and meretricious.

If the company nonetheless goes under, the regulator can always go after others – the management, the directors, the advisers. The incentives to delay recognition of insolvency are reinforced by the prospect of blaming others if it doesn't work out.

Waiting and suing tends to focus on individuals and specific acts, and to miss the larger picture. It's the villain theory again. Sometimes, indeed, wild and larcenous people are at the helm of a sinking company. They are colorful and make good copy. But they are less important by far than competitive decline and invited catastrophe as causes of insolvency.

The regulators would benefit from stating the systemic truths – that insolvencies are an inevitable accompaniment of competition, that competition is both desirable and inevitable, and that focusing regulatory energy on preventing insolvencies is futile and a bad idea anyway.

The goal is protecting the public, not the companies. Saving failed companies is an inefficient way of doing so, and one with bad odds and bad side-effects.

The new techniques for postponing recognition of insolvency are also more of a threat because they have economic constituencies, that is, other commercial interests which profit from them.

Years ago, a company that wanted to reduce reserves just did so. Now under-reserving is done by financial reinsurance. It has a powerful constituency – reinsurers and reinsurance brokers. The device of restructuring failing companies into survivors and run-offs has an even more powerful constituency – investment bankers.

Other devices for postponement give commercial banks, actuaries, accountants, lawyers and consultants an economic interest in selling them to troubled companies and regulators.

Time is no longer on the side of the regulator who delays the recognition of insolvency, for two reasons.

One reason is that, with so many devices at hand for taking the conservatism out of statutory accounting, the chances increase that by the time the regulator finally acts, the company's financial cushions will have been used up.

The second reason is that the regulator is no longer alone with the failing company. Now the rating agencies and the plaintiff's lawyers are watching. Each has the ability to fell the company and expose the procrastinating regulator.

The most worrisome replacement for the dilatory commissioner today – from the standpoint of state regulation – is not the rating agencies and certainly not the federal government, executive or legislative, but the state and federal courts. That has not yet occurred in regulation for solvency, but it is only a matter of time.

Saving Insurance Companies with Policyholder Money

The problem of delay is getting worse as the causes of insolvency multiply, as the devices for implementing delay are sold by so many influential businesses, and as the money to save the appearance of company solvency is coming more and more from its policyholders. That is new, a product of the last 15 years.

Consider the phrase – the money to let companies appear solvent is coming from policyholders, the very people regulation is sworn to protect. How can that be?

It looks like regulatory capture. It probably isn't, but even if so, it was certainly not intended by the regulators or, for that matter, by the industry as a philosophical matter. It comes about because of the villain theory and the ensuing desire to avoid facing the worst in specific cases.

The Devil is indeed in the details. Everybody wants to protect policyholders in the abstract. But in the specific case of a tottering company, something has to be done – and done fast – to head off the calamity. By definition the busted company does not have enough to go around. A contributor is required.

Who's handy? Not other companies anymore. They're about to be rid of a pest, which in its dying days was undercutting their prices. Not stockholders. They've had enough. Not taxpayers. They'll never contribute to a bailout. Not real investors. They want opportunities, not problems. Not guaranty funds.

Their members do not like to let go of cash, and they act like the insurance companies in whose shoes they stand.

Enter an investment banker, a commercial banker, another insurer, a pack of actuaries and accountants, an asset stripper, a run-off manager, a vulturous bidder, and always a platoon of lawyers – all arm-in-arm with management. Their unvarying proposition: This fine company can be restored to health if you only relieve it of these calamitous claims no human could have foreseen. Let us handle them and your company will be saved, your escutcheon will be untarnished and indeed burnished brighter.

Once the regulator goes for this approach in principle, there are lots of ways to bring it about. The simplest is the Islip Barge restructuring. That gets rid of the policyholders with outstanding claims. The rescue team fuels the run-off barge with just the right quantity and quality of assets, perhaps fortified with reinsurance or guarantees that at least look good, and then their experts opine that that is quite enough.

The management, shareholders and rescue team sail off to a golden future, fueled by as much of the failing company's best assets as the cooperating regulator lets them take away. The commissioner lets out a sigh of relief. But what has really happened? The regulator has helped save a fragment of a failed insurance company, at the expense of precisely the people the regulator is sworn to serve.

The declared purpose of insurance regulation is to have a sound industry and to protect policyholders. What has happened recently is an inversion of those regulatory priorities. Failed companies are kept alive, so the industry is less sound. Policyholders are unpaid and hustled off into a zombie company with a minimum of resources and no future.

That doesn't look like protection. The classic regulatory agenda is being stood on its head.

It is only a matter of time until someone – someone with an interest in political advancement, commercial advantage, sensational exposure, legal fees or perhaps just the merits – points it out.

Summary and Conclusion

For a long time, from 1850 to 1950, insurance regulation did not focus on individual insurance companies in order to protect the financial soundness of the industry as a whole. Instead regulators put government power behind a market structure – the fire insurance cartel – that made it difficult for a company to fail. It was a costly system, but for solvency it had its good points.

When an unfortunate company nevertheless got in trouble, the high cartel prices made it easier for the commissioner to find it a home with a stronger company or otherwise to pull it through. The mission of insurance regulation was described as preventing insolvency, which may sound individual but was really systematic. The market was set against company failure as a general proposition – public health for all rather than heroic medical intervention for one patient at a time.

Starting in the late 1940s, the cartel system unraveled, for legal and competitive reasons. Price competition squeezed profit margins. Mistakes were less frequently forgiven. Companies with high costs and no particular advantages were gradually squeezed out. That process continues today and will continue for decades into the future.

The commissioners continued to see their duty as preventing insolvencies, but now the market structure was hostile, not supportive. So the regulators turned to saving individual companies one at a time. They would have done better to see their duty not as saving failed companies but as saving the public from failed companies.

That was where matters stood in 1988 – regulators mistakenly thinking they were supposed to save individual insurance companies, in a marketplace that made it nearly impossible for them to succeed. Regulatory action was increasingly unpleasant and unpromising. So the commissioners delayed action. During the delay, the situation usually got worse and more people got hurt.

So far, the problem today is the same as in 1988. The regulatory mission is still seen as rescuing individual companies.

Yet the problem is more serious today than in 1988. The market is even more competitive and less forgiving, so the odds against successful rescue are even greater. Many prominent companies are weaker than they were 15 years ago. The techniques for delaying action on impending or actual insolvency have become more sophisticated and superficially attractive. And the techniques have

influential economic constituencies – businesses that make money by selling them.

We are now emerging from an interlude when external forces, not management or regulation, reduced the incidence of insurance company insolvency.

Government and business people who want better insurance regulation ought to use this respite. They can use it to make the situation better for policyholders, insurers and everyone else who depends on a reliable insurance business. It is by no means impossible, but it will call for overcoming some powerful and quite natural forces of financial ambition, regulatory habit and human nature.

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