#398

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

Mississippi Insurance Department: Its Effectiveness in Regulating the State's Insurance Industry

PEER reviewed the effectiveness of the Mississippi Insurance Department (MID) in protecting the public from the principal risks associated with operation of the state's insurance industry. PEER sought to determine whether the department adequately protects the public from the consequences of insurance company insolvencies; ensures that rates charged by insurance companies are not excessive, inadequate, or unfairly discriminatory; and, protects consumers from misconduct by insurance companies or their agents.

Concerning whether the department adequately protects the public from the consequences of insurance company insolvencies, PEER found that MID's regulatory activities provide the public with reasonable protection against these risks.

Concerning whether the department ensures that rates charged by insurance companies are not excessive, inadequate, or unfairly discriminatory, PEER found that MID does not submit all property and casualty rate filings for actuarial review. Actuarial review is a necessary step in determining the appropriateness of property and casualty rate requests.

Concerning whether the department protects consumers from misconduct by insurance companies or their agents, PEER found that MID does not verify critical information during the agent licensing process; does not have a formal system for receiving and utilizing complaint data in order to target its regulatory and educational efforts; and, does not adequately educate consumers regarding the risks posed by the industry and the steps consumers can take to avoid those risks.

November 9, 1999

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

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The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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November 9, 1999

The Mississippi Legislature

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On November 9, 1999, the PEER Committee authorized release of the report entitled **Mississippi Insurance Department: Its Effectiveness in Regulating the State's Insurance Industry**.

Representative Tommy Horne, Chairman

This report does not recommend increased funding or additional staff.

Table of Contents

Letter of Transmittal i

List of Exhibits v

Executive Summary vii

Introduction 1

Authority 1
Scope and Purpose....................1
Method 2

Background 3

Protection Against Insurance Company Insolvencies....................7

Regulatory Activities Designed to Prevent Insolvencies....................7
Regulatory Activities Designed to Ensure that Policyholder Claims Will Be Paid in the Event of an Insolvency....................13

Protection Against Excessive, Inadequate, or Unfairly Discriminatory Insurance Rates....................16

MID's Regulation of Property and Casualty Insurance Rates....................16
MID's Regulation of Life, Health and Accident Insurance Rates....................18
Verifying that Rates Charged are Rates Approved by MID for All Lines of Insurance....................19

Protecting Consumers Against Misconduct of Insurance Companies or their Agents....................20

Preventing Misconduct by Verifying Insurance Agent Competency and Trustworthiness Through the Licensure Process....................20
Detecting Company and Agent Misconduct....................24
Punishing Agent and Company Misconduct....................30
Protecting Against Misconduct Through Consumer Education....................31

Recommendations 33

Table of Contents (continued)

Appendix A: Mississippi Insurance Department: Organization Structure and Funding.....37

Appendix B: Insolvent Insurance Companies in Mississippi, 1990-1998.....40

Appendix C: National Association of Insurance Commissioners' (NAIC) Minimum Regulatory Components for an NAIC-Accredited State Department of Insurance.....42

Appendix D: MID's Regulation 91-101: Regulation to Define Standards and Commissioner's Authority for Companies to be Deemed to be in Hazardous Financial Condition.....44

Appendix E: MID Agent Licensure--Types and Terms.....46

Appendix F: MID Fines Levied Against Companies, FYs 1997-1999.....50

Agency Response.....53

List of Exhibits

1. Domestic and Foreign Insurers Regulated by the Mississippi Insurance Department in 1997, by Product Line of Insurance..........4

2. Glossary of Terms Related to Regulation of the Insurance Industry..........5

3. 1997 Total Premiums Paid in Mississippi, by Product Line of Insurance..........6

4. Types of 1998 Consumer Complaints Against Companies and Agents..........27

5. MID's Efficiency in Closing 1998 Complaints..........29

Mississippi Insurance Department: Its Effectiveness in Regulating the State's Insurance Industry

Executive Summary

PEER sought to determine the effectiveness of the Mississippi Insurance Department (MID) in protecting the public from the principal risks associated with operation of the state's insurance industry. PEER sought to determine if the department adequately:

- protects the public from the consequences of insurance company insolvencies;
- ensures that rates charged by insurance companies are not excessive, inadequate, or unfairly discriminatory; and,
- protects consumers from misconduct by insurance companies or their agents.

PEER found that MID, through its regulatory efforts, provides the public with reasonable protection against insurance company insolvencies. However, the department did not submit 59% of 1998 property and casualty rate filings for actuarial review to ensure that such rates were not excessive, inadequate, or unfairly discriminatory. MID also does not strictly enforce licensing requirements, use all available means to detect misconduct, or educate the public to recognize and report misconduct.

Protection Against Insurance Company Insolvencies

MID's regulatory activities provide the public with reasonable protection against insurance company insolvencies.

MID seeks to avoid insolvencies by:

- obtaining evidence of the financial stability of insurance companies and HMOs before allowing them to conduct business in Mississippi;
- using National Association of Insurance Commissioners standards to conduct ongoing financial examinations of insurers in order to detect impaired or hazardous financial conditions and using financial indicators to identify HMOs which merit extra regulatory attention; and,
- managing financially impaired companies back to stable financial condition.

Further, the state seeks to ensure payment of consumers' claims against insolvent insurers via guaranty associations. State law establishes maximum amounts which the guaranty associations can pay per policy.

Protection Against Excessive, Inadequate, or Unfairly Discriminatory Insurance Rates

MID does not submit all property and casualty rate filings which require actuarial review to an actuary for such review.

Actuarial review is necessary to determine whether property and casualty rates are excessive, inadequate, or unfairly discriminatory. In 1998, of the 654 rate requests which required actuarial review to ensure that those rates met the legal standard of not being "excessive, inadequate, or unfairly discriminatory," MID submitted only 268 (41%) to the actuary for review.

MID has no legal authority to regulate life, health and accident insurance rates except in the areas of Medicare supplements, long-term care policies, HMOs, credit life, and credit accident and health. MID has assumed authority, via its regulatory responsibilities, to limit annual increases of existing programs to 25%. However, this policy is not derived from any specific grant of legislative authority and MID personnel expressed concern over the department's legal authority if this policy were challenged in court.

Protection Against Misconduct of Insurance Companies or Their Agents

The purpose of licensing insurance agents, a responsibility of MID, is to provide basic assurance that agents are competent and trustworthy. State statutes require licensing exams,

background checks, and pre-licensure and continuing education training as components of the licensing process.

MID does not verify critical information during the agent licensing process.

MID does not use agent licensure test results obtained directly from testing companies to determine licensing exam scores independently, even though this is the only way to ensure score accuracy. Instead, MID relies on self-reporting of the licensing examination score by prospective licensees.

Also, while state law requires insurance companies to investigate the "character and record" of persons applying to act as their agents, MID has not prescribed the content of such investigations. As a result, there is no uniformity in the types of background checks performed by insurance companies and there is no assurance that checks which they do perform ensure that insurance agents meet qualifications established in state and federal law.

Concerning educational requirements for agents, House Bill 1243, passed during the 1999 regular session and effective July 1, 2000, sets uniform educational requirements for insurance agents and requires documentation of compliance with these requirements. This should correct the lack of documentation which currently exists with respect to education of life, health, and accident agents and the inconsistencies in educational requirements which currently exist between lines of insurance.

MID does not have a formal system for receiving and utilizing complaint data in order to target its regulatory and educational efforts.

After agents are licensed, MID's primary method of detecting agent and company misconduct is through complaints from consumers and the industry. While the department contends that it informally monitors complaint activity and makes necessary referrals to the legal staff and/or commissioner for further action, the department does not maintain adequate records of consumer and industry complaints to ensure that it addresses all complaints, nor does it have a formal system for analyzing the complaints for purposes of identifying patterns of misconduct. Implementation of a formal system for analyzing complaint data for information such as frequency of types of misconduct and violators would assist MID in targeting both its regulatory and educational efforts.

For those violations it has detected, MID has taken disciplinary action, including revoking licenses against agents and imposing monetary fines against companies.

When MID detects violations of insurance laws and regulations, it exercises its regulatory authority by imposing penalties against agents or companies. During 1998, MID took disciplinary action against fifteen agents, including revoking three agents' licenses. During the last three fiscal years, MID levied fines totaling $802,900 against fifty-four companies.

MID's public education program does not address the risks associated with the insurance industry and what steps consumers can take to avoid said risks.

Educating consumers as to the risks and hazards associated with the insurance industry is critical to effective regulation. Educated consumers protect themselves and can also protect other consumers by recognizing misconduct and reporting it to the state's insurance regulatory agency. MID's education program consists of responding to requests for information through a toll-free telephone number, distributing informational brochures, providing lectures on insurance topics to consumer groups, and participating in the Mississippi Insurance Counseling and Assistance Program. A national consumer advocacy group found that MID's informational brochures did not educate consumers about the risks and hazards of the insurance industry.

Recommendations

1. In order to ensure that it properly analyzes and acts on all property and casualty insurance rate, rule, and form filings, the Insurance Department should establish formal, written procedures governing handling of the filings. These formal procedures should cover:

   a. documentation of receipt of every filing;

   b. classification of every filing, according to the type of analysis necessary (if any) to act properly on the filing. For example, some "rate" filings are merely filings to correct a typographical error and therefore do not require analysis prior to approval; other filings may only require in-house review, while true rate filings require actuarial review.

   c. submission of every filing to the proper level of review and review of each filing according to written criteria. For example, in order to comply with state law (which requires that property and casualty insurance rates not be excessive, inadequate, or unfairly discriminatory) and to ensure a competitive insurance market with broad consumer access, MID should submit all true property and casualty insurance rate filings to actuarial review.

   d. documentation of the disposition of every filing (approved or disapproved), including documentation of analysis, methodology, and material assumptions made in arriving at the decision.

   Further, in order to provide greater assurance that the department follows its own procedures, MID should use existing resources to develop a computer database which documents compliance with all of the major provisions for handling of rate, rule, and form filings laid out in

formal procedures. At a minimum, the department's computer database should contain the following information on each filing: the date of receipt, name of company submitting the filing, the type of filing, entity performing the analysis of the filing, the final disposition (approval or disapproval and brief description of reason for action taken), and the date of the disposition. Also, the computer database should tie to any supporting hard copy files, such as correspondence with MID's consulting actuary. MID should also use the database to make sure that its analysis of filings takes place within the thirty-day limit established in MISS. CODE ANN. Section 83-2-7 (1972); otherwise, the filing could be deemed to be automatically approved even if the filing has not been properly analyzed.

2. In order to establish clearly the department's legal authority to regulate life, health, and accident insurance rates in areas not already authorized by state law and to give the department a firm position should its authority to regulate life, health, and accident rates in areas outside of current legal authorization be challenged in a court of law, the Commissioner of Insurance should develop recommendations for the Legislature regarding changes in state statutes. The recommendations should include appropriate language addressing the role which MID should take relative to life, health, and accident insurance rate requests; for example, language and definitions similar to those found in MISS. CODE ANN. Sections 83-2-3 and 83-2-7 governing property and casualty rates might be appropriate. Further, MID should recommend that the Legislature amend MISS. CODE ANN. Section 83-41-331 (1972), which requires MID to review HMO rate requests prior to approval, to include definitions of "excessive," "inadequate," and "unfairly discriminatory."

3. Given the importance of agent licensing requirements in assuring that agents are competent and trustworthy to sell the products which they offer to the public, MID should correct deficiencies in its agent licensing procedures by:

   a. verifying each applicant's passage of the licensing examination by utilizing test scores provided directly to MID by the testing services, rather than using scores submitted to MID by license applicants. Further, the Commissioner should not grant a license to any applicant who is unable to pass the licensing examination at the minimum validated passing score;

   b. ensuring that license applicants' files contain all necessary documentation of applicants' compliance with state law and departmental regulations prior to the department issuing a license to the applicant

(e.g., a letter certifying that an out-of-state applicant for a license in Mississippi has complied with all qualifications for licensure in the applicant's state of residence; documentation of compliance with pre-licensure and continuing educational requirements); and,

c. developing the elements of a background check necessary to certify that an applicant is of good moral character, is trustworthy and complies with all other background requirements set forth in state or federal law or regulations, including verifying whether an applicant has ever been convicted of a criminal felony. Also, MID should require that the insurance company seeking to hire a new agent submit a copy of the legally required background check on the agent directly to MID prior to MID's licensing the applicant.

4. In order to ensure that it is addressing all consumer and industry complaints on a timely basis, MID should ensure that its complaint database is accurate (e.g., includes all complaints, the date of the complaint, nature of the complaint, agent and company against which the complaint is lodged, analyst assigned to handle the complaint, date and nature of final disposition, amount of settlement attributable to MID's intervention) and up-to-date and should be programmed to flag complaints which remain open longer than the average for each category of complaint. Further, MID should analyze its complaint data, including identifying patterns of misconduct among agents and companies, in order to direct its regulatory efforts to areas of greatest risk. One example of how MID could analyze complaint data would be to determine complaint index ratios (see discussion on page 29).

5. MID should explore all cost-effective methods for proactively uncovering and addressing cases of agent and company misconduct.

6. To deter insurance companies' use of unlicensed and/or uncertified agents, the Legislature should amend MISS. CODE ANN. Section 83-17-11 to authorize the commissioner to fine the company, the agent, or both, for use of unlicensed and/or uncertified agents $500 for each policy or transaction sold or negotiated by the unlicensed or uncertified agent.

7. Because the products offered to consumers by insurance companies are complicated, frequently changing, often expensive, and critical to the consumer in terms of the claimed protection which they provide, MID should develop a formal public service program designed to educate the public to recognize industry risks, dangers,

and warning signs and to report insurance industry misconduct.

Further, the Commissioner of Insurance should include a summary of the department's handling of complaints in its annual report. Sorting complaint data by NAIC categories, this summary should include:

- complaints received by type of complaint;
- disposition of these complaints; and,
- total dollar amounts collected on behalf of consumers and total dollar amount of collections attributable to MID's intervention (see discussion on page 29).

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Mississippi Insurance Department: Its Effectiveness in Regulating the State's Insurance Industry

Introduction

Authority

The PEER Committee authorized a program evaluation of the Mississippi Insurance Department pursuant to the authority granted by MISS. CODE ANN. § 5-3-57 et seq. (1972). This review is a "cycle review," which is a determination of the effectiveness of a randomly selected budget unit in achieving its statutory purpose. Cycle reviews are not driven by specific complaints or allegations of misconduct.

Scope and Purpose

PEER sought to determine the effectiveness of the Mississippi Insurance Department in protecting the public from the principal risks associated with operation of the state's insurance industry. PEER sought to determine if the department adequately:

- protects the public from the consequences of insurance company insolvencies;
- ensures that rates charged by insurance companies are not excessive, inadequate, or unfairly discriminatory; and,
- protects consumers from misconduct by insurance companies or their agents.

In addition to its responsibility for regulation of the state's insurance industry, state law charges the Mississippi Insurance Department with responsibility for the State Fire Academy and the Liquefied Compressed Gas Board. Because the State Fire Academy is a separate budget unit, PEER will review this unit at a later date in its cycle review process. PEER excluded the

Liquefied Compressed Gas Board from this review because it is not involved in insurance regulation.

Method

In order to determine the effectiveness of the department in protecting the public from the primary risks associated with the insurance industry, PEER interviewed MID employees and analyzed Mississippi statutory provisions relative to the department and its regulatory operations. PEER also took the following steps to analyze the department's effectiveness relative to each risk:

- ***protecting the public from insurance company insolvencies:*** reviewed selected MID 1997 financial examination files and analyzed National Association of Insurance Commissioners (NAIC) standards relative to financial examinations;
- ***ensuring proper rates***: analyzed MID's database of 1998 rate, rule, and form filings; reviewed 1998 company rate files; and, corresponded with the American Academy of Actuaries;
- ***regulating agents and companies:*** reviewed MID's procedures and regulations governing the licensing of companies and agents; conducted random sample of 1998 agent licensing files; analyzed 1998 disciplinary actions against agents; reviewed MID's procedures relative to consumer complaints; analyzed NAIC's "Best Practices for Consumer Services;" and, analyzed MID's database of 1998 consumer complaints.

1997 is the last year for which all field work, examinations, and reports were complete for the full year.

Background

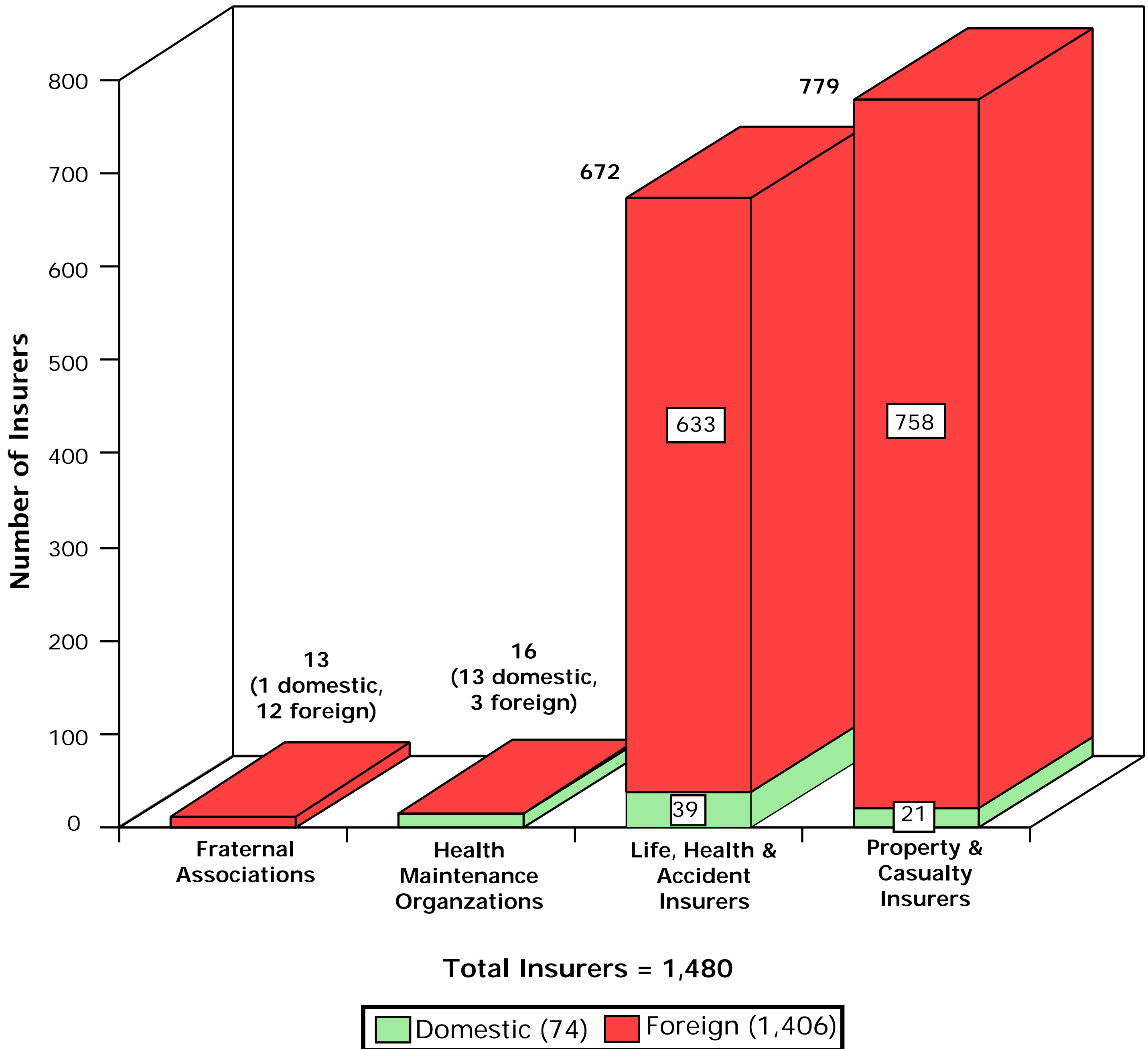
As shown in Exhibit 1, page 4, Mississippi's insurance industry is comprised of four major product sectors: property/casualty; life/health/accident; health maintenance organizations (HMOs); and, fraternal and burial associations. Of these companies, seventy-four are domestic insurers and 1,406 are foreign insurers. (Exhibit 2, page 5, contains a glossary of these and other terms related to regulation of the insurance industry). As shown in Exhibit 3 on page 6, 1997 premiums on insurance business written in Mississippi by the 1,480 companies licensed to sell business in the state totaled over $4.5 billion.

Title 83 of the MISSISSIPPI CODE charges the Mississippi Insurance Department with responsibility for regulating the state's insurance industry. The department is charged with the execution of all laws relative to insurance and all insurance companies, corporations, associations, or orders. The Commissioner of Insurance, elected statewide to a four-year term, oversees operations of the department. The current Commissioner is completing his sixth term of office.

Appendix A on page 37 contains a brief description of the department's organization and funding.

For regulatory purposes, fraternal and burial associations and HMOs fall under life/health/accident, unless otherwise noted.

Exhibit 1: Domestic and Foreign Insurers Regulated by the Mississippi Insurance Department in 1997, by Product Line of Insurance



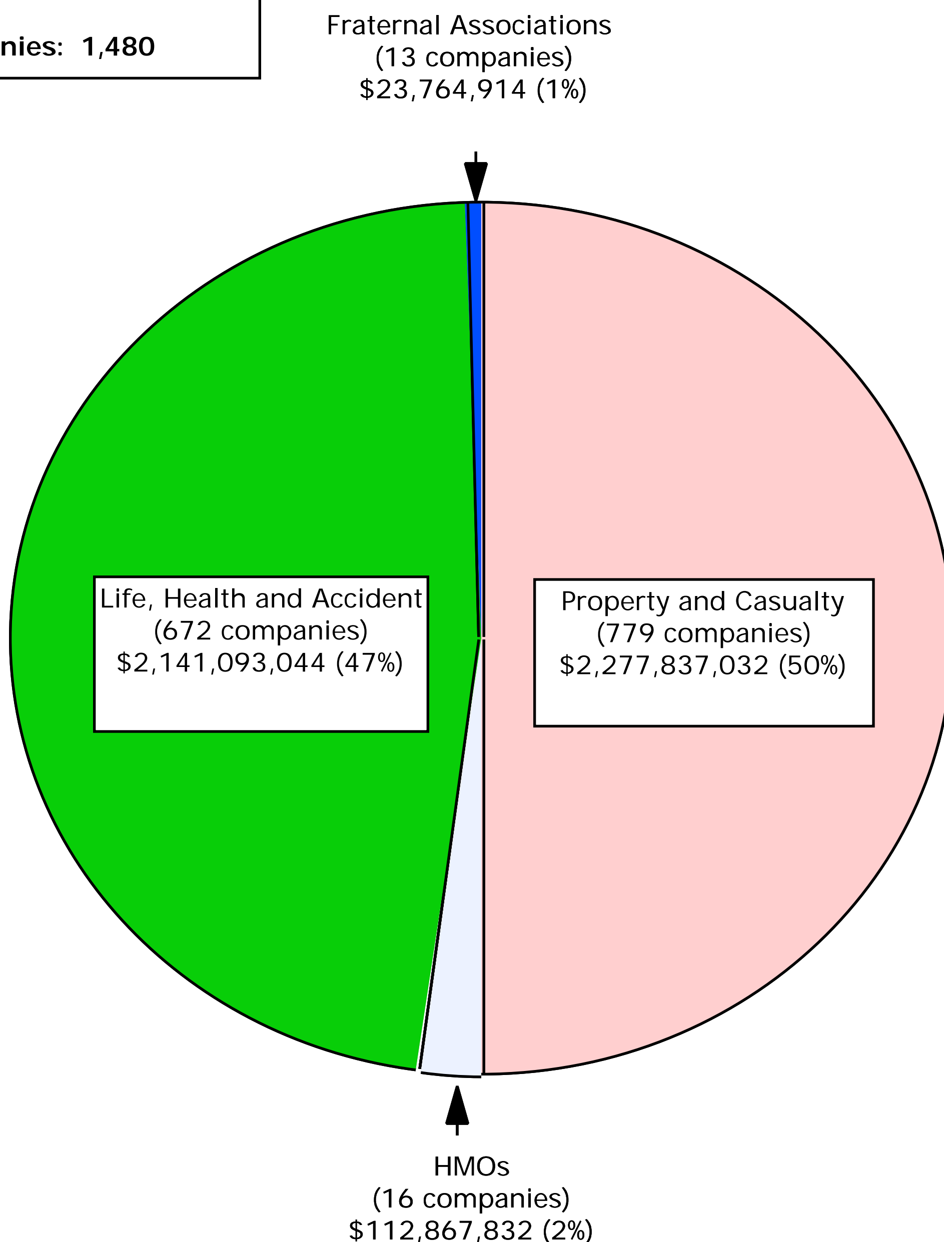
SOURCE: Mississippi Insurance Department.

Exhibit 2: Glossary of Terms Related to Regulation of the Insurance Industry

Report Term	Definition
Administrative expense ratio	measures the HMO's relative sales and administrative efficiency by showing what percentage of a premium was spent on sales and administrative expenses. Administrative expenses may include compensation of officers and employees, interest expense, occupancy, depreciation and amortization, and marketing
Annuity	contract sold by insurance companies that pays a monthly (or quarterly, semiannual or annual) income benefit for the life of a person (the annuitant), or for a specified period of time. While the basic purpose of life insurance is to provide an income for life for the annuitant
Burial association insurers	insurers which sell modest life insurance policy coverage to pay burial expenses upon the death of an insured
Corrective action plan	written plan which MID requires of insurers placed under administrative supervision which provides the steps the insurer will take to correct the impaired or hazardous financial condition
Delays in unpaid claims	delays in payment can indicate cash flow problems
Domestic insurer	those insurance companies incorporated according to the laws of Mississippi, whose principal legal residence is in Mississippi
Foreign insurer	those insurance companies who write business in Mississippi, but are domiciled and incorporated in another state
Fraternal association insurers	insurers which sell group coverage for members of a fraternal association, usually on a nonprofit basis
Lifetime loss ratio	the ratio of a company's incurred losses (losses which have occurred within a stipulated time period whether paid or not) plus loss adjustment expenses (cost involved in an insurance company's adjustment of losses under a policy) to its earned premiums
Medical claims loss ratio	determines the percentage of a premium represented by incurred claims, incurred but not reported claims (IBNR), and capitation. A lower ratio may indicate favorable risk selection, favorable medical cost management and/or favorable pricing of the product

SOURCE: PEER analysis of MID information and "Dictionary of Insurance Terms."

Exhibit 3: 1997 Total Premiums Paid in Mississippi, by Product Line of Insurance



SOURCE: 1997 MID Annual Report.

Protection Against Insurance Company Insolvencies

Insurance policyholders and investors depend on insurance companies being solvent to pay claims as well as to provide investment income.

MID seeks to avoid insolvencies by:

- obtaining evidence of the financial stability of an insurer prior to authorizing it to transact business in Mississippi;
- conducting ongoing financial examinations of insurers in order to detect impaired or hazardous financial conditions; and,
- managing financially impaired companies back to financial stability.

Further, the state seeks to ensure payment of consumers' claims against insolvent insurers via guaranty associations. State law establishes maximum amounts that the guaranty associations can pay per policy.

As described in Appendix B, page 40, four domestic insurers and fifty-three foreign insurers licensed to conduct business in the state became insolvent between 1990 and 1998. Guaranty associations paid approximately $83 million to policyholders of these companies.

MID's regulatory activities designed to prevent insolvencies, combined with the claims payment assurance provided by guaranty associations, provide the public with reasonable protection against insurance company insolvencies.

Regulatory Activities Designed to Prevent Insolvencies

MID Obtains Evidence of the Financial Stability of Insurance Companies and HMOs Before Allowing them to Conduct Business in Mississippi

Prior to authorizing an insurer to transact business in Mississippi, MID requires the company to submit documentation providing evidence of its financial stability. This documentation includes an annual financial statement, an actuarial opinion as to the adequacy of policy reserves, the company's most recent annual audited financial report, and the company management's assessment of its financial position,

operations, cash flow and liquidity. MID analyzes these documents to assess the company's financial condition.

A critical component of MID's analysis is the determination of the adequacy of the company's capital and surplus. Capital and surplus provide a cushion against unexpected increases in liabilities and decreases in the value of assets. Companies applying to do business in Mississippi must meet statutory minimums for capital and surplus, as well as any additional capital and surplus requirements imposed by MID based upon the type, volume, and nature of insurance business transacted.

In addition to the protection afforded by minimum capital and surplus requirements, state statutes require insurance companies to make security deposits into the State Treasury. These security deposits provide an additional means of protection in the event of an insolvency and may only be withdrawn with MID's approval and utilized to pay for expenditures related to an insolvency. Domestic insurance companies must deposit fifty percent of their capital stock, plus up to $100,000 in life reserves, either in cash or in securities and bonds. Foreign insurers must submit documentation of their making security deposits in their state of domicile. As of June 30, 1999, the Treasury held approximately $63 million in security deposits.

MID Uses National Association of Insurance Commissioners Standards to Conduct Ongoing Financial Examinations of Insurers in order to Detect Impaired or Hazardous Financial Conditions

The National Association of Insurance Commissioners has developed financial examination standards designed to ensure early detection of impaired or hazardous financial conditions.

The National Association of Insurance Commissioners (NAIC) has developed standards for the regulation and financial examination of insurance companies. These standards are designed to ensure early detection of impaired or hazardous financial conditions and to ensure that state insurance departments analyze the financial condition of their insurers in a consistent and thorough manner. (Appendix C on page 42 provides the minimum regulatory components endorsed by NAIC.)

MID adheres to NAIC financial examination standards for reviewing insurance companies licensed to do business in Mississippi.

NAIC accredits state insurance regulatory agencies which comply with its standards. NAIC conducts a full on-site examination and reaccreditation review every five years, with interim reviews to ensure compliance with NAIC standards. MID received NAIC accreditation in 1995. All state insurance departments except those in Nevada and New York are accredited by NAIC.

NAIC-accredited states conduct their own financial examinations of companies incorporated in their states and generally rely on and/or participate with the financial

examinations of other NAIC-accredited states for companies with out-of-state ownership. This system helps to avoid costly and duplicative financial examinations by each state in which a multi-state company transacts business.

NAIC has developed a system called the Insurance Regulatory Information System (IRIS) which helps to select those companies that merit highest priority in the allocation of the regulators' resources, thus enabling state insurance departments to direct their resources to the best possible use. The IRIS consists of two phases. The first is a statistical phase during which key financial ratio results are generated from the NAIC database, which contains financial information obtained from insurers' statutory annual statements. The second, an analytical phase, is a review of the annual statements and financial ratios by experienced financial examiners. Reports produced under the two phases have been deemed confidential and have been furnished to state insurance departments for regulatory use only.

In addition to its review of financial statements, MID conducts on-site financial examinations of domestic insurers. MISS. CODE ANN. Section 83-5-205 (1972) requires the Commissioner to conduct these financial on-site examinations of domestic insurers once every three years. During the course of triennial on-site financial examinations of domestic insurers, the department tests, utilizing sampling techniques set forth by the NAIC, financial data supplied by the company for both completeness and accuracy. The on-site examination also includes a market conduct exam which reviews the company's licensing of agents, handling of consumer complaints, handling of claims, utilization of approved form, and advertising. Upon completion of the on-site examination, MID prepares a written examination report of its conclusions and findings and requires that the company examined submit a written response addressing the corrective actions taken toward the report's comments and recommendations.

MID also conducts target exams of limited-scope issues or conditions of domestic insurers. These exams range from reviews of board action to specific financial transactions. In conducting a target exam, MID Financial Examination personnel check for compliance with MID regulations and statutory provisions. Most often the examiner is reviewing a specific concern or condition of the insurer, thus target exams are limited-scope examinations. NAIC promulgates the utilization of these limited-scope exams, but does not issue specific work standards or guidelines for such due to their uniqueness.

According to PEER's sample of MID's financial examination files, the department's use of NAIC standards has enabled it to identify, on a timely basis, impaired or hazardous financial conditions or non-compliance with statutory provisions.

PEER's sample of MID's financial examination files documented MID's adherence to NAIC standards in detecting insurers' hazardous or impaired financial conditions. PEER staff randomly selected and reviewed files for five MID domestic and foreign financial statement reviews and four domestic target financial examinations. These case studies indicated that MID identified, on a timely basis, impaired or hazardous financial conditions or non-compliance with statutory provisions. Within the five domestic financial statement reviews, MID had identified eleven financial ratios as outside the norm, which merited extra regulatory attention. Financial conditions identified in one of the target exams led to MID's placing the company in administrative supervision. MID's identification of insurers' financial conditions which exceed acceptable ranges set by NAIC and subsequent corrective measures serve to protect consumers from insolvencies.

MID noted improprieties of companies which led to federal investigation of Martin Frankel.

MID's routine triennial on-site financial examinations of two domestic insurers revealed improprieties which led to the federal investigation of the Connecticut investment advisor Martin Frankel. Mr. Frankel is believed to have embezzled between $215 and $915 million in funds from eleven insurance companies operating in five states. During MID's triennial examinations of these two domestic insurers, MID's financial examiners identified the companies' failure to have proper agreements with the security brokerage firm that the companies were using to trade their bonds. Mr. Frankel operated this brokerage firm.

During the course of requiring these domestic insurers to obtain the proper agreements, MID became aware of additional improprieties, including the unapproved change of control of these two domestic companies and an affiliated company that had recently moved from Alabama and incorporated in Mississippi. As a result of these findings, MID placed the companies under administrative supervision. (Administrative supervision allows MID to manage the company actively, with ownership of assets remaining with the company. When a company is in rehabilitation, MID not only manages the company but also takes ownership of its assets. See page 12 for a more detailed discussion of administrative supervision and rehabilitation.) Shortly thereafter, Mr. Frankel allegedly embezzled funds of these three companies, resulting in MID's placing the three domestic companies into rehabilitation.

MID Uses Financial Indicators to Identify HMOs which Merit Extra Regulatory Attention

The Mississippi Legislature passed legislation in 1995 requiring MID to regulate health maintenance organizations and to monitor their financial condition. MID developed and

uses financial indicators which are adequate to identify HMOs which merit extra regulatory attention.

MID developed financial indicators for HMOs to identify those in impaired or hazardous financial condition.

The Legislature passed the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act in 1995, which placed HMOs under MID's regulatory oversight. This legislation vested the Commissioner of Insurance and the state Board of Health with broad regulatory authority over HMOs. Specific to the Commissioner of Insurance were the powers of licensing, rate approval, and financial examination. The law also gave the Commissioner the authority to suspend or revoke HMOs' operating authority and the authority to place impaired HMOs into administrative supervision. Under these provisions, the Legislature gave the Commissioner of Insurance authority over HMOs that mirrors the Commissioner's authority over insurance companies. MID conducts the same levels of financial examinations of HMOs as it does for other insurers.

Because NAIC does not promulgate model standards for the financial analysis of HMOs and its IRIS ratios are not applicable to HMOs, MID developed its own indicators to identify HMOs in impaired or hazardous financial condition. In addition to monitoring HMOs' financial operations, MID's self-developed indicators monitor HMOs' compliance with statutory financial requirements, including MISS. CODE ANN. Section 83-41-325 (2) which requires a minimum net worth of at least $1,000,000 for each health maintenance organization licensed to conduct business in Mississippi. Other financial conditions of an HMO, as provided for in state law (e.g., premium volume, three months' uncovered health care expenditures, or its per capita payment basis) could require a greater minimum net worth, but each HMO is required to maintain at least $1 million in net worth. MID also calculates several expense ratios in order to identify weaknesses within HMO operations which could indicate or contribute to impaired or hazardous financial conditions--e.g., medical claims loss ratio, administrative expense ratio, and delays in unpaid claims. (See definitions of these ratios in Exhibit 2, page 5.)

During its financial examination of an HMO, if MID determines that the company no longer meets the $1,000,000 minimum net worth requirement, the department may put the HMO on a corrective action plan until the HMO deposits sufficient funds to correct the impairment.

PEER selected and reviewed files for four Mississippi HMOs which had been placed under some form of supervision (i.e., administrative supervision or rehabilitation) or on which MID had conducted target financial examinations in response to allegations of impropriety or instability. Within these case studies, MID had identified eighteen financial ratios as outside of the norm, which merited extra regulatory attention.

Subsequent review of financial conditions led to MID's placing three of the companies in rehabilitation and conducting an on-site financial examination of the fourth company.

Managing Financially Impaired Companies Back to Stable Financial Condition

MID managed five financially impaired companies during 1998, successfully returning one of these to a sound financial condition. MID continues to manage actively the four remaining companies.

State law authorizes MID to manage insurance companies in the state that the department has determined to be financially impaired. Of five companies that required regulatory management in 1998, MID returned one of the companies to financial soundness. MID has two levels of management available to it by law: administrative supervision and rehabilitation.

Administrative Supervision

MID places an insurer in administrative supervision (in which MID actively manages the company) if the insurer's continuance of business proves hazardous to the public or its insureds.

MISS. CODE ANN. Section 83-1-155 (1972) subjects an insurer to administrative supervision by the Commissioner if the insurer's condition renders the continuance of its business hazardous to the public or its insureds. In order to identify hazardous conditions, MID has promulgated Regulation 91-101, "Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which sets forth the standards which the department uses in identifying insurers whose continuance of business is hazardous to the public or to holders of the company's policies or certificates of insurance (see Appendix D, page 44).

If placed under administrative supervision, the insurer may not perform any of several financial transactions, including, but not limited to, investing any of its funds, incurring any debt, or withdrawing any of its bank accounts, without prior approval of the Commissioner or the Commissioner's appointed supervisor. MID placed four companies into administrative supervision and one directly into rehabilitation (see discussion below) during 1998. MID took one of the four companies placed into administrative supervision out from under administrative supervision after successful corrective action and placed one of the four companies into rehabilitation, with the other two companies remaining under administrative supervision.

Rehabilitation

MID places an insurer in rehabilitation (in which MID manages the company and takes ownership of assets) if administrative supervision does not correct the company's hazardous financial condition.

MISS. CODE ANN. Section 83-24-23 (1972) authorizes the Commissioner of Insurance to petition the chancery court for an order authorizing the Commissioner to rehabilitate an insurer for legal and regulatory violations (e.g., embezzlement, failure to allow MID access to financial records). MID requests rehabilitation if administrative supervision fails to return a company to a sound financial condition. MID may place a company directly into rehabilitation, without first placing it under administrative supervision, if administrative supervision would not correct the hazardous condition. As rehabilitator, the Commissioner takes possession of the company's assets and takes any actions necessary to reform and revitalize the insurer. The Commissioner or his appointed rehabilitator may request the court to terminate the rehabilitation if the company has been returned to a sound financial condition. Upon termination of rehabilitation, the insurer takes possession of its property and the control of its business. MID placed two companies into rehabilitation during 1998 (the one which MID directly placed into rehabilitation and the other which MID first placed in administrative supervision), with both of these companies remaining in rehabilitation as of August 3, 1999.

Regulatory Activities Designed to Ensure that Policyholder Claims Will Be Paid in the Event of an Insolvency

MID and guaranty associations ensure the payment of benefits to policyholders of insolvent companies, in accordance with statutory limitations.

Both the NAIC and the National Association of Guaranty Associations have promulgated model acts to ensure the payment of policyholder obligations subject to appropriate restrictions and limitations when a company is deemed insolvent. MISS. CODE ANN. Sections 83-23-101 et seq. and 83-23-201 et seq. comply with the model acts.

Liquidation

MISS. CODE ANN. Section 83-24-33 (1972) empowers the Commissioner to liquidate an insurer if further attempts to rehabilitate the insurer would substantially increase the risk of loss to insurers or would be futile. Although MID generally attempts to rehabilitate an insurer before liquidating it, the Commissioner may also petition the court to liquidate an insurer if the insurer meets any of the twelve grounds for rehabilitation, is insolvent, or if the insurer's future business would be hazardous. MISS. CODE ANN. Section 83-24-37 (1972)

provides that all of the insurer's obligations and policies will continue to be in force for at least thirty days, until the policy expires, until the insured has replaced the coverage with equivalent coverage, until the policy obligation is transferred to a solvent insurer, or until the date approved by the court to cancel coverage. MID did not liquidate any companies during 1998.

MISS. CODE ANN. Section 83-23-137 (3) (1972) provides for the available liquidated assets of an insolvent insurer to be disbursed to the guaranty associations to pay consumer claims.

Ensuring Claims Payment Through Guaranty Funds

State law authorizes two guaranty associations (one for property/casualty insurers and one for life/health/accident insurers) to provide for the payment of covered claims, to avoid excessive delay in payment, and to avoid financial loss to claimants or policyholders because of an insurer's insolvency. In order to pay the claims on insolvent insurers not covered through liquidation of the company's assets, the guaranty associations assess other insurers selling the same line of insurance an amount based upon each company's percentage of total premiums.

MISS. CODE ANN. Section 83-23-103 (1972) establishes the Mississippi Insurance Guaranty Association, which covers property and casualty insurance and workers' compensation claims. MISS. CODE ANN. Section 83-23-115 (1972) limits obligations to property/casualty policyholders to the amount of $300,000 per policy. The guaranty association will pay the full amount of any claim arising out of a workers' compensation policy. Since 1990, the association has paid 1,514 claims totaling $18,975,181 of nineteen insolvent property and casualty insurers.

MISS. CODE ANN. Section 83-23-203 (1972) establishes the Mississippi Life and Health Insurance Guaranty Association, which covers life/heath/accident claims, as well as burial association claims. MISS. CODE ANN. Section 83-23-205 (1972) limits obligations to policyholders to $300,000 in life insurance death benefits, $100,000 in annuity benefits on life insurance policies, and $100,000 in health insurance benefits. Since 1990, the association has paid approximately 102,878 Mississippi policyholders of thirty-eight insolvent life/health/accident insurers approximately $64,045,622.

HMOs are not covered by the guaranty association.

State law does not establish a guaranty association to cover the claims of an insolvent HMO's enrollees. State law authorizes the Commissioner to assess other HMOs doing business in the state. This is necessary because the Commissioner authorizes payment of claims for uncovered expenditures to HMO enrollees who are residents of this state and provides continuation of coverage for subscribers or enrollees not covered under law, provided that other HMOs have sufficient financial resources to assure continuing services to these members. MID requires HMOs to submit a plan for correcting financial deficiencies or for notifying enrollees of their subsequent discontinued coverage. Although none of Mississippi's sixteen HMOs have been liquidated, three are under rehabilitation (the two placed in rehabilitation during 1998 [see discussion on page 12], and a third which MID placed under rehabilitation in 1999) and two have voluntarily agreed to cease operations in the state.

Protection Against Excessive, Inadequate, or Unfairly Discriminatory Insurance Rates

The purpose of insurance rate regulation is to ensure a competitive market with broad consumer access. Excessive and unfairly discriminatory rates limit consumer access to insurance, while inadequate rates could result in the inability of a company to pay its claims and could also create a monopoly in the marketplace.

MID's Regulation of Property and Casualty Insurance Rates

In 1998, of the 654 property and casualty filings which should have been actuarially reviewed to ensure that rates were not excessive, inadequate, or unfairly discriminatory, MID submitted only 268 (41%) to the actuary for review.

MID has statutory authority to regulate property and casualty rates.

MISS. CODE ANN. Section 83-2-3 (1) (1972) defines a property and casualty rate as:

- "excessive" if it is likely to produce a profit that is unreasonably high for the insurance provided or if the expense provision included therein is unreasonably high in relation to the services rendered;
- "inadequate" if it threatens the solvency of the insurance company or tends to create a monopoly; or,
- "unfairly discriminatory" if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses.

MISS. CODE ANN. Section 83-2-7 (1972) requires MID to approve, in advance, all new and changes to existing policy forms and rates for licensed property and casualty companies.

Actuarial review is necessary to determine whether requested property and casualty rates are excessive, inadequate, or unfairly discriminatory. Actuarial Standard of Practice #9, "Documentation and Disclosure in Property and Casualty Insurance Ratemaking, Loss Reserving and Valuations," states that "a rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer." As part of their analysis, actuaries determine whether the company requesting the rate change is considering appropriate costs in the financial documents accompanying their rate request and whether they have used appropriate techniques to estimate these costs.

MID has not reviewed all property and casualty rate filings to ensure that requested rates are not excessive, inadequate, or unfairly discriminatory.

MID contracts property and casualty insurance rate reviews to an external actuarial firm. In 1998 MID failed to submit 386 rate requests, which required actuarial review to ensure that those rates met the legal standard of not being "excessive, inadequate, or unfairly discriminatory," to the actuary for review. When PEER inquired as to why the department had not submitted all rate requests for actuarial review, the department provided various reasons (e.g., filings that mirrored those of other companies, endorsements which broadened coverage but did not affect overall base rates). For some of these rate filings, MID reported that these were not sent due to the "nature of the filing;" when asked for criteria defining such "nature," MID staff responded that no criteria exists and that the decision is based on experience. PEER believes that actuarial review is necessary for every rate request in order to ensure that property and casualty rates are not "excessive, inadequate, or unfairly discriminatory."

To determine whether a pattern existed concerning which companies' rate filings MID chose to have actuarially reviewed, PEER analyzed the number of filings per company sent to the actuary to note significant discrepancies. Of the 253 companies which submitted rate filings, the frequency of filings by company sent to the actuary ranged from 52 companies having 100% of their filings forwarded to the actuary to 108 companies which had less than 15% of their filings forwarded for review.

PEER's review is not the first to identify deficiencies in MID's property and casualty rate reviews. In 1995, during meetings concerning a lawsuit against Trustmark National Bank in which plaintiffs had challenged the bank's credit property insurance practices, the Attorney General verbally advised MID that the department had a statutory duty to submit every rate filing to actuarial review in order to ensure that such rates were not excessive, inadequate, or unfairly discriminatory.

MID property and casualty's database does not document whether a rate revision is sent to the actuary for review.

Not only does MID not obtain proper actuarial review of all rate filings, the department's database does not contain a field which shows type of filing (i.e., a "rate," "rule," or "form.") Also, the database does not show which filings have been forwarded to the actuary. In order to determine whether all rate filings had been forwarded to the actuary for review, PEER searched the description fields of 4,428 record filings to determine those which contained the word "rate" within the description and identified approximately 1,016. Of these, PEER identified, through manual review, 654 actual rate filings which should have been reviewed by the actuary. Of that number, only 268 received actuarial review.

MID property and casualty records do not document compliance with statutory thirty-day requirements.

MISS. CODE ANN. Section 83-2-7 (1972) provides that any property and casualty filing submitted to MID is deemed to be approved unless disapproved by the Commissioner within thirty days after the date of filing. MID's database does not account for time lost in the process due to correspondence delays. Other than showing the date of receipt, the database does not indicate whether the approval process for a filing has exceeded the statutory thirty-day limit.

MID's Regulation of Life, Health and Accident Insurance Rates

MID has no legal authority to regulate life, health, and accident insurance rates except in three specific areas.

MID has statutory authority to review rates of Medicare supplements, long-term care policies, HMOs, credit life, and credit accident and health policies.

MID only has statutory authority to review rates in the three life/health/accident areas of Medicare supplements, long-term care policies, HMOs, credit life, and credit accident and health. MID approves rate changes for Medicare supplements and long-term care policies once these have met federal guidelines for lifetime loss ratios. MISS. CODE ANN. Section 83-41-331 (1972) requires HMOs to submit their premium rates to the department for approval prior to using such rates and provides that the rates not be excessive, inadequate or unfairly discriminatory, but does not define criteria for such. As discussed below, all HMO rate filings are subjected to the actuarial review necessary to make this determination.

MID lacks statutory authority to conduct actuarial rate reviews of other forms of life, health, and accident insurance.

State law does not specifically require MID to approve other initial life, health and accident rates or rate changes. MID has assumed authority, via its regulatory responsibilities, to limit annual increases of existing programs to 25% and has operationalized this in MID Bulletin 94-1. However, this policy is not derived from any specific grant of legislative authority and MID personnel expressed concern over the department's legal authority if this policy were challenged in court.

Although it has no statutory authority or responsibility for the regulation of life insurance rates or initial health insurance rates, except in the three areas of Medicare supplements, long-term care policies, and HMOs, MID has a contract actuary who analyzes all life, health, and accident insurance rate requests. Further, the department requires insurers to submit an actuarial opinion with each rate filing.

MID's actuary considers the company's loss ratio, as well as expenses, premiums and commissions, to determine if the rate is justified. With no statutory criteria, the actuary is held to the Actuarial Standards of Practice No. 8, "Regulatory Filings for Rates and Financial Projections for Health Plans," although this standard does not address the issue of rate adequacy. This standard sets forth fundamental actuarial procedures and considerations related to the preparing and reviewing of rate filings, including benefit plan provisions, consistency of business plan and assumptions, reasonableness of assumptions, and use of experience to project results.

Verifying that Rates Charged are Rates Approved by MID for All Lines of Insurance

MID verifies that insurers are charging rates which they have filed and had approved by the department.

During its on-site financial examinations of insurance companies licensed to conduct business in the state, MID verifies that insurers are charging the rates which have been filed with and approved by MID. The twenty-seven on-site examinations which MID conducted in 1997 revealed one HMO charging rates higher than MID rates in some cases. MID required the HMO to submit a corrective action plan.

Protecting Consumers Against Misconduct of Insurance Companies or their Agents

Consumers rely upon insurance companies to pay claims honestly, fairly, and in a timely manner for coverage agreed to in the contract for insurance; they rely upon agents to provide accurate information concerning insurance policies and to apply premiums properly.

MID does not strictly enforce licensing requirements, use all available means to detect misconduct, or educate the public to recognize and report misconduct.

Preventing Misconduct by Verifying Insurance Agent Competency and Trustworthiness Through the Licensure Process

MID does not verify critical information during the agent licensing process.

The purpose of licensing insurance agents is to provide basic assurance that they are competent and trustworthy. State statutes require the following components of licensure: licensing exams, background checks, and educational requirements (pre-licensure and continuing education). MID issues twenty-eight different types of insurance licenses to agents (see Appendix E, page 46), each with its own requirements and qualifications. MID is not effectively preventing agent misconduct through its licensure process due to weaknesses described below.

Licensing Examination

MID requires a 70% passing score on a written examination for insurance licenses.

MISS. CODE ANN. Sections 83-17-109 and 83-17-205(1) require that agent applicants take and pass "to the satisfaction of the Commissioner" a written examination. Tests for insurance agent applicants are administered by one of two private independent testing services. The examination, prepared by the testing service and approved by MID, covers the prospective agent's knowledge of the law, duties, obligations and principles of the type of insurance for which the individual seeks a license. MID considers seventy percent a passing score.

MID's reliance on agents' self-reported licensing examination scores has resulted in the unintentional licensing of at least one agent who did not pass the examination. Further, in its sample of new licensee files, PEER identified two cases in which the Commissioner waived

the 70% requirement for passage in order to allow applicants who had failed the test to receive licenses to sell insurance.

Because MID does not use licensing examination scores obtained directly from the test administrator, MID has issued at least one license to an individual who failed the test.

MID does not use test results obtained directly from the testing companies to determine applicant test scores independently, even though this is the only way to ensure score accuracy. Instead, MID relies on self-reporting of the licensing examination score by the prospective licensee. MID requires applicants to send a copy of their test result sheet, which includes the test score. Through complaints by competing agents, the department determined that one applicant had forged the test result sheet to indicate passage when, in fact, that individual had failed the examination. The fact that MID does not compare the test scores reported by the applicant with the test scores reported directly by the testing companies leaves open the question of how many other applicants may have forged their test results sheets and MID was not aware of the forgery.

The Commissioner waived the 70% passage requirement for two individuals, allowing them to obtain licenses despite failing the examination.

PEER reviewed test scores obtained directly from the test administrator for 205 randomly selected first-time/one-time test takers in 1998, out of a population of 437 first-time/one-time test takers. Within this sample, PEER identified two cases in which the Commissioner of Insurance arbitrarily issued licenses to individuals who failed their license examinations, one with a score of 60% and one with a score of 44%. In one of these instances, the Commissioner licensed the applicant subsequent to a request by the insurance company's chief Mississippi officer.

Exercise of such discretion defeats the purpose of statutory examination requirements, which is to ensure that agents have the competence necessary to sell the insurance products which they are licensed to sell.

Licensing of Non-Resident Agents

State law provides for reciprocity in the licensing of agents between states, provided the applicant has met qualifications for licensure in his/her state of residence and submits a letter from his/her state's department of insurance to this effect. Such reciprocity only applies to applicants from other states with reciprocity allowances for Mississippi residents seeking licensure in those states.

MID has issued licenses to non-resident agents without first obtaining legally required documentation of licensure in the applicant's home state.

PEER conducted a sample of files of 1998 non-resident agents seeking licensure in Mississippi to determine if they contained the required letter certifying the applicant's fulfillment of all qualifications necessary for licensure in his or her state of residence. PEER randomly selected 321 nonresident agent files and found that 314 of the files contained the appropriate documentation. Seven of the files, or two percent, failed to contain such documentation, but MID granted licenses to these seven applicants.

Background Checks

While state law requires insurance companies to investigate the "character and record" of persons applying to act as their agents, MID has not prescribed the content of such investigations. As a result, there is no uniformity in the types of background checks performed by insurance companies and there is no assurance that checks which they do perform ensure that insurance agents are of good moral character and trustworthy.

State law requires that insurance companies investigate the "character and record" of agent applicants to ensure that the applicant is "fit, competent, and trustworthy" to receive a license.

State law requires that life/health/accident and property/casualty insurance companies submit a certificate verified by the company that the company has investigated the character and record of any person applying for a license from MID to act as an agent and has satisfied itself that such person is of good moral character and is trustworthy to act as its agent. MISS. CODE ANN. Section 83-17-205 (2) (1972) also allows the Commissioner to request a credit check of a property/casualty agent if the commissioner deems such credit check necessary.

MID has not developed standards for the contents of background checks.

Although state law requires that agents be of good moral character and trustworthy, MID has not specified the elements necessary to certify that an applicant has these characteristics. In conducting investigations of agents, MID staff found that some companies only have credit checks, rather than a complete background check (e.g., including a criminal record check and a check of all licensure requirements specified in state law) of agents.

Federal and state law contain background requirements for some licenses, which are designed to in some way ensure the applicant's moral character and trustworthiness. For example, state law requires that property/casualty agents and bail bondsmen be at least twenty-one years of age. Title 18 of the UNITED STATES CODE, Section 1033 (e), requires that anyone involved in the business of insurance convicted of a criminal felony involving dishonesty or a breach of trust may only continue to work in the insurance industry with a written waiver from the State Commissioner of Insurance. MID does not require verification of these elements as a component of companies' background checks.

MID does not independently verify whether applicants honestly answer questions about their criminal history background.

Half of the agent disciplinary actions in 1998 were for falsifying application information.

In addition to requiring companies to attest to the character of applicants, MID requests information on its licensing application regarding whether the applicant has ever been arrested for or convicted of a felony. However, MID does not routinely verify the information provided by applicants on their applications, including the criminal history, if any, of the applicant. MID only verifies the information on the applications if the information appears implausible or if it receives allegations from outside sources that the information is incorrect. Falsifying application information is an offense for which a license can be administratively revoked or suspended and the individual agent can also face administrative fines. Eleven of the twenty-two total 1998 agent disciplinary actions referred to the Legal Division for prosecution involved falsification of agent applications (see discussion of punishment of misconduct on page 30).

Educational Requirements

Passage of House Bill 1243 (1999 regular session) effective July 1, 2000, which sets uniform educational requirements for insurance agents and requires documentation of compliance with these requirements, should correct the lack of documentation which currently exists with respect to education of life, health, and accident agents and the inconsistencies in educational requirements which currently exist between lines of insurance.

House Bill 1243 (1999 regular session) effective July 1, 2000, puts pre-licensure and continuing education requirements into law, versus MID regulation, and creates uniformity between the life, health and accident and property and casualty licensures. Both life/health/accident and property/casualty agents will be required to provide certifications of completion for both pre-licensure and continuing education, with passage of an examination necessary for credit if the applicant participates in a self-study training program for continuing education.

Currently, MID regulations specify educational requirements for some types of licenses.

MID does not require documentation of life/health/accident agents' pre-licensure education.

MID allows life, health, and accident agents to do self-study and self-reporting, whereas property and casualty applicants must undergo classroom instruction and document their attendance with a certificate.

MID does not require documentation of life/health/accident agents' continuing education.

MID Regulation LAH 80-002 requires life/health/accident agents to have twenty-five hours per year of continuing education, but only for the first four years of licensure. MID does not require additional continuing education after renewal in the fourth year. When agents submit notice that they have completed their continuing education, MID relies solely on the truthfulness of the agent seeking license renewal, with MID not verifying the continuing education listed by the agent on the renewal application. MID requires property/casualty agents to receive twelve hours of continuing education per year and to provide MID with a certificate of completion of training from the provider.

MID does not check pre-licensure and continuing education hours reported by the agent to make sure that the hours reported are sufficient to meet licensure requirements.

PEER sampled 340 randomly selected applications of agents first licensed in 1998 to determine whether the number of hours which they reported on their applications met licensure requirements and found that fifteen files (4%) failed to comply. Thirteen of the fifteen applications were life, health, and accident applications on which the applicant had left blank the required listing of pre-licensure study courses taken.

PEER also randomly selected 310 files of agents first licensed in 1997 who renewed in 1998 to determine whether the number of continuing education hours which the agents reported completing met licensure requirements. PEER found that ten agent files (3%) failed to contain evidence of the required number of continuing education hours. Three were property and casualty agent renewals who failed to provide documentation of continuing education attendance and ten were life renewal applications with no continuing education training listed in the appropriate blank on the form.

Detecting Company and Agent Misconduct

While MID's primary method of detecting company and agent misconduct is through complaints by consumers and the industry, MID does not have a formal system for receiving and utilizing complaint data in order to target its regulatory and educational efforts.

MID's complaint system should ensure that all complaints are addressed thoroughly and in a timely manner and that complaint data is analyzed to indicate patterns of misconduct which merit further regulatory action.

MID Relies Primarily on Complaints from Consumers and from Industry Representatives to Detect Misconduct

MID's primary mechanism for identifying company and agent misconduct is through complaints from consumers (about an individual claim or problem) and industry representatives (about the business practices of another company or agent [commonly called the "squeal rule"]).

State law requires the Commissioner of Insurance to investigate each consumer complaint.

MISS. CODE ANN. Section 83-5-79 (1972) provides that upon a "[c]omplaint being filed by any citizen of this state that any company authorized to do business in this state has violated any of the provisions of the insurance laws of Mississippi, the commissioner shall diligently investigate the matter."

MID's policy with respect to the handling of consumer complaints is to review the complaint, contact the insurance company or agent involved to determine their position on the complaint, keep the consumer notified during the complaint process, and notify the consumer of the resolution of the complaint.

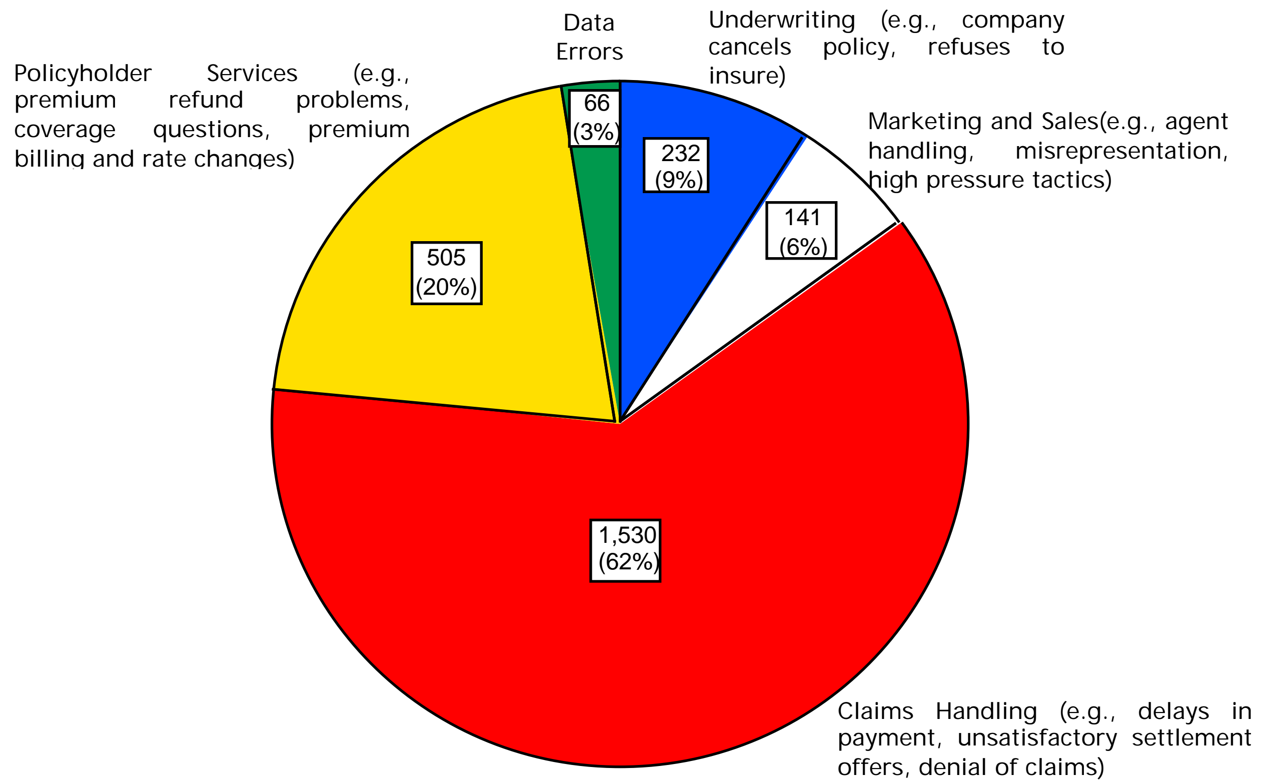
Exhibit 4, page 26, contains a breakdown of the types of complaints filed during 1998. The majority of the complaints (62%) concerned claims handling (e.g., delays in claims payment, unsatisfactory settlement offers, denials of claims). MID coded twenty-six percent of the complaints with codes that reflected disposition in favor of the company and coded twenty-one percent of the complaints with codes that reflected disposition in favor of the consumer. MID coded the other fifty-three percent of the cases in favor of neither side (for example, complaints that were out of MID's jurisdiction or which lacked sufficient information on which to proceed.)

While MID relies primarily on complaints for detecting misconduct, it does conduct some proactive activities designed to detect misconduct. Examples of the types of proactive activities which MID does engage in to identify misconduct include monitoring:

- through its financial examinations (refer to discussion on page 8):

  -company administration, including changes in ownership;
  -financial transactions; and,
  -whether all agents receiving commissions from the companies are licensed;

Exhibit 4: Types of 1998 Consumer Complaints Against Companies and Agents



Total 1998 Complaints: 2,474

SOURCE: MID Consumer Services Division

- NAIC bulletins and industry trade publications on a regular basis to identify any areas of review or investigation by other states; and,

- Securities and Exchange Commission filings.

While PEER found that MID conducts the above-listed proactive activities with respect to detecting misconduct, PEER found one example in which MID failed to be proactive in addressing misconduct. This case concerns a $250,000 multi-state settlement which MID received from Prudential Life Insurance Company in state Fiscal Year 1997. The fine levied against Prudential Life was due to misrepresentation by the company's agents of so-called "vanishing premium" life insurance policies. Courts have determined that the marketing of these policies was fraudulent and deceptive. While MID personnel were aware that other companies doing business in Mississippi were engaging in similar conduct, the department took no action to protect consumers by investigating such conduct on the part of any other company or its agents.

MID Does Not Maintain Adequate Records of Consumer and Industry Complaints to Ensure that it Addresses All Complaints

MID's consumer complaint database contains incorrect data.

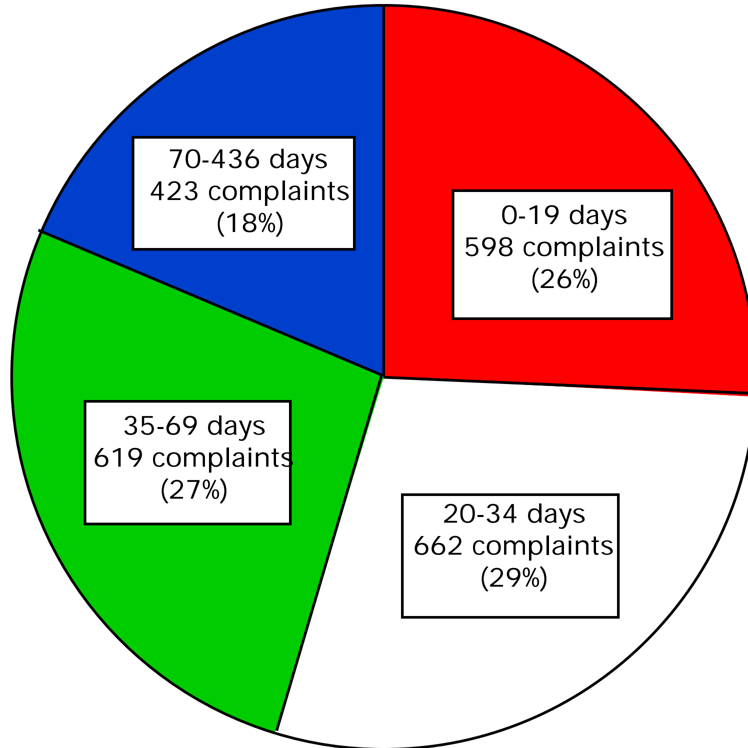
While MID maintains a consumer complaint database which is designed to print a list of complaints requiring attention every two weeks, PEER found that some of the data included in the database (e.g., case closure dates, case dispositions, and reasons for complaints) was incorrect.

Of the 2,474 consumer complaints that MID received in 1998, 47 complaints failed to appear on MID's review lists and thus remained open with no attention from MID staff. As shown in Exhibit 5, page 28, MID closed the majority of complaints within thirty-four days; however, the department took up to 436 days to process some complaints received during 1998.

MID does not keep complete records on complaints submitted by industry representatives.

MID does not use a database to track industry complaints (i.e., complaints from agents and company representatives), so it is not possible to determine how many complaints MID received from industry representatives in a given year or to determine the status or disposition of those complaints. Further, the lack of a database inhibits the department's accountability in its equitable handling of allegations of agent misconduct.

Exhibit 5: MID's Efficiency in Closing 1998 Complaints



MID closed the majority of complaints within 34 days.

Total 1998 Closed Complaints: 2,302

SOURCE: PEER analysis of MID Consumer Services' database of 1998 complaint data.

MID Does Not Analyze Complaint Data in order to Target Its Regulatory Efforts with Respect to Misconduct

Ultimately, MID should analyze complaint data for patterns of misconduct. PEER found that MID's current consumer database is not searchable by multiple fields (e.g., agent and company), which is necessary for analysis, and as previously stated, MID does not maintain a database of industry complaints.

In order to address more effectively the risk of industry misconduct, MID should analyze its complaint data for information such as frequency of types of misconduct and violators (agents and companies). This type of information would assist MID in targeting both its regulatory and educational efforts.

MID does not develop complaint index ratios, which would identify those companies that might need further regulatory attention.

One example of how MID could analyze complaint data would be to determine complaint index ratios. A complaint index ratio is the ratio of a company's market share to the share of complaints it receives (out of the total number of complaints). These ratios show which companies receive more or fewer complaints than their market share would indicate. For example, if Company A has 10% of the market for life insurance and 20% of the complaints about life insurance, then the complaint index would flag the company for further review.

MID does not determine the fiscal impact of the department's actions on complaint settlements.

Also, while MID records and reports the total dollar amount of each settlement resulting from a consumer complaint, the department does not report the dollar amount of the settlement attributable to MID's intervention. For example, if a consumer complaint with MID results in the company's increasing its settlement from $1,000 to $11,000, MID's intervention netted $10,000; whereas, if the initial settlement offer was for $10,000 and MID obtained a $11,000 settlement for the consumer, then MID's intervention netted $1,000. By reporting only the total recovered for the complaint, MID appears equally effective in both cases, when, in fact, the department had a much greater impact in the first case than in the second.

Punishing Agent and Company Misconduct

Taking Disciplinary Action Against Agents and Companies

For those violations it has detected, MID has taken disciplinary action against agents and companies.

MID may impose penalties against companies and agents for misconduct/ violation of state laws.

MID's regulatory authority provides for the department to impose penalties against agents or companies for misconduct or violation of state laws. A variety of penalties exist:

- license revocation
- license suspension
- license denial
- denial of license renewal
- monetary fines
- license probation

MID's statutory authority provides for the department to assess all penalties, except license probation, against both agents and companies, with license probation applicable only to agents.

MID revoked three agents' licenses during 1998.

MID's investigator receives and investigates all allegations of misconduct and/or violation of state laws filed against an agent. The investigator referred twenty-two cases of agent misconduct to the Legal Division in 1998 for disciplinary action. According to MID's docket book, into which all disciplinary actions against agents are to be entered:

- seven cases were pending;
- MID revoked three licenses;
- MID suspended three licenses, with the agents' license suspensions to be followed by probation;
- MID placed one agent on probation;
- two agents voluntarily surrendered their licenses;
- two agents failed to appear for disciplinary hearings (one license subsequently expired and MID has not taken any further action in the second case);
- MID denied one agent's license renewal;
- one agent withdrew his license application;
- MID cleared one agent of wrongdoing without a hearing; and,
- MID cleared one agent of wrongdoing after a hearing.

MID verifies agents' licensure during triennial on-site examinations.

MID conducted twenty-four field examinations of domestic insurers in 1997. The department found that eleven of these twenty-four companies paid commissions to agents who were not appropriately licensed to sell insurance for those companies. None of these companies nor agents were fined as a result of these examinations, but the companies were required to take corrective action to ensure proper licensing with MID, with such action explained in the companies' official responses to the financial examinations' findings. MID deemed the companies' actions to have remedied the inappropriate licensure of agents.

MID levied fines totaling $802,900 against fifty-four companies during the last three fiscal years.

MID collected a total of $274,500 in fines levied against seventeen companies during FY 1997. The department collected $98,900 from twenty-three companies in FY 1998, and $429,500 from fourteen companies in FY 1999. Appendix F, page 50, describes the specific actions for which MID levied these fines.

Protecting Against Misconduct Through Consumer Education

Educating consumers as to the risks and hazards associated with insurance is critical to effective regulation of the insurance industry. Educated consumers protect themselves and can also protect other consumers by recognizing misconduct and reporting it to the state's insurance regulatory agency.

MID's public education program does not address the risks associated with the insurance industry and what steps consumers can take to avoid said risks.

The products offered to consumers by insurance companies are complicated, frequently changing, often expensive, and critical to the consumer in terms of the claimed protection that they provide. In this complex environment, it is especially important that consumers are well informed about issues such as new types of insurance (such as HMOs), changes to state laws or MID regulations which impact consumers, and problems in the insurance industry, including dangers and warning signs.

MID's education program consists of responding to requests for information.

MID performs three basic consumer education activities:

- maintains a toll-free number for answering consumer complaints and questions about insurance;
- distributes informational brochures on general insurance subjects (e.g., home insurance, Medicare supplemental insurance, life insurance, auto insurance) to consumers who call and request information or who visit the MID web site;
- provides lectures on insurance topics to consumer groups, upon request; and,
- provides information to the Department of Human Services to assist in its administering of the Mississippi Insurance Counseling and Assistance Program, which is designed to answer senior citizens' questions about health insurance.

A national consumer advocacy group found that MID informational brochures did not educate consumers about the risks and hazards of the insurance industry.

The Consumer Federation of America, a Washington, D.C.-based nonprofit consumer advocacy group, found that while MID was providing the public with basic descriptive information concerning insurance, it was not educating consumers about the risks and hazards of the industry.

Recommendations

1. In order to ensure that it properly analyzes and acts on all property and casualty insurance rate, rule, and form filings, the Insurance Department should establish formal, written procedures governing handling of the filings. These formal procedures should cover:

   a. documentation of receipt of every filing;

   b. classification of every filing, according to the type of analysis necessary (if any) to act properly on the filing. For example, some “rate” filings are merely filings to correct a typographical error and therefore do not require analysis prior to approval; other filings may only require in-house review, while true rate filings require actuarial review (see recommendation 1.c, below).

   c. submission of every filing to the proper level of review and review of each filing according to written criteria. For example, in order to comply with state law (which requires that property and casualty insurance rates not be excessive, inadequate, or unfairly discriminatory) and to ensure a competitive insurance market with broad consumer access, MID should submit all true property and casualty insurance rate filings to actuarial review.

   d. documentation of the disposition of every filing (approved or disapproved), including documentation of analysis, methodology, and material assumptions made in arriving at the decision.

   Further, in order to provide greater assurance that the department follows its own procedures, MID should use existing resources to develop a computer database which documents compliance with all of the major provisions for handling of rate, rule, and form filings laid out in formal procedures. At a minimum, the department’s computer database should contain the following information on each filing: the date of receipt, name of company submitting the filing, the type of filing, entity performing the analysis of the filing, the final disposition (approval or disapproval and brief description of reason for action taken), and the date of the disposition. Also, the computer database should tie to any supporting hard copy files, such as correspondence with MID’s consulting actuary. MID should also use the database to make sure

that its analysis of filings takes place within the thirty-day limit established in MISS. CODE ANN. Section 83-2-7 (1972); otherwise the filing could be deemed to be automatically approved even if the filing has not been properly analyzed.

2. In order to establish clearly the department's legal authority to regulate life, health, and accident insurance rates in areas not already authorized by state law and to give the department a firm position should its authority to regulate life, health, and accident rates in areas outside of current legal authorization be challenged in a court of law, the Commissioner of Insurance should develop recommendations for the Legislature regarding changes in state statutes. The recommendations should include appropriate language addressing the role which MID should take relative to life, health, and accident insurance rate requests; for example, language and definitions similar to those found in MISS. CODE ANN. Sections 83-2-3 and 83-2-7 governing property and casualty rates might be appropriate. Further, MID should recommend that the Legislature amend MISS. CODE ANN. Section 83-41-331 (1972), which requires MID to review HMO rate requests prior to approval, to include definitions of "excessive," "inadequate," and "unfairly discriminatory."

3. Given the importance of agent licensing requirements in assuring that agents are competent and trustworthy to sell the products which they offer to the public, MID should correct deficiencies in its agent licensing procedures by:

   a. verifying each applicant's passage of the licensing examination by utilizing test scores provided directly to MID by the testing services, rather than using scores submitted to MID by license applicants. Further, the Commissioner should not grant a license to any applicant who is unable to pass the licensing examination at the minimum validated passing score;

   b. ensuring that license applicants' files contain all necessary documentation of applicants' compliance with state law and departmental regulations prior to the department issuing a license to the applicant (e.g., a letter certifying that an out-of-state applicant for a license in Mississippi has complied with all qualifications for licensure in the applicant's state of residence; documentation of compliance with pre-licensure and continuing educational requirements); and,

   c. developing the elements of a background check necessary to certify that an applicant is of good moral character, is trustworthy and complies with all

other background requirements set forth in state or federal law or regulations, including verifying whether an applicant has ever been convicted of a criminal felony. Also, MID should require that the insurance company seeking to hire a new agent submit a copy of the legally required background check on the agent directly to MID prior to MID licensing the applicant.

4. In order to ensure that it is addressing all consumer and industry complaints on a timely basis, MID should ensure that its complaint database is accurate (e.g., includes all complaints, the date of the complaint, nature of the complaint, agent and company against which the complaint is lodged, analyst assigned to handle the complaint, date and nature of final disposition, amount of settlement attributable to MID's intervention) and up-to-date and should be programmed to flag complaints which remain open longer than the average for each category of complaint. Further, MID should analyze its complaint data, including identifying patterns of misconduct among agents and companies, in order to direct its regulatory efforts to areas of greatest risk. One example of how MID could analyze complaint data would be to determine complaint index ratios (see discussion on page 29.)

5. MID should explore all cost-effective methods for proactively uncovering and addressing cases of agent and company misconduct.

6. To deter insurance companies' use of unlicensed and/or uncertified agents, the Legislature should amend MISS. CODE ANN. Section 83-17-11 to authorize the commissioner to fine the company, the agent, or both, for use of unlicensed and/or uncertified agents $500 for each policy or transaction sold or negotiated by the unlicensed or uncertified agent.

7. Because the products offered to consumers by insurance companies are complicated, frequently changing, often expensive, and critical to the consumer in terms of the claimed protection that they provide, MID should develop a formal public service program designed to educate the public to recognize industry risks, dangers, and warning signs and to report insurance industry misconduct.

   Further, the Commissioner of Insurance should include a summary of the department's handling of complaints in its annual report. Sorting complaint data by NAIC categories, this summary should include:

   - complaints received by type of complaint;
   - disposition of these complaints; and,

- total dollar amounts collected on behalf of consumers and total dollar amount of collections attributable to MID's intervention (see discussion on page 29).

Appendix A

Mississippi Insurance Department: Organization Structure and Funding

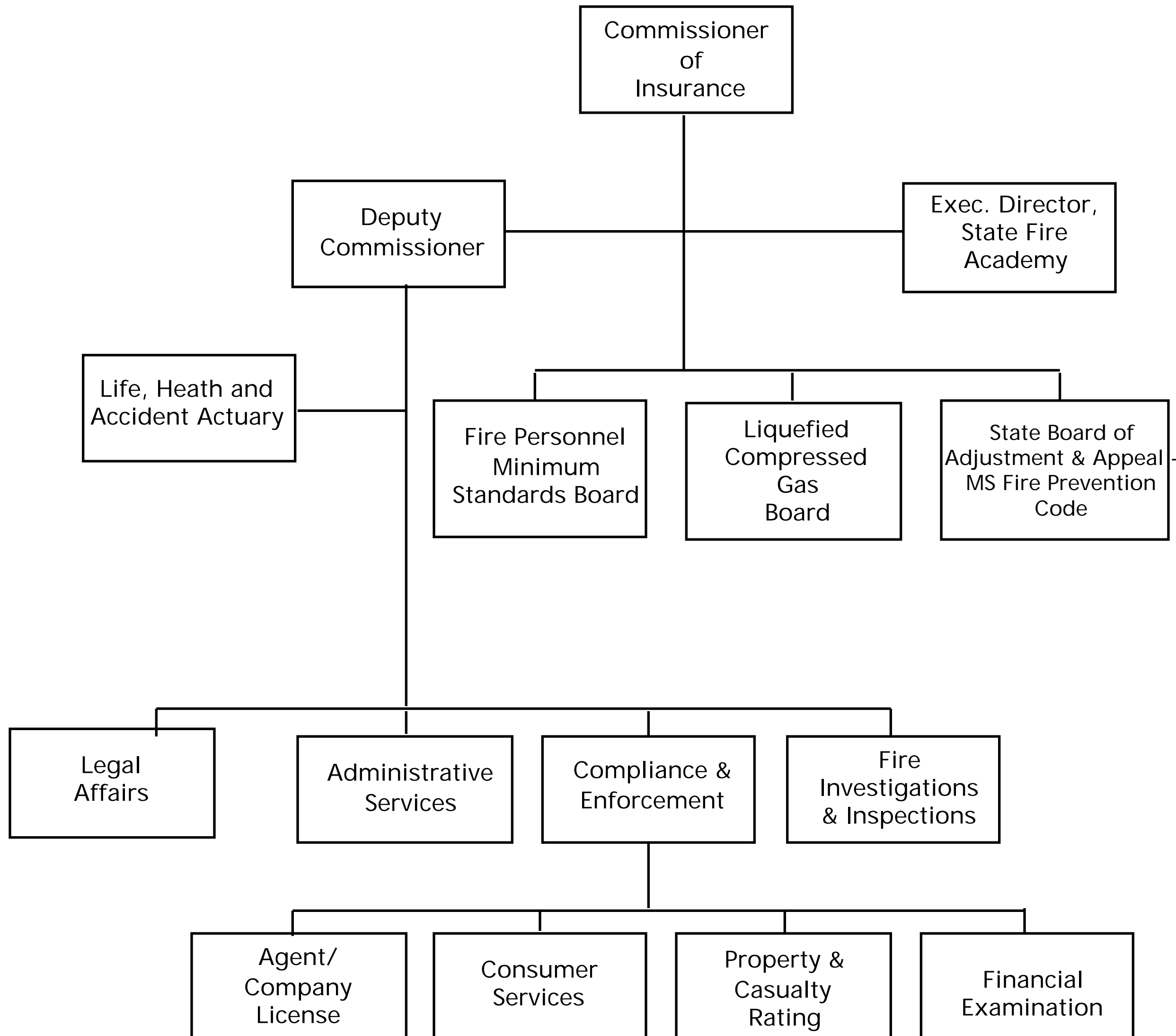
MISS. CODE ANN. Section 83-1-1 (1972) creates the Department of Insurance and charges it with the execution of all laws, except as otherwise specifically provided by statute, relative to all insurance and all insurance companies, corporations, associations, or orders. A Commissioner of Insurance, elected statewide to a four-year term, oversees operations of the department.

The Insurance Department is funded one hundred percent from special funds. The department gets its funding from statutory insurance filing fees, fines assessed against insurance companies for non-compliance with statutes and MID regulations, and a 1/4 cent per gallon tax levied upon businesses distributing liquefied compressed gas. The Legislature appropriated $6,751,690 and 114 positions to the department for FY 2000. As the result of a FY 1997 reorganizational study of the department conducted by Morris and Associates, the department received twenty-one additional positions during fiscal years 1998 and 1999. Forty-four of the department's 114 positions are assigned to the area of insurance regulation (compliance and enforcement). The remaining 70 positions are allocated as follows: 7 in legal, 19 in support services, 37 in fire investigations, and 7 in administration.

MID has a contract with the actuarial firm of Tillinghast-Towers Perrin in Atlanta, Georgia, to review insurance rate and/or form filings designated and provided by the Commissioner, to provide written actuarial observations and recommendations to the Commissioner on each filing and to discuss reviewed items and other items of actuarial nature with the Commissioner. MID compensated Tillinghast-Towers Perrin a flat monthly charge, regardless of the volume of filings reviewed, of $3,500 during FY 1998 and of $4,200 during FY 1999.

SOURCE: PEER analysis.

Mississippi Insurance Department Organization Chart As of July 1, 1998



SOURCE: PEER analysis of MID FY 2000 Budget Request.

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Appendix B: Insolvent Insurance Companies in Mississippi 1990-1998

Year	Company Name	Type	Residency	Policy Holders	Claims Paid	Claims Unpaid
1990	Mid American Casualty	P&C	Foreign		$23,782	$0
	Ohio General Insurance	P&C	Foreign		$12,275	$0
	Allied Bankers Life Ins. Co.	LHA	Foreign	1	$2,066	$0
	American Independence Life Ins. Co.	LHA	Foreign	680	$449,300	$187,200
	Great SW Life Ins. Co.	LHA	Foreign	*	**	**
	Life Ins. Co. of Indiana	LHA	Foreign	54	$15,856	$0
	Pacific Standard Life Ins. Co.	LHA	Foreign	62	$17,951	$16,231
1991	Universal Security Ins.	P&C	Foreign		$211,975	$0
	Protective Casualty	P&C	Foreign		$36,805	$0
	American Universal	P&C	Foreign		$2,943	$0
	Fidelity Bankers Ins. Co.	LHA	Foreign	*	**	**
	Inter-American Ins. Co. of Illinois	LHA	Foreign	200	$379,486	$18,865
	Old Southern Life Ins. Co.	LHA	Foreign	*	**	**
	Life Assurance Co. PA	LHA	Foreign	20	$72,293	$54,317
	Mutual Security Life Co.	LHA	Foreign	356	$130,121	$0
	United Equitable Life Ins. Co.	LHA	Foreign	897	$144,450	$0
1992	Andrew Jackson Life Ins. Co.	LHA	Domestic	10,207	$19,848,991	$403,566
	Andrew Jackson General Life Ins. Co.	LHA	Domestic	*	**	**
	Central Life Ins. Co.	LHA	Domestic	78,225	$1,443,202	$0
	Executive Life Ins. Co.	LHA	Foreign	3,219	$22,136,762	$11,328,069
	Guarantee Security Life Ins. Co.	LHA	Foreign	140	$758,260	$0
	Mutual Benefit Ins. Co.	LHA	Foreign	1,486	$25,001	$27,745
	First Southern Ins. Co.	P&C	Foreign		$180,949	$3,360
	Andrew Jackson Ins. Co.	P&C	Domestic		$1,850,721	$45,533
	Comco	P&C	Foreign		$279,159	$15,606
1993	Pelican State Mutual	P&C	Foreign		$250,963	$38,740
	Ins. Co. of Florida	P&C	Foreign		$54,713	$0
	Investment Life Ins. Co.	LHA	Foreign	89	$74,867	$0
	Kentucky Central Life Ins. Co.	LHA	Foreign	911	$168,611	$0
	Old Colony Life Ins. Co.	LHA	Foreign	24	$73,722	$40,605
	New Jersey Life Ins. Co.	LHA	Foreign	125	$161,378	$69,048
	Unison Intl. Life Ins. Co.	LHA	Foreign	659	$743,910	$0

Note: The number of policyholders for Property and Casualty companies is not available.

* Number of policyholders not available.

** The Mississippi Life and Health Insurance Guaranty Association had no statutory obligations in this insolvency or the Liquidation estate was able to cover all policyholder obligations up to the statutory limits.

SOURCE: PEER analysis of documentation provided by the Mississippi Insurance Guaranty Association and the Mississippi Life and Health Insurance Guaranty Association.

Year	Company Name	Type	Residency	Policy Holders	Claims Paid	Claims Unpaid
1994	Confederation Life Ins. Co.	LHA	Foreign	945	$939,013	$2,719,949
	Confederation Life Ins. & Annuity Co.	LHA	Foreign	(combined with above company)		
	Consumer United Ins. Co.	LHA	Foreign	151	$122,321	$0
	Consolidated National Life Ins. Co.	LHA	Foreign	1,185	$16,697	$0
	Fidelity Mutual Life Ins. Co.	LHA	Foreign	160	$0	$148,000
	National Heritage Life Ins. Co.	LHA	Foreign	440	$7,947,740	$1,104,035
	Summit National Life Ins. Co.	LHA	Foreign	445	$1,872,981	$63,211
	Employers Casualty	P&C	Foreign		$681,403	$244,587
	Premier Alliance	P&C	Foreign		$534,188	$0
1995	National American Life Ins. Co.	LHA	Foreign	40	$268,019	$1,319
	Commonwealth General	P&C	Foreign		$1,748,970	$236,820
	United Community	P&C	Foreign		$254,854	$44,331
1996	Coronet Ins. Co.	P&C	Foreign		$996,097	$75,361
	First National Life Ins. Co.	LHA	Foreign	65	$29,950	$0
	Coastal States Life Ins. Co.	LHA	Foreign	25	$109,148	$98,371
	Monarch Life Ins. Co.	LHA	Foreign	301	$0	$414,353
	Universe Life Ins. Co.	LHA	Foreign	480	$100,000	$0
	American Life Assurance Co.	LHA	Foreign	24	$62,322	$0
	Mid Continent Life Ins. Co.	LHA	Foreign	*	**	**
	First Capital Life Ins. Co.	LHA	Foreign	*	**	**
1997	Insurance Co. of America	P&C	Foreign		$1,237,795	$838,091
	American Eagle	P&C	Foreign		$317,439	$237,737
	United Southern	P&C	Foreign		$390,000	$347,777
1998	PIE Mutual	P&C	Foreign		$9,910,112	$8,363,853
	Centennial Life Ins. Co.	LHA	Foreign	1,250	$1,500,000	$0

Appendix C

National Association of Insurance Commissioners' (NAIC) Minimum Regulatory Components for an NAIC-Accredited State Department of Insurance

The model laws, regulations and policies for solvency regulation developed by the National Association of Insurance Commissioners (NAIC) and endorsed by the National Conference of State Legislatures (NCSL) help ensure that state insurance departments analyze the financial condition of their domestic insurers in a consistent and thorough manner. The standards require that insurance departments have adequate statutory and administrative authority, and that the departments have in place organizational and personnel practices designed for effective regulation. These model laws, regulations, and policies include:

a. adequate authority for insurance departments to examine insurance company finances and to order corrective actions;
b. adequate capital and surplus requirements and limits on risk retained by property/casualty companies based on their capital and surplus;
c. minimum standards for liabilities and reserves;
d. requirements that insurance companies adopt adequate accounting procedures and that they value and admit assets according to recognized standards;
e. regulations to ensure the safety of investments;
f. strict regulation of credit for reinsurance;
g. requirements for annual CPA audits and actuarial opinions;
h. mechanisms for placing an insurance company into receivership;
i. establishment of adequate guaranty funds for both property/casualty and life/health companies;
j. regulation of managing general agents and reinsurance intermediaries;
k. participation in the NAIC's Insurance Regulatory Information System (IRIS) for early detection of insolvencies; and,
l. adequate regulation of risk retention groups and producer controlled insurers.

NAIC's Accreditation Program mandates a full on-site examination and reaccreditation every five years.

Accreditation also requires interim annual review to ensure compliance with standards.

SOURCE: National Association of Insurance Commissioners

Appendix D

MID's Regulation 91-101: Regulation to Define Standards and Commissioner's Authority for Companies to be Deemed to be in Hazardous Financial Condition

The Commissioner may consider the following standards, either singly or a combination thereof, to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public. The Commissioner shall act reasonably and with a sufficient basis for making such a determination, and in doing so the Commissioner may consider:

1. adverse findings reported in financial condition and market conduct examination reports;

2. the National Association of Insurance Commissioners' Insurance Regulatory Information System (IRIS) and its related reports;

3. the ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus;

4. the insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;

5. the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written, as well as the financial condition of the assuming reinsurer;

6. the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than 50% of such insurers' remaining surplus as regards policyholders (defined as assets minus liabilities, all as determined on a statutory basis) in excess of the minimum required;

7. whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of a material monetary or other obligation;

8. contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which reasonably could be expected to affect the solvency of the insurer;

9. whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;

10. the age and collectibility of receivables;

11. whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

12. whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished materially false or misleading information concerning an inquiry;

13. whether management of an insurer either has filed any materially false or misleading sworn financial statement, or has released a materially false or misleading financial statement to lending institutions or to the general public, or has made a materially false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

14. whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet is obligations in a timely manner; or,

15. whether the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

SOURCE: PEER analysis of Mississippi Insurance Department, Regulation 91-101.

Appendix E: MID Agent Licensure - Types and Terms

Type of License	License Required	License Fee	Certificate of Authority	Certificate of Authority Fee	Pre-License Education	Examination Required
Property & Casualty						
Fire & Casualty Solicitor	yes	$25.00 27-15-87	yes	$2.00 83-17-217	no	yes
Full Line Property & Casualty	yes	$25.00 27-15-87	yes	$10-15.00	24 hrs Reg. 86-101	yes
Industrial Fire Limited license	yes	$25.00 27-15-87	yes	$10 -15.00	no	yes
Legal	yes	$10.00 83-49-47(2)	no	N/A	no	no
Limited Surety (Bail)	yes	$50.00 83-39-11	yes	$10 - 15.00	no	yes 83-39-1(g)
Personal Surety (Bail)	yes	$50.00 83-39-11	no	N/A	no	yes
Small Loan Property Limited license	yes	$25.00	yes	$10 - 15.00	no	yes
Title	yes	$20.00 27-15-99	yes	$10-15.00	no	no
Trip, Accident & Baggage	yes	$25.00 27-15-87	yes	$10-15.00	no	Exempt 83-17-109(b)
Vehicle Physical Damage Limited license	yes	$25.00 27-15-87	yes	$10-15.00	no	yes
Burial Association						
Burial (Life) Class 4, MCA Sec. 83-19-1	yes	$5.00 83-37-21	yes	$10 - 15.00	no	no
Life						
Credit Life, Health and Accident	yes	$20.00 27-15-95	yes	$10 - 15.00	no	Exempt 83-17-109
Industrial Life, Health & Accident (Permanent) Limited license	yes	$20.00 27-15-95	yes	$10 - 15.00	no	yes

NOTE: Fraternal agents are exempted from licensure under MISS. CODE ANN. Section 83-17-25 (1972)

SOURCE: PEER analysis of Mississippi statutes and information provided by MID.

Continuing Education Required	Term of License	Statutory Reference	Other
no	June/June	83-17-203	Must have 24 hrs pre-license education if solicitor changes to agent's license within one year of issue
12 hrs Reg. 90-101	June/June	83-17-201	Company required to document pre-license education; Agent must document completion of continuing education
no	June/June	83-13-17	Premiums usually collected on weekly basis; policies offer limited benefits
no	March/March	83-49-7; 9	Licensed agents offer prepaid legal services plans to subscribers
no	June/June	83-39-1	Represents insurance company which backs bonds
no	June/June	83-39-1	Personally liable on forfeited bond
no	June/June	83-17-211	Insures property given as collateral as a loan;
no	June/June	83-15-1 et seq	$20 fee is for each county in which agent writes title insurance.
no	June / June	83-19-1	Usually a ticket selling agent for common carrier; e.g., bus or plane
no	June/June	83-19-1(l)	Usually written via small auto dealers; insures against loss, personal injury and property damage
no	March/March	83-37-1 et seq	Benefits paid directly to funeral home; maximum benefit is $450
no	January/January	83-53-1	Insures life of debtor in connection with specific loan
no	January/January	83-19-31	Policy amount limited to $5,000 maximum benefit Only agents to take Home Security Council examination

Type of License	License Required	License Fee	Certificate of Authority	Certificate of Authority Fee	Pre-License Education	Examination Required
Industrial Life, Health & Accident (Temporary)	yes	$20.00 27-15-95	yes	$10 - 15.00	no	no
Life (Burial)	yes	$20.00 27-15-95	yes	$10 -15.00	no	no
Life, Health & Accident	yes	$20.00 27-15-93	yes	$10 -15.00	40 hrs Reg. 80-001	yes
Variable Contracts	yes	$20.00 25-15-93	yes	$10 - 15.00	no	no
Other						
Emergency Adjuster	yes	$50.00 83-17-409	no	N/A	no	no
Independent Adjuster	yes	$50.00 27-15-97	no	N/A	yes	yes
Adjuster Trainee	no	$50.00 27-15-97	no	N/A	no	no
Automobile Club	yes	$5.00 83-11-237	no	N/A	no	no
Bail Enforcement 83-39-1(f)	yes	$20.00 83-39-11	no	N/A	no	no
Bail Soliciting 83-39-1(c)	yes	$20.00 83-39-11	no	N/A	no	no
Home Warranty	yes	$25.00 83-57-35	no	N/A	no	no
Risk Retention Manager/ Broker	yes	$50-100.00	no	N/A	no	no
Stock Sales	yes	$10.00 83-5-19	no	no	no	no
Surplus Lines	yes	$50.00 83-21-19	no	no	no	no
Traveling Salaried Representative	yes 27-15-89	$20-50.00 27-15-89	yes	no	no	no

Continuing Education Required	Term of License	Statutory Reference	Other
no	120 days	83-17-119	License only good for 120 days
no	January/January	83-19-1	Pays benefits upon death of insured for burial expenses
25 hrs 80-002	January/January	83-17-101 et seq	
no	January/January	83-19-1(e)	Must have National Association of Securities Dealers (NASD) license and Life license
no	90-180 days	83-17-409	See MCA Sec. 83-17-409 for requirements
12 hrs 83-17-415	June/June	83-17-401	See exclusions which apply to examination and pre-license requirements
no	12 months	83-17-403(1)	License limited to one year; trainee may act without a license if name is registered with MID
no	April/April	83-11-237	Agent gets appointment only. Automobile service club requisitions certificate of authority from MID
no	June/June	83-39-1	Assists getting Defendant to court; does not actually sign bail bonds.
no	June/June	83-39-1	Solicits business on behalf of professional bail agent
no	March/March	83-57-35	
no	March/March	83-55-1 et seq	Managers are authorized to bind the reinsurer. MCA Sec. 83-19-203(g)
no	1 year duration	83-5-19	Good for one year; issued only by Commissioner or Deputy Commissioner; renewable
no	1 year from issue date	83-21-19	$3,000 bond required
no	January/January	83-17-203	Department policy is that agents may not solicit business from the general public

Appendix F: MID Fines Levied Against Companies, FYs 1997-1999

Company	Offense	Amount
Fiscal Year 1997		
Prudential Life Insurance Company	Improper sales activities of company and its agents	$250,000
Louisiana Pest Control Insurance Company/Blumberg & Associates, Inc.	Unlicensed company selling insurance	7,500
Progressive Gulf Insurance Company	Utilizing agents not properly authorized	10,000
Benefit Resources, Inc.	Failure to file Annual Statement on time *	500
Coverdell & Company, Inc.	Failure to file Annual Statement on time	500
G-M Underwriters Agency, Inc.	Failure to file Annual Statement on time	500
Genelco Incorporated	Failure to file Annual Statement on time	500
Gulf Health Plans TPA, Inc.	Failure to file Annual Statement on time	500
MHA Diversified Services, Inc.	Failure to file Annual Statement on time	500
Morgan-White Administrators, Inc.	Failure to file Annual Statement on time	500
MSMA Diversified Services, Inc.	Failure to file Annual Statement on time	500
R.E. Harrington, Inc.	Failure to file Annual Statement on time	500
Reinsurance Management, Inc.	Failure to file Annual Statement on time	500
Rogers Atkins Gunter & Associates Insurance, Inc.	Failure to file Annual Statement on time	500
Sedgwick Claims Management Services, Inc.	Failure to file Annual Statement on time	500
Southern Insurance Management Associates	Failure to file Annual Statement on time	500
W.J. Jones Administrative Services, Inc.	Failure to file Annual Statement on time	500
	FY 1997 Total	**$274,500**
Fiscal Year 1998		
Security Life Insurance Co./BLICO	Company using unlicensed Third Party Administrator	$7,500
Apex Healthcare of Mississippi, Inc./Rotech Medical Corp.	Failure to file timely request for MID approval of acquisition of control	75,300
American Administrative Group	Failure to file corrected Annual Statement on time **	500
American Insurance Group	Failure to file corrected Annual Statement on time	500
First Health Strategies, Inc.	Failure to file corrected Annual Statement on time	500
Healthsource Provident Administrators	Failure to file corrected Annual Statement on time	500
Membership Services	Failure to file corrected Annual Statement on time	500
MidSouth Benefit Administrators, Inc.	Failure to file corrected Annual Statement on time	500
SMC, Inc.	Failure to file corrected Annual Statement on time	500
Student Plans	Failure to file corrected Annual Statement on time	500
Andesa TPA, Inc.	Failure to file Annual Statement on time	1,000
Benefit Consultants, Inc.	Failure to file Annual Statement on time	1,000
Chrina Corporation	Failure to file Annual Statement on time	100
Cooperative Benefit Administrators, Inc.	Failure to file Annual Statement on time	1,000
Cybertek	Failure to file Annual Statement on time	1,000

* MISS. CODE ANN. Section 83-5-69 (1972) provides that MID fine a company $100 for each day the company neglects to files its annual statement.

SOURCE: PEER analysis of information provided by MID's Accounting Division.

Company	Offense	Amount
Human Affairs International, Inc.	Failure to file Annual Statement on time	1,000
John Hancock Signature Services, Inc.	Failure to file Annual Statement on time	1,000
Morgan White Administrators, Inc.	Failure to file Annual Statement on time	1,000
National Plan Administrators, Inc.	Failure to file Annual Statement on time	1,000
Planned Administrators, Inc.	Failure to file Annual Statement on time	1,000
P. Miller & Associates Computer Services, Inc.	Failure to file Annual Statement on time	1,000
Superior Vision Services, Inc.	Failure to file Annual Statement on time	1,000
Wright & Co.	Failure to file Annual Statement on time	1,000
	FY 1998 Total	**$98,900**
Fiscal Year 1999 (as of June 3, 1999)		
Prudential Property and Casualty Insurance Company	Payment of Market Conduct Examination	$300,000
Preferred Abstainers	Failure to amend license and to obtain proper certificates of authority	3,000
Preferred Risk Mutual Insurance Company	Failure to amend license and to obtain proper certificates of authority	3,000
Midwest Mutual Insurance Company	Failure to amend license and to obtain proper certificates of authority	3,000
Argonaut Great Central Insurance Company	Failure to amend license and to obtain proper certificates of authority	2,000
Lincoln General Insurance Company	Failure to amend license and to obtain proper certificates of authority	3,000
Lumber Mutual Insurance Company	Failure to amend license and to obtain proper certificates of authority	3,000
Westport Insurance Company	Failure to amend license and to obtain proper certificates of authority	1,000
Americas Surplus Lines Co.	Failure to file timely request for approval of acquisition of control	100,000
Utica Insurance Co.	Failure to amend license and to obtain proper certificates of authority	3,000
Graphic Arts Mutual Insurance Company	Failure to amend license and to obtain proper certificates of authority	1,000
Foremost Insurance Co.	Failure to amend license and to obtain proper certificates of authority	2,000
Foremost Signature Insurance Co.	Failure to amend license and to obtain proper certificates of authority	500
Maryland Casualty Insurance Co.	Failure to amend license and to obtain proper certificates of authority	3,000
Navisys Insurance Solutions	Failure to file Annual Statement on time	1,000
Sierra Healthcare Options	Failure to file Annual Statement on time	1,000
	FY 1999 Total	**$429,500**
	TOTAL	**$802,900**

STATE OF MISSISSIPPI
Mississippi Insurance Department

GEORGE DALE
Commissioner of Insurance
State Fire Marshal

RONALD E. HANNA
Deputy Commissioner

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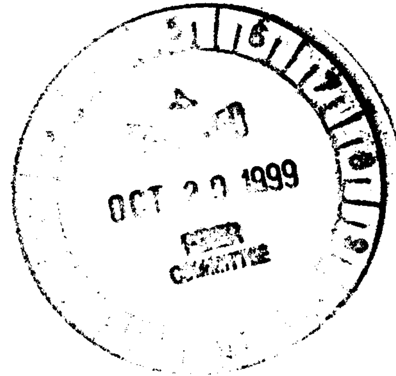
October 29, 1999



Dr. Max Arinder
Executive Director
Joint Legislative Committee on Performance
Evaluation and Expenditure Review
222 North President Street
Jackson, MS 39201

Dear Dr. Arinder:

As a result of our meeting on Tuesday, October 19, 1999 I am withdrawing the October 1 response by the Mississippi Insurance Department of the PEER Report on this Agency and provide you with the attached information as the Agency's final response.

We are enclosing some supplemental information which you requested on the Mississippi Insurance Counseling and Assistance Program.

Respectfully,

GEORGE DALE
Commissioner

GD/rh

Enclosures

Response of the Mississippi Insurance Department to the PEER Report of-

MISSISSIPPI INSURANCE DEPARTMENT:
Its Effectiveness in Regulating the State's Insurance Industry

The Mississippi Insurance Department has received the copy of the Executive Summary of the Report and has reviewed the supporting documentation compiled by PEER's staff.

It is MID's position that there is a major difference in management philosophy with PEER on priorities of the Agency, and the Department does not agree with a number of conclusions drawn in the report. While we strive to continually enhance the services offered by MID to the public, PEER has offered some recommendations in which we intend to consider based on budgetary constraints and Legislative support.

We regret that the Report did not highlight more of the positive programs offered by the Agency; however, we stand on our record of service with the staff and resources available through the budgetary process. The Agency stands committed to providing the best regulation of insurance and protection for the consumers of our State.

GEORGE DALE
Commissioner of Insurance

PEER Committee Staff

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Ted Booth, General Counsel

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