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FAILED PROMISES

Insurance Company Insolvencies

A REPORT

BY THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC, February 7, 1990.

TO MEMBERS OF THE COMMITTEE ON ENERGY AND COMMERCE: It is my pleasure to transmit to you a report by the Subcommittee on Oversight and Investigations entitled "Failed Promises: Insurance Company Insolvencies" This report sets forth the Subcommittee's findings from its extensive investigation into the causes of insurance company failures in the United States. The report was adopted by unanimous vote of the Subcommittee.

The Subcommittee found that the present system for regulating the solvency of insurance companies is seriously deficient. Consequently, the number of insolvent companies has increased dramatically, and the resulting costs to the public have skyrocketed due to the changing nature of the insurance industry. With an accelerating international market and the leverage provided by excessive reinsurance, the costs of liquidating failed companies is starting to reach billions of dollars and take many years to resolve.

The parallels between the present situation in the insurance industry and the early stages of the savings and loan debacle are both obvious and deeply disturbing. They encompass scandalous mismanagement and rascality by certain persons entrusted with operating insurance companies, along with an appalling lack of regulatory controls to detect, prevent, and punish such activities. Because the ill effects of fraud and gross incompetence may be hidden for 10 years or more after a policy is written, the problems observed by the Subcommittee could quickly escalate into a real threat to the solvency of the insurance industry if reforms are not implemented very soon.

The regulatory system must anticipate and deal effectively with the activities of the pirates and dolts who inevitably will plague an attractive industry such as insurance, where customers hand over large sums of cash in return for a promise of future benefits. The Subcommittee will continue its inquiry with an open mind regarding the types of actions that will correct the problems described in this report. The public rightfully expects that responsible industry participants and officials of Federal and State governments will move immediately to address abuses and deficiencies in the present solvency regulatory system.

An honest and soundly financed insurance industry is a goal shared by all Members of the Committee. The Subcommittee's inquiry has drawn broad bipartisan support. We will continue to pursue the important issues raised by this report in a spirit of cooperation with those in industry and government who are committed to finding and implementing workable solutions to the severe consequences of insurance company insolvencies.

Sincerely,

JOHN D. DINGELL, *Chairman.*

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SUMMARY

The insurance industry sells a unique and important product that is vital to world commerce and individual security. That product is a promise to pay all or a part of the costs associated with some future event. The promise is based upon the payment of premiums by a policyholder in advance of the event that triggers an insurer's promise to pay.

When an insurer wrongfully fails to honor its promise to pay, the whole concept of insurance also fails. A promise is an intangible whose value is entirely dependent upon an insurer's willingness and ability to pay. Because the insurer accepts prepayment of premiums, often years in advance, there is a special responsibility to act in a manner that assures both sides of the contract will be met. The expectation that an insurance company will be around to pay legitimate claims is the first and most basic consumer right of every policyholder.

An insurer's willingness to pay can be controlled after the fact by government regulation or a policyholder's access to the legal system. An insurer's ability to pay—its solvency—must be subjected to proper regulation on a continuing basis, from the time premium payments are accepted until the time all anticipated insured events have occurred. The policyholder must rely on the competence of the regulatory system, as well as the skill and integrity of the insurer, for protection from insolvency.

Insurance is an easy business to enter. Because making promises does not require expensive plants and equipment or time-consuming construction, all that is really necessary is to meet regulatory capital and skill requirements, and convince potential customers that the promise of insurance will be honored at an attractive price. The cash flow is up front, and the payment of insurance claims can be years away.

The simplicity of the insurance concept is matched by extreme complexity in its implementation. Pricing the promise properly, managing funds, sharing risks through reinsurance, establishing adequate reserves, and handling claims all require sound judgment, good organization, and personal talent. When these are lacking due to wrongdoing or incompetence, insurance can also be a very easy business to leave.

The Subcommittee on Oversight and Investigations has spent a year and a half inquiring into the reasons for insurance company

insolvencies. This inquiry comes on the heels of the greatest financial fiasco the United States has ever seen—the decline and bailout of the savings and loan industry. As a result of its findings thus far, the Subcommittee believes the insurance industry is vulnerable to the types of mismanagement and fraudulent activity that led to the savings and loan crisis.

The Subcommittee has found no evidence of an overall crisis threatening the existence of the insurance industry at the present time. However, the same early warnings of potential disaster are abundantly evident, as they were 5 years ago in the thrift industry. If such warnings are not heeded, the insurance industry and the nation could face a solvency crisis rivaling the present savings and loan situation.

The growth of insolvencies as a threat to the industry's health was documented in an April 1989 study by the National Association of Independent Insurers. According to that study, over 150 property/casualty insurance companies have become insolvent since 1969, with nearly half of them occurring during the past 5 years. The number of companies designated for regulatory attention by the National Association of Insurance Commissioners because of financial problems has more than quadrupled in the past 10 years, and the cost of insurer insolvencies is growing at an alarming rate. Between 1969 and 1987, insurance company assessments paid to state guarantee funds to cover the costs of insolvencies totalled $2.2 billion. Nearly half of that amount—$900 million—was assessed in 1987 alone.

The Subcommittee examined in great detail the failures of Mission Insurance Company, Integrity Insurance Company, Transit Casualty Company, and Anglo-American Insurance Company. Collectively, these four failures are projected to cost the American public more than $5 billion, with Transit and Mission being by far the most costly. The near-failures of Omaha Indemnity Company and the Insurance Company of Ireland were also reviewed by the Subcommittee.

There were many similarities and common elements among the insolvent and problem companies studied by the Subcommittee. These included rapid expansion, overreliance on managing general agents, extensive and complex reinsurance arrangements, excessive underpricing, reserve problems, false reports, reckless management, gross incompetence, fraudulent activity, greed, and self-dealing. There were also similar failures of state regulators and independent audit firms to identify and correct such problems before they got out of control. Industry sources have said these same problems extend well beyond the six companies observed by the Subcommittee.

The most disturbing similarity was the deplorable management attitudes at most of the companies involved in the cases included in the Subcommittee's inquiry. The driving force was quick profits in the short run, with no apparent concern for the long-term well-being of the company, its policyholders, its employees, its reinsurers, or the public. Senior managers abdicated their responsibility to set sound policies and control the activities of their subordinates and agents, and instead actively promoted and participated in the reckless mismanagement that caused the demise of the companies

they were entrusted to safeguard. They treated the reinsurance process as a way to pass loss problems to somebody else in exchange for easy premium dollars, rather than as a prudent method to share risks with other companies.

When the fatal results of these outrageous attitudes reached the breaking point, the officers and directors running these companies simply disclaimed responsibility and walked away. Their response was to let others pay and clean up their mess, with no signs of remorse or desire to provide restitution for their scandalous behavior. In fact, many of them remain active in the insurance industry, and some have been involved in multiple insolvencies. Dealing with such intolerable attitudes must be a top priority for improving the regulatory system.

The business of insurance is uniquely suited to abuse by mismanagement and fraud. Making believable promises is a stock item in every con man's bag of tricks. The prepayment of large, often vast, sums of money with few restrictions lends itself naturally to monumental wasting of assets through greed, incompetence, and dereliction of duty. This combination of easy money based on easy promises makes the insurance industry an irresistible target for financial knaves and buccaneers.

Although the overwhelming majority of men and women in the insurance industry are dedicated and talented professionals, the Subcommittee's record of inquiry on both the insurance and thrift industries shows that a relatively few crooks, scoundrels, and incompetents are capable of bankrupting huge companies, and possibly an entire industry. Honest and competent people in industry and government must be constantly alert to the certainty that somebody, somewhere, is not playing by the rules. A regulatory system based on the presumption that all companies will be managed honestly, competently, and prudently is doomed to failure.

A true irony of the whole situation is that well-managed insurance companies are hit twice by the acts of the unscrupulous and inept. The good companies first lose business to the artificially low prices of unsound companies. When the results of mismanagement lead to insolvency, the healthy companies must then pay the costs of the bailout. As one industry official observed, "Every time they write a bad policy, my company is involuntarily placed on the underwriter's slip, where they get the premiums and we pay the losses."

Based upon the Subcommittee's work to date, the key weaknesses in the present system of solvency regulation can be summarized as follows:

(1) Delegated Management Authority

Through excessive reliance on the judgments of managing general agents, brokers, and other companies, many insurance company managers essentially delegate their most fundamental responsibilities to third parties who may have conflicting interests or inadequate abilities. The inevitable problems spawned by such irresponsible delegation increase dramatically when this condition is coupled with rapid business expansion, particularly into unknown product lines.

(2) Holding Companies and Affiliates

Insurance companies can be too easily overleveraged and milked of their liquid assets by affiliated companies. In addition, these affiliates are often used as dodges to confuse and evade the scrutiny of regulators and other interested parties. Holding companies may also permit the persons responsible for insurance company insolvencies to insulate themselves from the consequences of their actions.

(3) Reinsurance

At present, the crucial process of selecting dependable reinsurers is apparently an unfettered exercise of discretion by insurance company managers, who are often dealing with unregulated entities in a vacuum of solid factual information. Nobody seems to know for sure where the reinsurance chain goes or whether its links are all sound, yet the entire insurance system and the very existence of some companies is based on the belief that reinsurers will actually pay their stated portion of claims. When reinsurers fail to pay their share of claims on time for any reason, there is frequently no effective system to protect the solvency of frontline insurance companies that are required to pay the legitimate claims of policyholders in full. State regulators have not successfully resolved problems associated with regulating reinsurance.

(4) Unreliable Information

Much of the information used to measure solvency by state regulators, industry participants, and ratings services is simply unreliable as a basis for accurately determining an insurance company's financial condition. Most such information is provided by insurance companies themselves, with no verification by regulators, independent auditors, or qualified actuaries. Information may also be outdated and based on "guesstimates", omissions, creative accounting, and even bold-faced lies. Loss reserve projections can be particularly misleading.

(5) Insufficient Regulation

Solvency regulation in the United States suffers from inadequate resources, lack of coordination, infrequent regulatory examinations, poor information and communications, and uneven implementation. Broad licenses to write property/casualty business are commonly granted to seriously undercapitalized companies, with little in the way of background checks or monitoring the activities of the persons and entities responsible for operating those companies. Instead of demanding the highest financial, technical, and character qualifications from applicants, there has been a shocking reluctance in some states to deny granting or to withdraw an insurance license unless a person has a legally proven record of criminal fraud. In many ways, the regulatory system presumes that all participants in the insurance process will be honest and competent, with no effective checks and balances to help assure that goal.

(6) Enforcement

The present system devotes insufficient efforts to investigating the causes of insurance company insolvencies, and punishing the persons who are responsible. Both administrative actions and criminal prosecutions seem hampered by resource deficiencies, procedural and jurisdictional problems, limited penalties, and unwillingness to pursue wrongdoers. As a result, there is no meaningful deterrent to dissuade those who are inclined or tempted to plunder insurance companies.

Despite the challenging problems relating to solvency regulation, the Subcommittee is encouraged by the significant number of industry participants and state regulators who appear committed to implementing needed changes. Their cooperation in working with Congress, sharing their ideas, and developing real answers to the issues that must be addressed provides an opportunity to deal with inadequate solvency regulation before it becomes a crisis for the insurance industry and the public. The Subcommittee intends that this report and followup hearings will accomplish an openminded inquiry in a public forum which will lead to practical solutions.

Early in its inquiry, one industry source told the Subcommittee that "insurance is all about small percentages of large numbers." This observation has proven beneficial in understanding both the legitimate concepts behind the insurance business, as well as the incentives and selfish rewards for abusing the process. Prompt and serious reform of solvency regulation will help assure that the percentage of insurance company insolvencies will remain small, the losses to the public will not become dangerously large, and the contract of future payments in return for today's premiums will be honored as promised. That prospect will greatly assist the financial health of the industry, and also provide a more stable and fair marketplace for insurance consumers.

THE SUBCOMMITTEE'S INVESTIGATION

The Subcommittee on Oversight and Investigations began its inquiry into the insurance industry in May 1988. A rising number of insurance company insolvencies raised questions regarding the adequacy of the regulatory system that is supposed to protect the public from fraud, mismanagement, and poorly capitalized companies. While insurance company solvency is presently regulated by the various states, there is a need for Congress to understand how the regulatory system works, and how it impacts on interstate and international commerce. There are also immediate Federal responsibilities in the areas of fair disclosure under the Federal securities laws and enforcement of Federal criminal statutes, such as mail and wire fraud.

The course of inquiry chosen was to investigate the causes of the largest insurance failures so far. This case study approach permitted the Subcommittee to develop the factual record which will be necessary to evaluate proposals for change. Starting the process without an agenda of solutions in mind has given the Subcommittee the freedom to follow the facts to whatever conclusions are appropriate.

The use of case studies worked well 5 years ago when the Subcommittee began inquiring into widespread problems associated with savings and loan insolvencies. Through review of documents, interviews, and listening to the testimony of key participants in the system, the Subcommittee recognized patterns of misconduct and events which seemed to be evident in almost every problem situation. The attitudes and illusions of those persons responsible for making the system work also became apparent.

During the course of several hearings in 1985 and 1986, the Subcommittee was told by former managers, auditors, and regulators of failed thrift institutions that such failures were not their fault. The primary Federal regulatory agency, the Federal Home Loan Bank Board, downplayed the problems observed by the Subcommittee. The Bank Board said the expected drain on the Federal Savings and Loan Insurance Corporation was in the range of $6 billion, which could be handled by the system. Four years later, the public is being forced to pay for the incredible, yet persistent, refusal of Federal and state regulators to recognize reality.

Present legislation to bail out the savings and loan industry calls for expenditures of $166 billion. The General Accounting Office (GAO), however, estimates the ultimate cost will be more than $300 billion. The overall cost has grown enormously because of the delay in dealing with problems that were clearly evident years ago.

How could such an enormous deficit have occurred, and how could it have grown so quickly? The Subcommittee investigated four insolvent or troubled savings and loan institutions in-depth, and studied several others as part of its inquiry. It found there were a number of common elements which resulted in remarkable similarities among the failures observed. These included rapid growth, excessive risk taking, expansion into unfamiliar business lines, mismanagement, inadequate or nonexistent operating and financial controls, poor records, accounting gimmicks, lax audits, and superficial regulation. Furthermore, there was no effective law enforcement to punish and deter wrongdoing.

Reports and testimony by the GAO supported the Subcommittee's findings, and established them as the primary causes of problems and failures across the savings and loan industry. The driving force behind this phenomenon was management greed and incompetence, accompanied by self-dealing, conflicts of interest, lavish life-styles, violations of laws and regulations, and outright fraud. The key to the whole savings and loan debacle was that the perpetrators were risking and using other people's money, guaranteed by the United States government.

The same patterns of industry and regulatory conduct have emerged from the Subcommittee's recent investigations of insurance company insolvencies. While state insurance regulators appear bogged down by jurisdictional restraints, unreliable information, and poor resources, the fast operators in the industry are ignoring the rules, creating new schemes to enrich themselves, and walking away unscathed. Unless something meaningful is done to strengthen solvency regulation of insurance companies, the financial rewards of greed, fraud, and incompetence will continue to attract growing numbers of people who practice such traits with relish and abandon. Fortunately, many respectable participants in

the insurance industry seem aware that substantial improvements are needed now.

Because of its work detailing the causes of individual company failures, as well as industry problems which result from reckless behavior, the Subcommittee is convinced that solvency must be the first priority of regulation. Attractive rates and benefits are meaningless to policyholders if the company that promises them is not there to fulfill its obligations when they come due. A solvent and honestly managed company is rightly the most basic expectation of every insurance policyholder.

Another reason for the Subcommittee's focus on solvency is that it is an area which lends itself well to cost-effective and practical regulation. Adequate minimum standards for capital, reporting, investing, and appropriate behavior can be reasonably established and monitored on an ongoing basis, if sufficient checks and balances are built into the system. Like airplane safety precautions, solvency protections are essential for the long-term, but are sometimes deferred or overlooked in the short-term because of competitive rate and profit pressures.

Sources within the insurance industry were unanimous in recommending that the Subcommittee investigate the three largest failures to date—Mission Insurance Company, Integrity Insurance Company, and the Transit Casualty Company. The current aggregate cost to the public of these three failures alone is estimated to reach $5 billion. The Subcommittee's efforts to learn what happened in these cases has yielded a series of common factors which the regulatory system must address. Those findings were augmented and confirmed by examining the problems of Anglo-American Insurance Company, Omaha Indemnity Company, and the Insurance Company of Ireland.

The Subcommittee believes its hearings and investigations have been useful to the insurance industry and state regulators, as well as to Congress. The Subcommittee is apparently the only body with the authority, resources, and desire to learn the facts, and look at the broad national and international solvency aspects of a very powerful and important financial industry. Concerned business executives, law enforcement officials, regulators, and state legislators have encouraged and assisted the investigation.

THE PROPERTY/CASUALTY INDUSTRY

The insurance industry as a whole had assets totaling $1.75 trillion in 1988, usually broken down into general categories of life, health, and property/casualty insurance. All the major insolvent companies studied by the Subcommittee were engaged primarily in commercial property/casualty coverage, so that $477 billion segment of the industry has been the focus of the present inquiry. The smaller coverage amounts and actuarial certainty of the life and health business apparently make those companies less sensitive to market swings and the effects of bad management, although the Baldwin-United failure in 1983 demonstrates that they are not immune to such problems. The irresponsible junk bond practices of First Executive Corporation also point to the serious consequences of misconduct in that area by both life and casualty companies.

Commercial property/casualty is traditionally the most price-competitive segment of the insurance industry. Because the premiums for covering large governmental units and Fortune 500 companies can run into millions of dollars, there is a real incentive to write this business, particularly at the higher layers of coverage where the risks seem remote. The danger is that when commercial claims do go beyond expectations, they can reach devastating amounts, as shown by the claims for asbestos, toxic waste disposal, Agent Orange, and the Dalkon Shield.

The casualty component, covering liability for sickness, injury, and death, is particularly dangerous in causing insolvency when improperly underwritten. Even the largest commercial buildings and properties are subject to fairly accurate measurement for setting premiums and reserves. However, forecasting adequate rates and reserves for the financial consequences of unforeseen disasters such as the Bhopal poisoning, the Lockerbie airliner bombing, and the Johns-Manville asbestos claims requires great skill and caution.

Commercial property/casualty premium rates are far more volatile than rates for life insurance and personal property/casualty coverage. The large size and specialized coverage of commercial property/casualty policies means that much of the business is written in the excess and surplus lines market, which is less regulated and more competitive because participants in that market are expected to be knowledgeable professionals. The result is that careful underwriting and sound management controls are essential for insurance companies that intend to participate in the market on a continuing, profitable basis.

The commercial property/casualty market has proven to be cyclical, with periods of high interest rates and good investment opportunities attracting additional capacity that depresses premiums and increases competition. Insurance companies compete for market share and premium volume, and are often willing to accept greater underwriting losses in the hope that investment income will compensate for those losses. Mounting losses from underpriced business and poor investment returns eventually reverse the cycle and reduce available insurance capacity, leading to sharply higher rates for customers on the same or even lower risk coverage.

Beginning in 1979, the property/casualty industry entered a soft market cycle with severe price competition and excessive capacity due to high interest rates on investments available at that time. This cycle continued until 1985, when rates skyrocketed because of rising losses. Excessive reinsurance capacity permitted companies such as Mission, Integrity, and Transit to aggressively expand the amount of business they wrote and reinsured during the depths of the soft market in the early eighties. These companies were overwhelmed when the losses from that business began to snowball a few years later.

LOSS RESERVING

Establishing adequate loss reserves is crucial for companies writing commercial property/casualty coverage. This is especially important for casualty coverage where claims often are not filed or

payment amounts known until several years after the policy period has expired. Financial reporting rules for insurance companies require that reserve amounts be established each year based on known and expected losses insured under policies written during all prior years. Reserve amounts must reflect current knowledge at the time of the report regarding the amount of losses expected to be paid eventually, meaning that reserves established for past business must continually be updated.

Reserve reports have two basic components—the amounts needed to cover losses on known claims that have actually been filed with the company, and the amounts estimated to cover losses on future claims that have not yet been filed. This second component, called "incurred-but-not-reported" loss reserves, should be calculated using actuarial studies, loss experience data, and current developments affecting policy coverage to reach a reserve estimate that accurately measures future losses. The incurred-but-not-reported component of loss reserves has become critically important because the period for future claims is growing longer, the amounts claimed are much larger, and the number of claims has increased significantly.

Reserve estimates of incurred-but-not-reported losses are subjective judgments that have a substantial impact on financial reports to regulators and investors. Increasing reserves directly decreases reported income and available capital surplus. Managers have a strong immediate financial incentive to keep reserves low in the hope that any significant deficiencies will somehow resolve themselves in the future.

Mission, Integrity, and Transit established reserve amounts that were completely inadequate, and their incurred-but-not-reported reserves have proven to be vastly deficient. The result of this massive underreserving was to falsely and materially inflate their reported profits, and justify improper dividends. Even worse, their rosy financial reports enabled them to compound their havoc by continuing to operate for years while actually insolvent.

REINSURANCE

Reinsurance is the process whereby insurance companies spread their risk exposure by transferring portions of specific policy liability to other insurance companies in return for their receiving part of the premiums. The company that originates business is compensated for its efforts, brokers earn commissions for arranging reinsurance of the business, and intermediary agencies receive commissions for managing pools where reinsurance companies share in specific risks as joint venture participants. These reinsurance pools are a key method for coordinating the joint participation of many companies in sharing business that is centrally managed.

Agencies that manage reinsurance pools are usually responsible for underwriting business accepted by the pools, handling claims, collecting and distributing premiums to pool members, and establishing adequate reserve guidelines. Within set limits per risk and general management terms, such agencies can obligate pool members on any type of property/casualty business, and accept as many separate risks as they consider desirable during the 1-year period

common to most pool agreements. Pool members are, therefore, dependent on the managing agency to determine the quality and amounts of business accepted by a reinsurance pool.

For reinsurers, the benefit of reinsurance participation is an opportunity to share for a fee in the business generated by other companies, without the responsibility for developing customers and handling claims. For insurance companies whose business is reinsured, the benefit is to reduce their risk exposure on specific policies, and increase the amount of new policies they can write. Business that is properly reinsured and secured by letter of credit or trust funds put in escrow by the reinsurer can be removed from the originating company's balance sheet. Because a company's ability to accept new business is controlled by the ratio of business on its books to its capital surplus, transferring business to the books of reinsurance companies creates room to write new business and earn more fees.

Although the concept of reinsurance is sound, problems have arisen in the insurance industry when a reinsurer is either unwilling or unable to pay its share of claims. This creates a chain effect of strain on the system, requiring the companies that were reinsured to pay the defaulting company's share. There is no formal system to regulate the solvency of reinsurance companies, and the existing system of letters of credit and trust funds intended to secure the performance of reinsurers has been woefully insufficient to cover actual losses in the cases studied by the Subcommittee.

In the cases of Mission, Integrity, and Transit, the reinsurance system broke down entirely. These companies abused the system by using complex arrangements involving hundreds of reinsurers around the world to transfer most of the risk on the extremely unprofitable business they were writing to other companies. When huge losses started to accrue, they were required to pay the entire amounts because their reinsurers refused or were unable to pay their shares. Many of the reinsurers have alleged fraud and misrepresentation as legal justification for not paying, but the ultimate result was to force Mission, Integrity, and Transit into bankruptcy because of their inability to collect reinsurance proceeds.

PROBLEMS WITH MANAGING GENERAL AGENTS

The use of managing general agents (MGA's) by insurance companies to write business on their behalf is an industry practice that can be exceedingly dangerous. In the worst cases, an insurance company hands over responsibility for its business to the MGA, granting the agent power to underwrite business, obligate the company, handle claims, and even arrange for reinsuring the business written by the MGA in the company's name. Such a complete delegation of authority would be dangerous by itself, but the problem is compounded by the fact that MGA's are compensated by commissions on the amount of business they write.

There is an inherent conflict for MGA's between writing quality business and earning commissions on the volume of business written. MGA's are not insurance companies, and their activities are not generally regulated by state insurance authorities.

Mission had two subsidiaries, Sayre & Toso and Pacific Reinsurance Management Corporation, that acted as MGA's on behalf of Mission and its reinsurance pool members. Integrity and Transit used a nationwide system of independent MGA's to write direct business and arrange reinsurance on their behalf. Underpricing and minimal or poor underwriting by their MGA's were leading contributors to the failure of all three companies.

Mission, Integrity, and Transit were "fronts" used by their MGA's to write business that was intended to be passed almost 100 percent to reinsurers. Since insurance policies can only be legally written in the name of licensed insurance companies, the use of Mission, Integrity, and Transit as fronting companies was quite valuable and convenient for the MGA's because the three were licensed to write policies in all fifty states. At least one MGA even created his own private offshore reinsurance companies to capture the bulk of the premiums on the business he wrote for Transit, in addition to receiving commissions for originating and reinsuring the same business.

Insurance companies that basically rent their name in a fronting arrangement earn a fee, but they risk financial disaster if the reinsurers arranged by the MGA's refuse, or are unable, to pay their share of claims. In that situation, the fronting insurance company with its name on the policies is required to pay 100 percent of the claims. That is exactly what happened to Mission, Integrity, and Transit, and that was the immediate cause of their insolvencies.

THE FAILURE OF MISSION

The Mission Insurance Company was a California-domiciled company with its headquarters in Los Angeles. It was the largest of several insurance company and agency subsidiaries owned by the Mission Insurance Group, a holding company traded on the New York Stock Exchange. The primary Mission Group-owned agencies were Sayre & Toso and Pacific Reinsurance Management Corporation (Pacific Re), which were instrumental in writing large amounts of business for Mission and other insurance companies.

After Mission Insurance Group reported huge losses in 1984 and 1985, the regular triennial examination of Mission was commenced on March 25, 1985 under the direction of the California Department of Insurance, in coordination with other state regulatory authorities. On October 31, 1985, the California Insurance Department obtained a court order of conservatorship regarding Mission. The receivership court found that Mission had over $900 million in unpaid claims and a reserve deficiency of $169 million. Various rehabilitation plans involving Mission's creditors, reinsurers, and the regulatory authorities failed to produce a workable scheme, so the California Commissioner of Insurance placed Mission and its subsidiaries into liquidation on February 24, 1987.

The Subcommittee decided in May 1988 to look into the failure of Mission after several sources in the insurance industry said that it would be the largest insolvency in history. The process of inquiry involved extensive contacts with Mission's state-appointed receiver, interviews with reinsurers and former senior managers, review of company documents and the independent auditor's workpapers,

and hearings held on August 9 and 10, and September 9, 14, and 15, 1988. These efforts and subsequent correspondence have resulted in a substantial record from which the Subcommittee has reached several conclusions.

The factual causes of Mission's demise are quite clear. As the receiver succinctly stated, the two direct causes were high losses from the nature of the business Mission held, coupled with the failure of the company's reinsurers to pay their share of those losses. He described the situation as two guns, one pointed at each temple. The cause of insolvency was a question of which bullet did the job, since each was a fatal shot on its own.

The receiver estimated the ultimate cost to the public of Mission's collapse will be $1.6 billion. The obvious question is, "How could a company with less than $240 million in capital surplus write enough bad business to cause a $1.6 billion failure?" The answer lies in excessive use of reinsurance.

Mission was both a reinsurer for other insurance companies, and also a direct primary insurer that reinsured most of the risks it wrote with an array of large and small reinsurance companies around the world. More than 600 reinsurers were involved in reinsuring Mission's direct business, and the receiver is trying to collect $2.2 billion, or 91 percent of the liquidation assets, from these companies. About $500 million cannot be collected because some of the reinsurers are either in liquidation or do not have sufficient funds to meet their obligations to Mission. In the cases where Mission reinsured the direct business of other insurance companies, those companies have had to absorb $180 million in paid losses that will not be covered by the Mission liquidation estate.

Mission's excessive reliance on reinsurance began around 1980. Prior to that, the company had a solid reputation as a regional workers' compensation carrier, and was highly rated by Best's rating service. This good reputation was useful in helping Mission achieve rapid expansion of its business through reinsurance when management decided to write large volumes of commercial property/casualty insurance during the soft market of the early eighties.

The vehicle for aggressive growth through reinsurance was the use of Sayre & Toso and Pacific Re as managing general agents (MGA's) for Mission and its reinsurers. These wholly-owned subsidiaries wrote business in Mission's name as a licensed insurance company, and simultaneously reinsured the vast bulk of it with other companies. Most of those were unlicensed carriers that could not write policies themselves, so Mission was the "front" to write business that was immediately transferred to the books of unregulated companies.

The present regulatory system requires unlicensed reinsurers to post letters of credit to secure their payment of losses. This system failed miserably at Mission and every other case examined by the Subcommittee. Like an empty fire extinguisher, it looked fine until it was needed.

The primary problem with letters of credit is that they are based upon loss reserves, which almost by definition are deficient at insolvent companies. At Mission, the receiver is trying to collect $2.2 billion from reinsurers, but has only been able to recover $143 million from letters of credit and other sources. The Mission receiver

has also had trouble getting some banks to pay on the letters of credit, which are supposed to be irrevocable and immediately available when a reinsurer fails to honor a valid claim. Thus, the amount of security was entirely inadequate, and availability has not worked smoothly.

There were three basic segments to Mission's business. The first was the traditional workers' compensation coverage that was largely centered in California and a few other western states. Next was commercial multiple peril, excess and surplus lines, and general liability coverages that were directly written by Sayre & Toso for Mission, and reinsured with different companies. The final segment was direct business written by other companies that was reinsured by Mission through Pacific Re, and largely reinsured again by passing most of the risk to outside members of Pacific Re's reinsurance pools.

All three segments contributed to Mission's brief spurt of expansion and its ultimate collapse. Although workers' compensation rates are set by state regulation, Mission was widely known for attracting more business through excessive premium rebates and cash incentives for its agents. Industry sources have told the Subcommittee that underpriced workers' compensation coverage meant inevitable trouble for the carrier.

Sayre & Toso aggressively wrote the large direct commercial liability policies that generated substantial commission income for Mission Insurance Group at the holding company level. The six percent commission earned by Sayre & Toso as an MGA was apparently intended to offset the extra risks associated with underpricing, since Mission was retaining less than five percent of the business for its own portfolio. The rest was reinsured by Sayre & Toso with other companies that paid fees in the range of 15 to 25 percent for assuming business produced by this MGA.

As MGA for Mission and outside reinsurers, Pacific Re operated annual reinsurance pools where participants paid six percent of gross premiums for Pacific Re to find and manage reinsurance business on their behalf. These pools were basically joint ventures among the participating companies, with Mission sharing ten to twenty percent of the risks assumed. Again, Mission Insurance Group enjoyed the benefits of the fees collected by Pacific Re for writing large amounts of business, while Mission supposedly retained a minimum risk exposure.

The agency operations of both Sayre & Toso and Pacific Re were based on the premise that reinsurers of the substantial risks written in Mission's name would always be there to pay their full share of any losses. However, this premise was undermined by the way the reinsurance programs were handled. In addition to the complex arrangements and multitude of companies involved, the geographic dispersion and financial viability of many of the reinsurers selected by Sayre & Toso and Pacific Re virtually assured that the system would break down.

Many of the approximately 600 reinsurers used by Sayre & Toso for Mission's direct business were United States companies not admitted to do business in California. About 75 percent of the reinsurers were foreign companies based in Germany, France, Italy, Japan, Belgium, the Netherlands, Finland, Norway, Denmark,

Greenland, Kuwait, Great Britain, Australia, Algeria, Egypt, India, Israel, and many other countries. On the Pacific Re assumed reinsurance side, there were 78 reinsurers of Mission, and 56 of them were either not admitted to do business or were foreign companies.

There have been allegations that Mission intentionally sought reinsurers which were far away and unsophisticated because they would be more likely to believe what they were told without checking. For example, the Subcommittee was informed that in Europe it is considered impolite to audit reinsurance programs, as it implies a lack of trust in the business relationship. In view of the Subcommittee's findings, this curious attitude should be reexamined for the benefit of everyone involved.

Others have charged that the unlicensed reinsurers conspired to use Mission as a front to gain access to lucrative premiums in the United States marketplace. They say the reinsurers were knowledgeable professionals who have only themselves to blame for failing to meet their responsibilities. The result of such claims and counterclaims has been acrimonious and extensive litigation between the Mission receiver and the reinsurers who have not paid the gigantic losses from the business written by Sayre & Toso and Pacific Re.

Both Mission and its reinsurers had ample reasons to enjoy the party while it lasted. The reinsurers took hundreds of millions of dollars in premiums, while Mission puffed up its own financial image and earnings. It is clear that Mission and its subsidiaries knowingly deceived the reinsurers who relied on them, and it is equally clear that many reinsurers may not have exercised prudence and sound judgment in their dealings with Mission.

Now that the party is over, there is a bitter fight to determine who shall pay the ultimate costs of Mission's failure. As noted by the company's receiver, the real issue is not merely the resolution of legal rights and duties as between the Mission companies and the reinsurers, but rather a resolution of the broader obligations of both the Mission companies and the reinsurers to the insurance buying public.

RECKLESS MANAGEMENT

The story of Mission's failure is really a tale of reckless and incompetent management. This took various forms, including poor underwriting, severe underpricing, grossly inadequate reserving, accounting gimmicks, false reporting, and an overall disregard for the well-being of Mission and the constraints of the marketplace. The record developed by the Subcommittee displays an attitude among senior management of arrogance and indifference, accompanied by a readiness to blame everyone but themselves for the inevitable results of their actions and omissions.

At the helm was Mr. E. Richard De Rosa as president and chief executive officer responsible for Mission Insurance Group and its subsidiaries. For almost 20 years, Mr. De Rosa firmly directed the activities of Mission with a style he described as "hands-on" management. The initial decision and full implementation of Mission's fatal plunge into reckless growth and excessive reinsurance occurred under Mr. De Rosa's leadership.

In testimony before the Subcommittee, Mr. De Rosa said he was ultimately responsible for Mission's activities, and that he believes he succeeded in meeting his responsibilities. He then blamed the demise of Mission on a 6-year cycle of depressed insurance rates when history failed to repeat itself at regular 3-year intervals. He dismissed the $1.6 billion cost of the company's failure as a liquidation value which precluded Mission from getting paid back as a going concern. Mr. De Rosa offered no explanation as to how Mission could possibly be a going concern when the reinsurance network established under his direction refused to pay because the business written under his supervision was so bad.

The Subcommittee also received testimony from Mr. Louis J. Marioni and Mr. Michael Mulholland, who were, respectively, the chief operating officer and the chief financial officer of Mission Insurance Group during its glory years. Their testimony often conflicted with the views of Mr. De Rosa, but both described their senior management jobs in narrow terms as they denied responsibility for such major problem areas as inadequate reserves, Sayre & Toso, the Pacific Re operation, and false financial reports. Mr. De Rosa, Mr. Marioni, and Mr. Mulholland all disclaimed any detailed or actual knowledge of the pervasive deception and incompetence at Mission, which illustrates the depth of the company's ingrained management problems.

Further testimony was given by Mr. Ronald Bengston and Mr. Robert Marsh, who together managed the Pacific Re subsidiary where some of the most fraudulent activities occurred. Their testimony was full of contradictions, memory lapses, and incredible statements which are described in a subsequent section of this report.

The Subcommittee notes that the persons responsible for mismanaging Mission and causing its failure have fared very well. None has yet been charged with any regulatory or criminal violations, and all are ironically being defended and protected from civil liability by directors and officers insurance coverage that is so difficult to obtain in other industries. They have not suffered financially as have many of the policyholders, shareholders, and insurance companies that trusted them to perform their duties responsibly.

Mr. De Rosa retired comfortably from Mission Insurance Group in early 1984, just as the developing losses from his aggressive growth plan began to hit Mission hard. He sold approximately 116,000 shares of Mission stock on January 9, 1984 in a corporate-guaranteed deal that provided him a huge profit and a 41 percent premium over market value, just weeks before Mission publicly reported its first loss of $37.2 million for the fourth quarter of 1983. While Mr. De Rosa maintained that he did not violate Federal insider trading laws, he did concede that his timely stock sale could be characterized as "an extremely fortunate business decision."

Mission had an executive compensation program which awarded stock options and bonuses to key management personnel on the basis of Mission's financial performance relative to the industry. This obviously provided them with personal financial incentives to pursue activities that inflated the company's financial reports. Former officers and employees have told the Subcommittee that success at Mission was tied to following Mr. De Rosa's dictates, and

that meant going ahead full throttle with expansion in a soft market.

Mr. Marioni and Mr. Mulholland left Mission in 1985 when the company was rapidly falling apart. They acquired Superior National Insurance Company in October 1985 from members of the royal family of Kuwait. Superior National is based in California, and was essentially an inoperative, undercapitalized shell corporation with an insurance license when it was acquired. The company is presently seeking additional licensing to do business in other states.

Mr. Marioni is now president and Mr. Mulholland is chief financial officer of Superior National. They told the Subcommittee that they are actively back in the insurance business writing workers' compensation and commercial property/casualty coverage of the same types they handled at Mission. About thirty percent of the financing for Superior National has come from former Mission agents who prospered from dealings there, and the eventual goal is to raise more capital in the public securities markets.

Mr. Bengston and Mr. Marsh left Mission in early 1983 to start their own reinsurance intermediary company, which has since ceased business after helping destroy Integrity Insurance Company. They sold their Mission stock well before the sad results of its growth program were revealed to the public. Mr. Bengston presently claims to be retired from the insurance business, but Mr. Marsh is employed by the receiver for Transit Casualty Company to evaluate bad business written by that company's former management.

In testimony before the Subcommittee, Mr. Bengston and Mr. Marsh denied any responsibility for the failure of Mission. Mr. Bengston said the failure was "unfortunate," but there were so many factors involved that it is not correct to blame the top management of any specific division. Mr. Marsh agreed that no individual could be the cause since the failure was "the fault of many, many factors." Both men said they were not embarrassed about what happened at Mission.

FRAUDULENT ACTIVITIES

The Subcommittee found several types of fraudulent activity at Mission. Most of these practices had been continuing for years before the company's final collapse. If the senior management truly failed to detect such widespread activity, there was indeed an exceedingly high level of supervisory incompetence in the management structure. Among the practices noted by the Subcommittee were:

(1) Reserve Suppression—Fraudulent suppression of loss reserves was apparently rampant at Mission. Adequate reserving was more critical for Mission than for other companies because loss ratios from its policy of lowball pricing, ranging from 400 percent to 1,000 percent and even higher, were far above the industry average. Artificially low reserves were instrumental in boosting the company's financial results reported to reinsurers and the public.

The improper calculation of incurred-but-not-reported loss reserves was the biggest problem. Sayre & Toso was receiving reports from its field offices that reserves should be in-

creased substantially, but these were ignored at the main office. Mission's actuaries were busy calculating inadequate reserves based on wrong information given them by management.

The incurred-but-not-reported reserve formula used by Pacific Re for the assumed reinsurance pools was fabricated with no factual support. It was simply a 5-year straight declining balance formula that was based on no supporting studies or evidence, was never reviewed for adequacy, and yielded absolutely no reserves after the fifth year when the losses started snowballing. Despite the fact that Pacific Re had internal reports which clearly showed incurred-but-not-reported reserves to be grossly inadequate when compared with actual losses, the 5-year formula was rigidly applied year after year.

Miscoding of business was another method used to suppress reserves. There was no incurred-but-not-reported provision for property coverage, so combined property/casualty policies needed some process for determining how much incurred-but-not-reported reserves should be allotted for the casualty portion. The method used was simple enough, but again departed from reality.

If a policy was thought to be more than fifty percent property coverage, the entire policy was coded as property, and no provision was made for incurred-but-not-reported losses. Policies considered to be more than fifty percent casualty coverage were assigned incurred-but-not-reported reserves for the whole policy. The assumption seems to have been that property and casualty claims would be a "wash," so that incurred-but-not-reported reserves computed this way would be adequate.

The reality was that casualty claims far exceeded property claims, and incurred-but-not-reported reserves developed by the assumed fifty-fifty coding system were much too low. The problem was compounded by coding most combined policies as property and applying an artificially low incurred-but-not-reported reserve formula, meaning that too little of the business written received too little in the form of loss reserves. There was also evidence in certain cases that policies were retroactively recoded to reduce Mission's exposure after losses started to occur.

(2) False Reports—The Mission Insurance Group and its subsidiaries provided false reports to regulators, business partners, and the public starting at least as far back as 1976. This fraudulent reporting accelerated after 1976 when the results from rapid expansion through reinsurance really took effect. Most false reporting was rooted in basic financial figures, but some of it involved special accounting gimmicks.

Reserve suppression was the primary reporting problem because its massive impact rippled through every financial report that was issued. It affected reported capital surplus, earnings, investments, and assets. Most importantly, the effects of reserve suppression enabled Mission's management

to continue their damaging activities for at least 3 years during which the company was, by most accounts, insolvent.

The Mission receiver told the Subcommittee the company may have been insolvent on the date of each of the dividends paid by it in 1982, 1983, and 1984. Others with access to the books and records say that it was definitely insolvent at those dates if reserves for incurred-but-not-reported losses had been calculated competently. Dividends are not appropriate under California law when an insurance company is insolvent, so violations of laws and regulations may well have resulted.

Of particular interest to the Subcommittee was the "discretionary reserve fund" used by Pacific Re in reporting to its reinsurance pool members. This so-called reserve was essentially a secret slush fund established by Mr. Bengston that was used as a smoothing device from 1976 to 1982 to give the impression that the reinsurance pools were consistently profitable. As president of Pacific Re, Mr. Bengston would arbitrarily add or subtract from the discretionary reserve in order to reach a target combined operating ratio of approximately 99 percent.

The discretionary reserve fund had no validity as an accounting technique, and its sole purpose was deception. It was hidden in the wrong reserve account, and Mr. Bengston told nobody of its existence. When the chief financial officer of Mission Insurance Group, Mr. Mulholland, discovered the discretionary fund in the early 1980's, he dismissed it as immaterial in amount, but told nobody about it.

Mr. Mulholland testified that he "really didn't care" about the fund because reserve estimates are not "real money." A consequence of this attitude is that the $1.6 billion net cost of Mission's failure to establish proper reserves will be paid by the public in real money. Regardless of his beliefs, Mr. Mulholland took the precaution of increasing reserves on Mission's share of the pool business without telling the other reinsurers.

To the Subcommittee, the discretionary reserve fund is significant far beyond its dollar amount. This fund illustrates a pattern of intentional deception over several years until there was no excess money to keep it going. The name of the fund quite accurately described its purpose, if anyone except Mr. Bengston and Mr. Mulholland had known about it.

Mr. Bengston used additional reporting gimmicks, such as lumping together the financial results of all the annual reinsurance pools. That procedure enabled the positive cash flow from writing extensive new business to cover up the mounting losses from earlier years. His incredible 5-year incurred-but-not-reported formula produced inadequate reserves at Mission, but the effects were extended to the outside reinsurers, covering eighty to ninety percent of the risks written by Pacific Re, because those companies were relying on the fraudulent financial results reported to them in setting their own reserves.

(3) Bad Faith Dealing—The Subcommittee's record demonstrates a pattern of bad faith dealing by Mr. Bengston as president of Pacific Re. The management agreement between Pacific Re and the participants in its assumed reinsurance pools set forth certain limitations on the types of business Pacific Re would accept. These limitations were simply ignored by Mr. Bengston and Mr. Marsh, the chief underwriter for the company.

The management agreement stated eight specific types of business that Pacific Re was not allowed to accept; however, material amounts of such business were written. For example, there were absolute exclusions for facultative risks and foreign business, yet twenty percent of all the business Pacific Re wrote from 1977 to 1984 fell into these two excluded categories alone.

Other limitations included the size of participation on individual risks that would be accepted, but Pacific Re was telling brokers it would take amounts that were two or three times larger than what the pool members were told. Accepting these larger levels of dollar-amount participation increased the risk exposure for the reinsurance pools, and by 1982 Pacific Re was writing leading lines generating nearly $18 million of premium. Lower layers of risk exposure where most losses occur were to be generally avoided by Pacific Re, but large volumes of such "working casualty" business were written, so that 32 percent of all business accepted in 1981–1982 was in this category.

At Sayre & Toso, the reinsurers of Mission's direct business were apparently deceived by multiple counting of the amount Mission would retain. The amount retained by the primary insurer is an inducement for reinsurers to participate because a larger retention means more risk for the insurer, and presumably better underwriting. The Subcommittee has been told that Sayre & Toso would represent Mission's stake as 25 percent in a given deal, and then use the same money to count as Mission's stake in as many as twenty separate deals. This resulted in Mission's actual retention being a small percentage of all the deals combined, yet the participating reinsurers in each deal were led to believe Mission had much more of its own money at risk.

(4) Lies—The pattern of bad faith dealing pursued by Mr. Bengston at Pacific Re involved obvious misrepresentation and even outright lies, since his intentional acts did not match his statements to reinsurers. This pattern of conduct was repeated when Mr. Bengston and Mr. Marsh formed Continuity Reinsurance Company to handle business for Integrity Insurance Company.

The fraudulent activities and insider dealing found by the Subcommittee are serious matters that undermine the entire insurance system, in addition to contributing substantially to Mission's failure. The Subcommittee also found significant discrepancies among the sworn testimonies of Mr. Bengston, Mr. Marsh, and other, more credible witnesses who appeared before the Subcom-

mittee. Accordingly, the Subcommittee has referred these matters to appropriate Federal law enforcement and regulatory authorities.

ACCOUNTING AND AUDIT PROBLEMS

Mission's fatal problems were recognizable for several years before its collapse in 1987, yet the company's internal auditors did not detect or disclose its problems to policyholders, shareholders, reinsurers, regulators, or the public. Under the Federal securities laws, Mission Insurance Group was required to have annual independent audits for the benefit of shareholders and the public. These audits also failed to reveal the disaster that was brewing at Mission, and the question must be asked why?

Coopers & Lybrand was the independent auditor for Mission Group during its multiyear period of reckless expansion. Every year until 1984, Coopers & Lybrand gave a clean audit opinion on the accuracy of Mission Group's financial statements. In 1984, the audit opinion was qualified for unknown litigation contingencies, but not for any concerns by Coopers & Lybrand regarding improper reserves or Mission's financial viability.

The Subcommittee's investigation included a review of the Coopers & Lybrand workpapers, as well as an interview with the audit partner in charge of the engagement. With assistance from GAO auditors, the Subcommittee found weaknesses in the Mission audit that helped permit the company's perilous condition to remain concealed. Those weaknesses involved the two key problem areas of inadequate reserves and excessive reinsurance.

Generally Accepted Accounting Principles (GAAP) allow insurance companies to reduce gross claims liabilities on their balance sheets by the amount such liabilities are reinsured with other companies. This accounting treatment has been criticized by the GAO because a company's gross claims exposure in the event of unpaid reinsurance is not shown on its balance sheet. The situation is aggravated at overly reinsured companies like Mission, where risk exposure on the balance sheet is understated while total commissions from writing more and more business are fully recognized in reported income. This reporting quirk provided every incentive for Mission's management to cover deteriorating underwriting results by substantially increasing commission income, and so they did.

Even under current standards, Mission's financial statements did not include material disclosures on its reinsurance activities. The standards require footnote disclosure of total estimated losses, including incurred-but-not-reported amounts, that are to be reimbursed by reinsurers. Not only did Mission Group fail to report any incurred-but-not-reported amounts, but Sayre & Toso did not calculate incurred-but-not-reported reserves at all, and Pacific Re used its ridiculous 5-year incurred-but-not-reported formula. Coopers & Lybrand raised no objection to this departure from Generally Accepted Accounting Principles.

Because incurred-but-not-reported reserves were not calculated or were inadequate, Mission's estimates of reinsurance recoverables were greatly understated. Coopers & Lybrand, however, was basing its assessment of reinsurance collectibility on these incomplete estimates, so the audit firm's evaluation did not measure the actual

ability of reinsurers to pay the $2.2 billion which the Mission receiver is now trying to collect. In addition, Coopers & Lybrand often relied upon the financial condition or reputation of a reinsurer's parent company when determining collectibility, although Mission's legal recourse extended only to the reinsurance subsidiary.

It appears the primary audit procedure used to test losses was to have a Coopers & Lybrand actuary review the client's actuarial computations. According to a 1984 memo by that actuary summarizing his work on Mission over the years, he reviewed only the understated recorded reserve figures, and there were significant differences between his estimates and those of Mission's management. He recommended in January 1983 that an independent appraiser be employed to resolve these differences, but it was not done. He was never asked to review the Pacific Re reserves, and his concerns failed to result in any qualification of the Coopers & Lybrand audit opinions.

The audit partner for Coopers & Lybrand told the Subcommittee that he was satisfied with the scope of the firm's audit, although it did not cover the reinsurance activities at Pacific Re because he considered them to be immaterial. When asked how he verified Mission's extensive reinsurance transactions, he said that he reviewed the file information provided by the company's management. He did not believe it was necessary to confirm that information by directly contacting reinsurers or institutions holding letters of credit as security.

While Coopers & Lybrand defends the sufficiency of its methods, the Subcommittee notes that such "file audits" failed to detect fraudulent activity at the ZZZZ Best Co. and other cases examined by the Subcommittee, and that the audits by Coopers & Lybrand did not alert shareholders and the public to Mission's severe problems.

BENGSTON AND MARSH

The exploits of Mr. Ronald Bengston and Mr. Robert Marsh are worth recounting in some detail. Their activities over a 12-year period clearly illustrate how persons who help inflict a fatal illness at one insurance company can easily move on to inflict the same illness at another company. The Subcommittee is greatly concerned that this "Typhoid Mary" syndrome has caused great damage in the insurance industry, but has not been effectively addressed by the regulatory system.

Although Mr. Bengston and Mr. Marsh were not informative or convincing witnesses during two appearances before the Subcommittee, they were able to convince approximately 75 reinsurance companies to do business with them over a period of several years. There was deliberate misrepresentation involved; however, the Subcommittee's investigation has shown that anyone with a basic knowledge of insurance could have detected the wrongdoing. A large number of state regulatory officials, company officers and directors, independent auditors, and reinsurers all had ample incentive to look for the problems, but they were never discovered. In too many cases, responsible people did not even check because it was more convenient to trust Mr. Bengston and Mr. Marsh.

The end result is that the activities of Mr. Bengston and Mr. Marsh directly helped to kill two major insurance companies, and have been a cause of severe difficulties for many more. Their mismanagement of Pacific Re contributed to the $1.6 billion failure of Mission, with consequent problems for policyholders and participating reinsurers. Their subsequent operations at Continuity Reinsurance Company (Continuity Re) hastened the $300 million collapse of Integrity, with additional problems for its policyholders and reinsurers.

Mr. Bengston took over the operations of Pacific Re in 1974, and Mr. Marsh joined the company as chief underwriter that same year. By 1976, Mr. Bengston was president of the company, which was run as an autonomous subsidiary of the Mission Insurance Group. He held that position until he left in February 1983.

Mr. Marsh became executive vice president of Pacific Re in 1976. He handled all the underwriting of business that Pacific Re managed for its reinsurance pool members, and he reported to Mr. Bengston. Although the testimony of Mr. Bengston, Mr. De Rosa, and Mr. Marioni conflicts on this point, Mr. Bengston apparently reported directly to Mr. De Rosa as chief executive of the Mission Group.

The basic split of responsibility at Pacific Re was for Mr. Bengston to handle customers and relations with the Mission Group, and Mr. Marsh would make the decisions on what business to accept. As a rule, Mr. Bengston was the only Pacific Re official permitted to talk to customers and Mission Group officers. He testified that he performed his duties competently, and ran the operation conservatively.

The management style of Mr. Bengston and Mr. Marsh defies logic and general notions of how to run a business. Most important decisions were made according to how they felt at the time, rather than reasoned analysis and judgment. Some examples will illustrate how they ran the company.

Mr. Bengston told the Subcommittee that he did not get involved in the details of Pacific Re's business, preferring to leave that to Mr. Marsh. Because he trusted Mr. Marsh, Mr. Bengston did not supervise his activities or inquire into the underwriting of specific business. This was similar to the relationship between Mr. Bengston and Mr. De Rosa at the Mission Group, who took a "hands off" approach to managing actual operations at Pacific Re.

In monitoring the affairs of Pacific Re and reporting to Mr. De Rosa and the pool members, Mr. Bengston relied upon the bottom line on financial reports. The substance of the business was apparently unimportant if revenues and earnings looked good on the reports. Many of Mr. Bengston's activities were directed toward achieving that result.

There were no written operating policies or underwriting guidelines at Pacific Re. Mr. Bengston and Mr. Marsh said they considered it to be a subjective business which was not suited to such management controls. Occasionally, they might confer, but periodic management and staff meetings do not appear to have been part of their management style.

It was Mr. Bengston who encouraged Mission Group officials in 1980 to let Mission "front" for Pacific Re. He also arranged for the

establishment of Pacific Reinsurance Corporation in 1980 as a risk-bearing insurance company, with himself and Mr. Marsh as president and executive vice president, respectively. The eventual purpose of Pacific Reinsurance Corporation was to replace Mission as the front for business written by Pacific Re, which meant that Mr. Bengston and Mr. Marsh would control both the MGA bringing in the business and the fronting insurance company that retained the Mission Group's share.

Underwriting was done by Mr. Marsh on the sole basis of his judgment. While he claims to have reviewed submissions carefully and acted conservatively, the results of his efforts were disastrous for Mission and the outside pool members. Subsequent review of his underwriting files has revealed little in the way of independent analysis or verification of information provided by brokers.

There were no detailed reports describing underwriting activities or results which would have enabled anyone to evaluate them. Nor were there any independent underwriting audits of Pacific Re by anyone at the Mission Group. Mr. Bengston testified that he personally never arranged for an outside underwriting audit because he felt the staff at Pacific Re could audit themselves.

One of the major controls used by prudent reinsurers is an audit of the primary insurer's underwriting, claims handling, and reserving practices because the reinsurer's financial well-being is dependent upon them. Although Mr. Marsh told the Subcommittee that he audited ten percent of all the business Pacific Re wrote, others who were there at the time or have audited the files said he did not. There is no evidence available at Mission to support Mr. Marsh's assertion that he conducted audits of primary companies that ceded business to Pacific Re's reinsurance pools.

During sworn testimony before the Subcommittee, Mr. Marsh had great memory lapses regarding the names of any companies or persons associated with his purported audits, though he insisted they were performed. When asked who might have seen or received copies of such audits, Mr. Marsh could only name Mr. Bengston. Mr. Bengston testified that he was sure he would have received such reports, but he could not remember any details or recall a specific name.

Mr. Marsh said his audit reports could be found in the general correspondence files of Pacific Re. Because they dealt with so many companies, he did not want to clutter the underwriting files. Curiously, the Mission receiver was unable to locate the general correspondence files when requested to do so by the Subcommittee.

Mr. Bengston's preoccupation with reported results rather than actual business operations showed itself in Pacific Re's financial reports. Despite his lack of background in casualty reinsurance and the fact that he is neither an accountant nor an actuary, Mr. Bengston made all the key adjustments that masked the company's true state of affairs. The resulting rosy reports kept everyone satisfied until Mr. Bengston and Mr. Marsh decided to leave Pacific Re in early 1983.

The 5-year straight declining balance formula used to set incurred-but-not-reported reserves was a major factor. Mr. Bengston said that he inherited this formula when he took over Pacific Re in 1974, and that he used it steadfastly for 8 years because he "felt

the formula was a correct one." He admitted there was no basis for it other than his feeling because he considered no other incurred-but-not-reported formulas, performed no studies to justify his formula, never reviewed it for adequacy, and never felt that actual losses cast doubt on it as his "best estimate."

The secret and unique discretionary reserve fund was created by Mr. Bengston because he felt it was a "fairer way of reporting" to pool participants, although he did not tell them about it. The discretionary reserve was used to make reported results more consistent. He conceded that his additions and subtractions from the fund were not based on any formula, but were just his best guess.

Other reporting devices were the coding of combined property/casualty policies to reduce incurred-but-not-reported reserves, and the blending of all pool years to offset mounting losses with current revenues. Oral communications and correspondence were also used by Mr. Bengston to enhance Pacific Re's results with its pool members. He told them things that were not true or were misleading to keep them satisfied and available to accept more Pacific Re business.

STARTING CONTINUITY RE

During the fall of 1982, Mr. Bengston and Mr. Marsh decided to leave Pacific Re and the Mission Group to start their own company. They set up Continuity Re as a reinsurance intermediary that would operate the same type of assumed reinsurance pools as they had run at Pacific Re. Instead of being salaried Mission Group employees, they shared fifty-fifty in owning Continuity Re, which would use a fronting insurance company other than Mission. Like Pacific Re, Continuity Re was not an insurance company itself, so they needed no regulatory approval to start writing business.

The company selected as the front for Continuity Re's new reinsurance pools was the Integrity Insurance Company of Paramus, New Jersey. Integrity was a good choice for Mr. Bengston and Mr. Marsh because it relied upon MGA's to write, manage, and reinsure its business, yet the company had not developed an assumed reinsurance operation. In addition, Mr. Bengston and Mr. Marsh knew the management at Integrity because they had reinsured a lot of its direct business with Mission and outside pool members while operating Pacific Re.

According to information produced by its receiver, Mission acquired $28.6 million of Integrity business through Pacific Re. This was high risk coverage that has caused losses far above industry averages. At June 30, 1988, actual losses had already reached over $50 million, and incurred-but-not-reported losses had not yet been calculated.

Mr. Bengston and Mr. Marsh apparently felt so good about their relations with Integrity's management that they solicited a $500,000 line of credit to start Continuity Re while they were still Mission Group employees managing Integrity business. Integrity loaned the money to them personally with no collateral requirement. With the money, they obtained plush offices in Pasadena, California, signed a management agreement with Integrity, and started writing business in mid-1983.

Continuity Re was run exactly the same as Pacific Re, including the use of the same unsupported 5-year incurred-but-not-reported formula that Mr. Bengston "felt" was correct. The company was even more autonomous than Pacific Re because it was a private firm, and Integrity's management was a continent away. Mr. Marsh also used the same underwriting skills to produce a book of business that was as bad or worse than the debacle of Pacific Re, according to the receiver for Integrity's estate.

The pattern of fraudulent misrepresentation evident at Pacific Re was also continued at Continuity Re. When Integrity's reinsurers alleged fraud in their dealings with Continuity Re as reason for nonpayment of claims, the Integrity receiver asked the New York law firm of Mendes & Mount to investigate and provide an opinion regarding the validity of such charges. The fraudulent behavior found at Continuity Re by Mendes & Mount resulted in its advising the receiver to settle with the reinsurers, and the receiver thus adjusted the claims downward to recover what he could.

There were several examples of fraudulent behavior practiced by Mr. Bengston and Mr. Marsh at Continuity Re. They told reinsurers that the company would only write $6 million of total premiums in 1983 at a time when they already knew that one treaty alone would generate that amount of premium. Mr. Bengston and Mr. Marsh further estimated a total premium volume of $21 million for 1983 and 1984, when in fact gross writings actually made for the same period were between $52 million and $60 million, which greatly increased the exposure of reinsurance pool participants.

After promising not to write previously reinsured business, Continuity Re immediately began writing material amounts of that type of business. Mr. Bengston told the pool members that Continuity Re would only accept small percentages of ten to twenty-five percent on a given treaty to reduce risks. In actuality, Continuity Re accepted 100 percent exposure on the treaties that generated 80 percent of the total premium volume, and these treaties caused the greatest proportion of losses.

In one significant case, Mr. Bengston and Mr. Marsh wrote retrocession coverage that had Integrity reinsuring itself on business developed through Continuity Re. The Integrity receiver testified that this circular reinsurance transaction was so outrageous that it could not have been accomplished by a competent and scrupulous professional. He compared this type of activity by Mr. Bengston and Mr. Marsh with the fraudulent behavior observed by the Subcommittee at Pacific Re and Mission.

The entrepreneurial venture at Continuity Re ended in December 1985 when Integrity's management informed Mr. Bengston and Mr. Marsh that Integrity was finished. Without a licensed insurance company to front for their activities, they were forced to cease doing business after 3 years of replicating the disaster at Pacific Re. The Integrity receiver told the Subcommittee that New Jersey state officials are investigating to determine if civil or criminal violations were involved. The receiver has since filed civil charges against Mr. Bengston and Mr. Marsh for breach of duty and fraud.

PROFITING WITH REINSURANCE AGENCY INC.

The story of Mr. Bengston and Mr. Marsh would not be complete without a description of their relationship with a reinsurance brokerage firm in Chicago named Reinsurance Agency, Inc. (RAI). That firm was headed by Mr. Paul Davies. Mr. Davies and RAI were instrumental in bringing large volumes of high risk business to Mr. Bengston and Mr. Marsh at both Pacific Re and Continuity Re.

Having known Mr. Marsh previously when he was at Allstate Insurance Company, Mr. Davies was the person who linked Mr. Bengston and Mr. Marsh together with two of the largest insurance company insolvencies in history. All three men profited from their mutual dealings regarding Mission and Integrity. Their business relationship over a 6-year period demonstrates how close ties and strong financial incentives to write more business can combine to create huge losses.

In testimony before the Subcommittee, Mr. Davies said RAI was the ninth largest reinsurance intermediary in the United States, and that he had come to own the firm after 27 years of service there. He described RAI's function as representing primary insurance companies that want to reinsure business with other companies. For a brokerage fee ranging from one to ten percent of premiums, RAI finds reinsurers and negotiates price and terms on behalf of the ceding company.

Mr. Davies found a willing recipient in Mr. Marsh for the tough working casualty business RAI was trying to reinsure. As chief underwriter at Pacific Re, Mr. Marsh apparently accepted large amounts of business from RAI based on his personal relationship with Mr. Davies, with little or no independent inquiry. According to information provided by Mission's receiver, over $73 million, or 18 percent, of the total production at Pacific Re came through RAI. Almost all of the Integrity business reinsured with Mission was placed by RAI, and the known losses on that business have been twice as high as the losses on business taken from other brokers.

Mr. Davies introduced Mr. Bengston and Mr. Marsh to the senior management at Integrity. When they sought to form Continuity Re and find a fronting company, Mr. Davies brought them together with Integrity's management for the initial meeting. Ironically, this meeting occurred in RAI's suite at the 1982 regulatory convention of the National Association of Insurance Commissioners in Miami.

From its start in mid-1983 until its demise in 1986, Continuity Re wrote approximately $87 million of business using Integrity as a front. Of that amount, RAI produced $28 million or one-third. Mr. Bengston testified that RAI was the company's largest broker.

Similar to their style at Pacific Re, Mr. Bengston and Mr. Marsh arranged for most of Integrity's reinsurance to be assumed by foreign reinsurers and syndicates of the now-defunct New York Insurance Exchange. Two of these syndicates were recently the subject of insolvency proceedings by the New York Insurance Department. Integrity was the leading creditor of both syndicates, which settled their claims during 1988 for approximately 25 cents on the dollar.

While the companies operated by Mr. Bengston and Mr. Marsh profited from the commissions and management fees earned on the substantial volume of business brought to them by RAI, Mr. Davies and his agency also did very well financially. He told the Subcommittee that RAI received total brokerage fees of $2.7 million from business placed with PRMC and Continuity Re during the period of 1981 through 1986. Mr. Davies defended his dealings with both companies by asserting that a broker has no responsibility to determine whether the business it markets is profitable to the company accepting it.

GOING FOR THE GOLD AT INTEGRITY

The Subcommittee began investigating the collapse of the Integrity Insurance Company after discovering its extensive dealings with Mission and the common element of assumed reinsurance operations run by Mr. Bengston and Mr. Marsh. With cooperation from Integrity's receiver and his outside attorneys, the Subcommittee found that Integrity, like Mission, was a story of rapid growth and even more rapid calamity through extensive reinsurance and reliance on MGA's. Additionally, the experience at Integrity introduced the Subcommittee to a bold scheme of how to profit from an insurance company without knowing much about insurance.

Formed in 1957 as an affiliate of a group of private companies engaged in financial services, Integrity spent its first 20 years serving the needs of institutional lenders from its headquarters in Paramus, New Jersey. By the late 1970's, the company's management decided to expand its operations by selling diverse forms of commercial property/casualty insurance through a nationwide network of MGA's. At that time, Integrity was licensed to do business in all fifty states and the District of Columbia.

Integrity soon became what its receiver called "the quintessential MGA operation" by appointing approximately 80 different MGA's to conduct its business. These MGA's were essentially independent operatives with authority to appoint subagents, issue policies and endorsements, collect premiums, and arrange for reinsurance. Some were also authorized to adjust and pay claims, and to establish loss reserves.

Integrity's MGA's wrote such a wide variety of uncoordinated coverage that the receiver referred to the situation as "twelve insurance companies rolled into one." These coverages included excess and umbrella liability, hospital professional liability, commercial auto and truck programs, personal auto programs, residual values, commercial fire, inland marine, commercial special multiperil, and general liability. In the surety business, there were Small Business Administration programs, contract surety, financial guaranty surety, and numerous special lines, such as workers' compensation and yachts. They also assumed reinsurance from other companies on both a treaty and a facultative basis.

The excess and umbrella business was particularly important because it was the single largest source of premiums and the nature of the coverage was extremely broad. Integrity wrote so much of this business that it became one of the Nation's largest carriers in this area, insuring approximately 300 of the Fortune 500 corpora-

tions and many governmental entities from coast to coast. These policies covered portions of such well-known claims as the Bhopal disaster, the MGM Grand fire, the space shuttle Challenger, Love Canal, Agent Orange, and toxic shock syndrome.

The enormous risks written in Integrity's name by its MGA's were largely reinsured with other companies. The intent of Integrity's management in using the company as a front was to profit from commission overrides received from the reinsurers. By retaining a minimal risk exposure, sometimes as little as one percent, the company's management believed they could profit even with loss ratios exceeding 200 percent.

Basically, the attitude of Integrity's management was to use the company as a cash management vehicle to earn profit on the spread between its commission income and its minimal retention loss payments. Integrity was highly rated by Best's rating service, so its real asset would be selling its reputation and its ability to issue policies nationwide. From this viewpoint, dubious quality and low pricing on the risks covered would be more than offset by the commission income earned on Integrity's large volume of business.

As a result, Integrity's rapid growth was not based on understanding the insurance business, but rather on the belief that financial wizardry could beat the system. By relying on MGA's to operate and manage the insurance transactions, there was no need to develop a sales and support network. Premium growth soared from $33 million in 1977 to over $220 million in 1985.

Who were the wizards that got Integrity into all this? According to the receiver, Integrity's three top executives had no prior management experience in the property/casualty business. These executives failed to hire an adequate staff to monitor and control the MGA's, and they also failed to manage the financial activities that were supposed to be the source of their collective genius.

Like Mission, the rapid expansion of Integrity's business occurred in a soft market, and was based on the presumption that the company's reinsurers would always be willing and able to pay their full share of losses. Also like Mission, Integrity's dependence on reinsurance was destined for disaster because the arrangements were so complex and the numbers were so large. Integrity was a party to approximately 350 reinsurance treaties and thousands of facultative certificates with more than 500 United States and foreign reinsurers, some of which had severe solvency problems.

Not surprisingly, the Integrity receiver reached the same conclusions as Mission's receiver regarding the root causes of insolvency. In testimony before the Subcommittee, Integrity's receiver identified the two basic causes of insolvency as rapid growth through MGA's and unpaid losses from reinsurance programs. Unlike Mission, the situation at Integrity was exacerbated by the sheer number of independent MGA's involved and the failure to install adequate management information systems.

The receiver described how Integrity had embarked on nationwide MGA expansion without ever fashioning a home office structure capable of controlling that program. There was no in-house management information system that could efficiently process the voluminous data generated by the MGA's in diverse product lines. Although Integrity became in actuality a large commercial insurer,

the computer system used by the company right up to the time of its liquidation was a limited one that it purchased to handle personal lines.

Staffing problems were also acute, as exemplified by a general inability to control Integrity's MGA's. There was no staff actuary, a shortcoming that was especially important due to the loss reserve difficulties inherent in the excess and umbrella liability business that was the company's major line. The receiver noted that he could not find anyone at Integrity who had the necessary skills to set reserves.

Clever management of enormous cash flows from the fronting operation was supposed to be the source of profits, but Integrity's management could not even handle the money competently. Approximately 75 percent of the premiums collected by Integrity were paid out as reinsurance premiums to its reinsurers, yet the receiver discovered an inability to accurately bill reinsurers, as well as significant amounts of unbilled reinsurance and balances due from reinsurers. Premiums due from MGA's were chronically late, and these debts were allowed to mount.

Mission was Integrity's largest reinsurer. The Integrity receiver wrote off $19 million of reinsurance due from Mission in 1986, and expects eventual losses from that account to exceed $75 million. None of this will be recovered, as confirmed by Mission's receiver in testimony before the Subcommittee.

There were several instances of Integrity reinsuring itself. This arose from its MGA relationship with Continuity Re, managed by the seemingly ubiquitous Mr. Bengston and Mr. Marsh. In one case involving Northwestern National Insurance Company, they arranged for Integrity to simultaneously reinsure its own direct business through Northwestern and also retain 40 percent less than promised to other participating reinsurers. This maneuver jeopardized the collection of reinsurance from Integrity's reinsurers that were members of Continuity Re's assumed reinsurance pools. The Northwestern reinsurance relationships were also very costly in dollar terms, because the Integrity receiver was forced to settle with Northwestern and its affiliate for a loss of $50 million when those companies ceased writing business.

Integrity was finally placed into liquidation on March 24, 1987 after 3 months of unsuccessful rehabilitation efforts by the New Jersey Insurance Department. The company's receiver estimates the ultimate net cost of Integrity's failure to be $300 million or more. The receiver has concluded that blame for Integrity's rampant mismanagement and inevitable collapse lies with its officers and directors, the officers and directors of its publicly owned holding company, and negligence by Touche Ross & Company, the independent auditors from 1981 to 1985.

In May 1988, the New Jersey Insurance Commissioner filed suit against certain officers and directors of Integrity and its parent company, Yegan Holding Corporation, as well as Touche Ross. The complaint alleges negligent misrepresentation, breach of fiduciary duty, fraud, diversion of corporate assets including the illegal payment of $12.9 million in dividends by Integrity at a time when it was insolvent, and violation of the civil provisions of New Jersey's antiracketeering law. The complaint seeks damages of $300 million.

The Subcommittee was particularly interested in the Integrity receiver's testimony regarding false reporting to regulators and the public. Integrity was the only subsidiary of its parent company, which showed shareholders' equity of approximately $15 million for the quarter ending September 30, 1986. This sum contrasts sharply with an audited report on Integrity done just 3 months later by a new accounting firm employed by the New Jersey Insurance Department. That report showed a capital shortfall of $142 million instead of a $15 million surplus.

Integrity's parent company voluntarily deregistered with the SEC in 1987. The last regulatory report filed by Integrity for year end 1985 showed a net worth of over $20 million. The receiver's investigation found that the company was most likely insolvent under statutory accounting principles by the end of 1981. These findings indicate that violations of Federal and state securities and insurance laws probably occurred for years prior to Integrity's demise.

INSIGHT ON MGA's

The Subcommittee received illuminating testimony regarding the activities of other MGA's from the outside counsel who accompanied the Integrity receiver as a witness. This attorney was, in fact, a licensed MGA himself in Texas. He said the states do not do much to monitor the activities of MGA's, other than administering a basic test to receive a license.

The attorney said the present system is based on the presumption that insurance companies delegating underwriting authority to MGA's will carefully audit and control their activities. The MGA's, however, have strong incentives to operate recklessly or dishonestly because they earn commissions on the volume of business they write, and also earn substantial interest on premiums they collect and hold before paying such funds to the insurance company they represent. The attorney then told the Subcommittee two intriguing stories from his own personal experience.

Around 1979, an ARMCO Steel Corporation subsidiary named Bellefonte Insurance Company lost several million dollars through an MGA in California that wrote assumed aviation reinsurance at below market rates on behalf of Bellefonte. It proved extremely difficult to terminate the MGA's authority to represent Bellefonte because MGA contracts typically provide for prior notice of 90 days or even 6 months before the termination is effective. During the termination notice period, the MGA busily continued to write more underpriced business in Bellefonte's name, and even wrote at least one policy after the notice period expired. Having delegated its underwriting authority, Bellefonte was effectively a hostage to the MGA's whims until the termination process was completed.

In another case, Ranger Insurance Company used an MGA in Huntington, Long Island to write assumed reinsurance. Although Ranger had only $50 million of capital surplus, the losses from business produced by this MGA cost the company over $22 million. When Ranger terminated his contract, the MGA sued the company for breach of contract and for driving him out of business. The legal expenses of defending against these charges were averaging

$60,000 to $70,000 per month, so Ranger's management decided to pay the MGA an additional $2 million just to settle the litigation.

This testimony confirms the Subcommittee's own view that using MGA's can be exceedingly dangerous. Although they may operate for all intents and purposes as insurance companies, the activities of MGA's are not really regulated. Uncontrolled MGA's have been a root problem in every major insolvency studied by the Subcommittee, and the presumption that all insurance companies will control their MGA's is clearly false.

TRANSIT CASUALTY: THE TITANIC OF INSOLVENCIES

Shortly after beginning its Mission investigation, the Subcommittee was told by industry sources that the failure of Transit Casualty Company would be even larger and more ominous in its implications for the insurance industry. The Subcommittee began to explore these charges, and quickly found a willing and cooperative ally in Transit's present state-appointed receiver for liquidation. The receiver, who has termed Transit the "Titanic of insurance company insolvencies," has been very active in seeking the causes and persons responsible for the failure, as well as attempting to coordinate an orderly liquidation.

The efforts of the Subcommittee and Transit's receiver have illuminated a situation that truly merits its description as the biggest and most outrageous insurance insolvency in history. The receiver's estimates of the cost to the public from Transit's failure have climbed progressively from $400 million to $2 billion to his latest figure between $3 billion and $4 billion. He admits that no exact estimate of cost can be given at this time because of disarray and uncertainty in the company's book of business.

What is certain about Transit at this time is that its levels of management incompetence, excessive reinsurance, and reckless expansion through MGA's equal or exceed those observed at Mission and Integrity. The story of Transit's failure also includes the bailing out by its holding company when trouble appeared, and tales of sordid deceit and breathtaking underwriting by certain MGA's. Unlike the Titanic, the captain and the owners of Transit jumped ship before it went down, and left the results of their handiwork to be borne by regulators and the public.

The Subcommittee's investigation of Transit's failure included interviews and testimony from the receiver and his staff, as well as former officers and directors of Transit and its holding company. The independent audit firm was interviewed and its workpapers reviewed. Additionally, the activities of one MGA subagent, Carlos Miro, were carefully scrutinized through document requests, testimony, and interviews in the United States and Great Britain. Subcommittee hearings relating to these matters were held on March 13 and 29, and April 5, 11, and 19, 1989.

Prior to its demise, Transit operated from its headquarters in Los Angeles, California as a licensed insurance company in all fifty states and the District of Columbia. The company was chartered in Missouri in 1945, and its primary business originally was writing commercial property/casualty coverages for motor transportation risks such as municipal buses, charter buses, and long-haul truck-

ing. The move to Los Angeles occurred in the mid-1970's after Transit was acquired several years earlier by the Beneficial Standard Corporation.

The Beneficial Standard Corporation was a holding company for life insurance, property/casualty insurance, and real estate subsidiaries. Although it was a public company with shares traded on the American Stock Exchange, Beneficial Standard was controlled by the Mitchell family which founded the business, and owned approximately 35 percent of its stock. The company was run by Joseph N. Mitchell as president and chief executive.

As a wholly owned subsidiary of Beneficial Standard, Transit shared the same Los Angeles headquarters building with the holding company, and there were several interlocking directors. In 1974, Mr. Mitchell selected George P. Bowie to be President of Transit, and in 1977, Mr. Bowie was elevated to chairman of the board and chief executive officer. Mr. Bowie also continued to serve as Transit's general counsel, a position he had held for many years before becoming chief executive.

The traditional commercial transportation business had been generally profitable for Transit over the years, but it was cyclical and becoming increasing unprofitable due to competition. By 1979, Mr. Bowie and Mr. Mitchell agreed that Transit should expand its operations into nontransportation property/casualty coverages. At Mr. Mitchell's suggestion, Transit also expanded into joint ownership of insurance agencies that wrote such business so that Transit might share in commissions as a producer to offset underwriting risks.

During the 1979–80 timeframe, just as the soft market was beginning, Transit made a dramatic departure from its traditional business by embarking on two new programs which became known as Risk Management and Mercantile Multi-Peril. A new division, called the Risk Management Division, was formed to handle these fronting and related risk coverage programs. The Transit receiver told the Subcommittee that this major move from the transportation business foretold the ultimate doom of the company.

Like Mission and Integrity, the management of Transit decided to expand rapidly into unknown business areas through the use of MGA's. The underwriting risk was considered minimal because Transit would primarily be used as a front to write business in return for a fronting fee from the MGA's, who would then reinsure the business with other companies. The head of the Risk Management Division described the program in 1981 as follows: "Risk Management was established to diversify Transit's product mix to build on Transit's claims-handling expertise, and to position the company to take advantage of the changes in the purchase and management of commercial insurance which will occur in the 1980's." With its top rating from A.M. Best to attract new business, Transit appeared perfectly suited to pursue its program aggressively in the face of an ever-softening market.

One company official noted at the time that it seemed "too good to be true," and of course it was. Transit's bold leap into Risk Management quickly became a foolish flight from reality. Mr. Bowie and the Transit board simply ignored two fundamental flaws in their plan. The first was Transit's enormous credit risk that its re-

insurers would be unwilling or unable to pay, and the second was that Transit was completely unprepared to handle the incredible volume of Risk Management business produced by the MGA's.

Transit sold its commercial transportation policies traditionally through 200 independent agents who generated 500 to 800 policies per year in a product line the company understood. To a large extent, these policies and related claims were processed manually, and the company's procedures and controls were geared for low volume transactions. For reinsurance, Transit used a single well-known company located in the United States.

During the Risk Management era from 1980 to 1985, Transit used 17 MGA's and approximately 1,000 subagents to write high risk coverages in product lines such as fire, marine, medical malpractice, auto liability and property, aircraft, surety, toxic waste sites, satellite launches, liquor liability, taxi drivers, race horses, and assumed reinsurance. The number of policies written skyrocketed, with the business plan calling for 37,000 policies in 1981 alone. These policies were reinsured by the MGA's with 1,200 to 1,400 other companies, which were primarily offshore and unauthorized to do business in the United States. All this activity produced massive records in 256 locations throughout the United States, and the 70 percent recovered so far by the receivership are stacked eight feet high and cover 20,000 square feet.

In testimony before the Subcommittee, the Transit receiver described the impact of the Risk Management program on the company. Direct premiums soared from $93 million in 1979 to $227 million at the end of 1984, the height of the expansion era, while assumed premiums grew tenfold from $5 million to $51 million. Premiums paid by Transit to its reinsurers rose dramatically from $23 million to $217 million during the same period. Most of this growth occurred during a time when Transit's statutory capital hovered just below $44 million. The receiver observed that these numbers are drawn from Transit's statutory annual reports, which bolstered the company's apparent financial condition as a result of faulty accounting and recordkeeping.

In fact, Transit's financial situation was perilous from the moment it unleashed its army of MGA's to write volumes of new business in Transit's name. The MGA's were given no underwriting guidelines, and their activities were not monitored. Because there was a 6 to 8 month time lag for the MGA's to report premiums, Transit could only wait to see where it stood. When the reports did begin to arrive in a flood, the company had no adequate computer system to process them.

By the end of 1983, the reinsurance operation was out of control. The MGA's signed up subagents and reinsurers without any approval by Transit that they were soundly managed and capitalized. Transit had no master list to record all the blank policies that were furnished to MGA's, or to determine what policies had been written, so there was no way to reconcile premiums to individual policies. Thus, the information used to develop Transit's financial statements was incomplete, inaccurate, and outdated. The receiver testified that Transit was insolvent at least by yearend 1984, and that its financial statements were materially misstated for 2 or 3 years before then.

Although based in California, Transit was under the regulatory authority of Missouri because it was chartered and domiciled in that state. The scheduled examination of Transit for the 3 years ended December 31, 1983 was commenced on September 10, 1984 by the Missouri Division of Insurance, with participation by examiners from Delaware, Georgia, and California. The examination report was released on April 15, 1985, and the Missouri regulators ordered Transit to stop writing new policies. After being placed into rehabilitation by Missouri in November, 1985, the company went into final liquidation by court order only weeks later on December 3, 1985.

GIVING AWAY THE PEN

Transit's complete reliance on 17 MGA's and 1,000 subagents to implement the Risk Management program provides a textbook case of the myriad problems that can occur in such situations. As described by the receiver, it was as though Transit gave away its "pen and checkbook" and said, in effect, "go write". Basically, the company handed its future and its solvency to a large band of uncontrolled and uncoordinated salesmen driven by the desire to earn commissions on their sales volume.

The MGA's and subagents were granted authority that was broad even by MGA standards, and they operated for all practical purposes as separate insurance companies. Transit delegated its authority to underwrite, issue policies, place reinsurance, adjust and pay claims, collect reinsurance recoverables, and handle cash and investments. The MGA's were also responsible for setting the amount of security required to be posted by reinsurers, and to obtain the necessary letters of credit from them.

To be successful, the fronting program needed adequate fronting fees and security to guarantee payments by reinsurers, but Transit achieved neither of these imperatives. The bulk of the premiums, about $457 million, went to several hundred unauthorized reinsurers in 30 foreign countries, including Great Britain, Germany, France, Switzerland, Italy, Japan, China, Romania, Venezuela, Brazil, Argentina, South Africa, and Singapore. Transit's receiver is now attempting to recover $400 million to $800 million from those reinsurance companies.

Through the magic of reinsurance accounting, Transit's MGA's were able to write unbelievable amounts of coverage in the name of a company with capital surplus of only $44 million. These enormous liabilities were simply removed from Transit's books when reinsured, as if they had disappeared. More business could then be written to generate more commissions.

Two of Transit's MGA operations deserve special attention. They were the largest operations, as well as the best examples of the behavior that caused Transit's downfall.

1. Muldoon and Miro

On January 1, 1981, Transit entered into an MGA agreement with Donald F. Muldoon and Company. Mr. Muldoon was supposed to be an expert in arranging for insurance with offshore "captive" companies, generally located on islands in the Caribbean where

regulation is minimal. The concept behind such captive insurance companies is that large corporations will have equity ownership, tax-deductible premiums, and control of the company that insures their commercial risks. Transit had its own equity interest in Mr. Muldoon's agency, and gave him full authority to do business in Transit's name, and appoint subagents to do the same.

Mr. Muldoon exercised his authority on January 31, 1981, by granting Carlos I. Miro complete powers as a subagent to represent Transit, with a maximum insurance limit of $10 million per occurrence, no limit on Transit's retention, and no constraints on the types of coverages he could write. Although only 26 years old, Mr. Miro had already spent several years in the industry and with Alexander & Alexander, a large insurance brokerage firm which he left because he "wanted to be a millionaire." Transit relied upon Mr. Muldoon's judgment in selecting Mr. Miro and other subagents.

Mr. Miro immediately seized his big opportunity for great wealth by establishing a business empire in the United States and offshore that could take money from Transit at each step of the insurance process. His empire was quite successful at reaping millions of dollars as a result of ignorance, incompetence, and illusion on the part of Transit, Mr. Muldoon, and the regulatory system. Mr. Miro's activities also raise serious questions about the integrity and competence of certain corporate customers, brokers, and reinsurers in both the United States and London.

The first part of the empire was Miro and Associates, Mr. Miro's private firm in Dallas, Texas, that was granted full authority to represent Transit by Mr. Muldoon. With Transit's "pen", Mr. Miro staffed his firm with former colleagues from Alexander and Alexander, and began aggressively writing high-risk commercial coverage at whatever price the customer would pay. Worker's compensation and general liability coverages were favorites, and Miro and Associates took a six percent commission on every premium received for a Transit policy.

After paying Transit and Mr. Muldoon each a 4.5 percent fronting fee for providing his ticket to fortune, Mr. Miro reinsured the business written by Miro and Associates 100 percent with an offshore captive reinsurance company. At first he used Southern Oil Insurance Limited, a legitimate captive established to serve oil producers, but its requirement of equity ownership precluded writing the volume and types of business Mr. Miro desired. That problem was overcome by starting his own "captive", Lafayette Reinsurance Company, in the Cayman Islands, where regulation is so lax that it is a crime to ask who owns an insurance company. Lafayette was simply a legal shell company that would theoretically act as primary reinsurer, and accept any coverages written by Miro and Associates. Lafayette was later moved to the Isle of Man, a tax haven off the coast of Great Britain.

Having his own unregulated captive reinsurance company enabled Mr. Miro to keep another 65 percent of the premiums Miro and Associates collected in the name of Transit. Lafayette was supposed to pay the first $100,000 to $250,000 of every claim filed with Transit on such policies, but in practice the whole operation was run by Mr. Miro in Dallas, apparently without even a separate

bank account for Lafayette. Mr. Muldoon knew about Lafayette. Nevertheless, he did nothing to prevent the obvious conflicts of interest inherent in Mr. Miro's representing and handling all the money for both Transit and Lafayette.

Mr. Miro had developed a reputation for having connections at Lloyd's of London to arrange excess of loss and aggregate stop loss reinsurance for Lafayette and other captives. These coverages were intended to protect Transit if captive primary reinsurers such as Lafayette could not pay their claims. Lloyd's involvement and reputation enhanced Mr. Miro's credibility in selling his schemes and products. The agreement with Transit called for $20 million excess of loss protection on any claim beyond Lafayette's share, and $1 million aggregate stop loss protection if the accumulation of first level claims threatened Lafayette's ability to pay.

As Transit's agent, Mr. Miro was responsible for all policy and claims matters, all reinsurance arrangements, all money collections and disbursements, and all records for everything he did. He was also responsible for reporting on how he was doing to Transit and Mr. Muldoon. The situation was custom-made for Mr. Miro's apparent goal to become a millionaire quickly.

Mr. Miro's activities at Miro and Associates, Lafayette, and with Lloyd's of London are best documented by outside audits commissioned by Transit, and by the Subcommittee's investigation. In many cases, records are nonexistent, incomplete, false, or meaningless. The Subcommittee's efforts to obtain documents and testimony directly from Mr. Miro have not yet been successful.

According to Transit's subsequent outside audits, Miro and Associates wrote gross premiums totaling $102 million for the years 1982, 1983, and 1984, but only $60 million was reported to Mr. Muldoon and Transit. Approximately $32 million was paid in claims, and another $10 million for reinsurance. After paying commissions and fronting fees, there appears to be $45 million which remains unexplained. The audit reports describe an operation where records were haphazard, worksheets were destroyed or never existed, promised payments and book corrections were not made, files were "unavailable" or lost, and corresponding numbers did not tally. Key personnel and cash records were kept away from the auditors, while senior management denied obvious irregularities, made farfetched excuses, or simply said "all insurance companies do things this way."

A good example of Mr. Miro's business conduct is his handling of a worker's compensation policy he wrote on behalf of Transit to cover Wal-Mart Stores, Inc. employees in eighteen states during 1983 and 1984. The Wal-Mart deal was brought to Miro and Associates by Alexander and Alexander, the firm which accounted for 90 percent of all his business at brokerage fees averaging ten percent. Although worker's compensation rates are established by state regulatory authorities and are subject to adjustments based on actual experience, Mr. Miro sold such policies to Wal-Mart and other companies at bargain-level flat premiums that he guaranteed would not change.

Mr. Miro arbitrarily set the Wal-Mart premium at $3.5 million per year, which was apparently half of the amount that should have been charged. His agency then filed misleading reports with

state authorities to give the impression that the correct premiums were paid. He collected an additional $884,000 from Wal-Mart covering losses before the policy period, but did not report that amount to Mr. Muldoon and Transit, or pay the related fronting fees.

When a payroll audit of Wal-Mart first informed Transit that a $6 million increased premium adjustment was due, Mr. Miro assured Wal-Mart officials that Transit and state regulators could be satisfied by an illusory transaction that would cost nothing. He then proposed a "payment" from Wal-Mart that would be recorded by Miro and Associates, and then refunded to Wal-Mart the same day by means of a "dividend" from Lafayette. Incredibly, officials at Wal-Mart and Alexander and Alexander agreed to this sham transaction, and it was not completed only because Transit finally revoked Mr. Miro's authority. In subsequent litigation, the trial judge found in his opinion that Mr. Miro and the others knew the only purpose of the fake payment would be to fool Transit and state regulatory authorities.

In response to the outside auditors' further inquiry as to why $8.5 million of documented additional premium was not billed to Wal-Mart, Mr. Miro replied that it did not matter because the policy was sold at a guaranteed cost, which was all that Wal-Mart would pay. He said that policy endorsements, experience modifiers, and audits that justified higher premiums were conducted and filed merely to meet state requirements. Losses from the Wal-Mart policies have cost Transit $22 million, and it is just the largest of many such "deals" where Mr. Miro received average premiums of $400,000.

Mr. Miro's vaunted reinsurance skills were no more sophisticated than his ability to sell half-price insurance. His primary reinsurer, Lafayette, had no separate identity, underwriting knowledge, assets, staffing, or ostensible purpose other than to give Mr. Miro complete dominion over the bulk of the premiums he generated using Transit's name. The Miro insurance empire was essentially a poorly run slush fund in Dallas that used premiums from new policies to pay incoming claims, creating the familiar Ponzi-scheme pattern of growth and collapse.

The outside audits of Mr. Miro's companies disclosed that the umbrella reinsurance arranged with syndicates at Lloyd's of London was clearly deficient. About one-third of the 336 risks to be covered were not reinsured at all, and reinsurance payments for those covered were sporadic, delayed, and improperly documented. By the end of 1984, excess of loss recoveries were only $2.2 million of the $5.3 million due, and no claims had been made for aggregate stop loss payments. Mr. Miro admitted to auditors that such reinsurance recoveries were due, but expressed concern that filing the claims would cause the aggregate stop loss carrier to cancel. The audit firm concluded that Mr. Miro had failed to provide both the breadth and amounts of umbrella coverage promised to Transit.

The Subcommittee interviewed the Lloyd's broker and the lead underwriter who dealt with Mr. Miro on Transit's reinsurance. One participant said that Mr. Miro was well known in the London market for his combination of gobbledygook and pompous jargon, called "Miro-speak," that was used to convey an aura of real mean-

ing to otherwise incomprehensible statements. They confirmed that reinsurance had indeed been placed and would be honored according to its terms, however, they were not in a position to judge whether the reinsurance was adequate. The Transit receiver has been unable to make aggregate stop loss claims because the dismal records kept by Mr. Miro prevent calculating the amounts due and providing the supporting documentation.

Since Mr. Miro had originally sought aggregate stop loss reinsurance at Lloyd's for Gulf coast oil producers, he dealt with a marine lead underwriter who eventually accepted the many nonmarine risks, such as Wal-Mart, added on a seemingly daily basis by Mr. Miro. Mr. Miro became a member of the underwriter's syndicate, and arranged for Transit to completely reinsure all of the syndicate's aggregate stop loss business, including the 30 percent that came from Transit. The Transit receiver called this deal a "looping" transaction because Mr. Miro secured the lead underwriter's participation in Transit business while completely removing the risk to his syndicate back to Transit. The underwriter denied any connection between his syndicate's reinsurance of Transit and Transit's reinsurance of the syndicate.

Neither the Lloyd's broker nor the underwriter inquired into Mr. Miro's background or his combined ownership of the agency representing Transit and the primary reinsurer. Both men said such inquiry was "irrelevant" because their judgments were based entirely on their substantive knowledge of the reinsurance risks accepted, rather than the character of the persons and companies producing the risks. The Subcommittee finds this attitude to be curious, in view of the primary insurer's responsibility to keep records and administer policies that ultimately determines the Lloyd's reinsurance syndicate's share of premiums, claims, and its profitability on risks covered.

Mr. Muldoon and Transit's management completely failed to exercise oversight or control of Mr. Miro's activities. The Transit receiver recovered $25 million for breach of duty by Mr. Muldoon and Mr. Miro, but that amount is just a small part of the losses caused by Mr. Miro and other subagents in the $300 million MGA operation run by Mr. Muldoon. Mr. Miro's use of fraud and deception to reap million of dollars from Transit did not require skill or brilliance; it only required that he pursue his objectives, unfettered by any sensible controls or inquiry by those foolish enough to give him such an opportunity. As Mr. Miro observed to one attorney for a major insurance company, "If they are dumb enough to let me get away with it, they deserve what they get."

2. National Underwriting Agency

National Underwriting Agency served as an MGA for Transit from 1979 to 1985. Based in Chicago, Illinois, the marketing strategy for this MGA was to write excess and surplus lines insurance for Fortune 500 companies. Basically, National Underwriting Agency wrote coverages for classes of business which were not available from the direct insurance market during that period of time. Among the insured were drug companies, asbestos manufacturers, and hospitals.

According to Transit's receiver, the scope and amounts of business written by National Underwriting Agency were simply incredible. Over a 6-year span, this single agency wrote more than $31 billion of liability, property, and assumed coverages for Transit. The National Underwriting Agency marketing plan had Transit participating in predominantly general, products, and professional liability insurance in the low level coverages where most claims occur.

An independent actuarial evaluation commissioned by the receiver found that the business written by National Underwriting Agency was extremely risky, and was not well balanced among various industries. With high concentrations in particular industries, a catastrophe striking a single industry often affected Transit adversely on a number of individual companies that were covered. Examples include asbestos, environmental pollution, and products liability coverages. The evaluation predicted that Transit's losses arising from National Underwriting Agency's activities alone could reach $2.4 billion, causing the receiver to raise his estimate of total losses from the company's failure to a range between $3 billion and $4 billion.

Transit owned 37.5 percent of National Underwriting Agency, and Transit's top two officers were on the agency's board of directors. The remainder of National Underwriting Agency was owned by H. S. Weavers, Weavers Holding Company, London United Investments, and the agency's managing director. According to the receiver, all the companies owning National Underwriting Agency profited from their commissions on the huge volume of insurance and reinsurance produced by the agency. The receiver points to the National Underwriting Agency operation and its tremendous losses as a major reason for describing Transit as an out-of-control financial calamity.

COLOSSAL MISMANAGEMENT

Why did Transit's management abandon the company's traditional business to gamble its future on MGA's writing unknown lines of business, with no effective controls or support systems to justify any reasonable hopes of success? This question is even more compelling when viewed against a background of repeated warnings to management that Transit was headed for disaster. There were no apparent changes in the company's ownership or management which easily explain its swift descent into reckless and irresponsible behavior.

The Subcommittee sought to answer this question by inviting the testimony of Transit's former chief executive, Mr. Bowie, as well as the testimony of Beneficial Standard's former chief executive, Mr. Mitchell. The assumption was that the chief executives of Transit and its holding company were in the best position to explain why the sudden and wholesale transformation from traditional insurance company to big-time risk taker occurred. A review of their testimony, however, indicates that neither Mr. Bowie nor Mr. Mitchell was in control of Transit's activities at the time, even though the record demonstrates otherwise.

Although described by themselves and others as "hands on" managers who knew what they were doing and what was going on, Mr. Bowie and Mr. Mitchell told the Subcommittee that Transit's fate was determined by management structures and committees, boards of directors, shareholders, MGA's, and other ill-defined forces that somehow swept these chief executives into a whirlpool of events that ended in insolvency. Mr. Mitchell described himself as a victim whose family lost $13 million in a business he never really understood, despite the fact he was the senior officer managing the family-controlled holding company that owned and operated Transit for over 20 years. As chief executive of Transit, Mr. Bowie said he spent 80 percent of his time performing general counsel duties, and that he had no reason to question his presumption that the Risk Management Division and others were taking care of problems discussed in management meetings. In response to Subcommittee questions, both men agreed they were adequately informed about Transit's activities, and were responsible for inquiring into the company's problems and correcting them.

The testimony of Mr. Bowie and Mr. Mitchell differs substantially from the documents and accounts provided by the receiver and former employees of Transit. These sources portray Mr. Bowie as the driving force in establishing the Risk Management programs and the MGA network, with the full involvement and approval of Mr. Mitchell. The receiver further described repeated warnings of serious problems to top officials at Transit and Beneficial Standard, who failed to heed them or take action.

Transit hired a consulting firm to advise the company on how to implement its diversification into the Risk Management programs. In a May 1981 report, the consultants told Transit that major changes would be needed to manage such a shift in its business, including highly automated administrative support systems and effective program controls for the MGA's and the reinsurance operations. These recommendations clearly anticipated the problems that ultimately killed Transit, but they were never implemented.

Warnings from senior officers inside the company also began in 1981. The vice president responsible for financial and accounting administration wrote a memorandum stating that Transit was not prepared to handle the high-volume Risk Management programs. It said, "Turning on the spigot for this kind of business, before the administrative and processing systems are in place, is an invitation for trouble." This same officer wrote a follow-up memorandum 1 year later, saying: "The Company's lack of written procedures, lack of managerial controls, and lack of expertise in setting up new operations jeopardize any smooth transition into high-volume processing operations. Fronting may have no risks associated with it from an underwriting view, but as you know, it does have a financial risk. Agents and reinsuring entities must be financially sound. Where they are not, practices start appearing which expose the primary carrier to significant risk."

Transit's dangerous new directions were also described by the executive vice president of Risk Management in a 1982 memorandum to management as follows: "We are entering areas where we don't belong. We have picked up programs which have historically been unprofitable industrywide, and provided coverage where most com-

panies wouldn't participate. We really don't have the background or experience in some of these areas and, frankly, it scares me."

Additional warnings started in 1983 when Transit employed a leading reinsurance audit firm to review the MGA operations of Mr. Muldoon, Mr. Miro, and other producers. The managing partner of the audit firm sent Mr. Bowie a personal letter in May 1983 outlining a series of problems that would plague Transit throughout the Risk Management era. These included improper reporting of premiums, no review of loss reserves or incurred-but-not-reported loss calculations, processing backlogs, no audits or control of producers, and weak or insolvent reinsurers. The letter concluded, "In summary, I am very worried since the Transit policies are up front, the captives in some instances are under capitalized, and controls are practically nonexistent." Subsequent audit reports from the same firm continued to emphasize the growth of such problems through 1985.

Mr. Bowie received yet another personal warning in August 1983 from the head of one Transit MGA that was apparently soundly managed. The agent told Mr. Bowie that Transit could soon lose its MGA network due to a ratings drop by A. M. Best Company and the problems caused by Mr. Muldoon. He said, "I feel it's my obligation to do everything I can to keep everything running well here, even if it means writing a letter I wish I didn't have to write. By this letter, it is my hope to persuade you to do something NOW to change the course of things."

Beneficial Standard and Transit also were informed many times by the holding company's independent audit firm, Touche Ross and Company, about Transit's administrative and control deficiencies. Starting in 1979, Touche Ross pointed out important weaknesses in policy controls, outstanding agents' balances, data processing, reinsurance matters, improper accounting, and MGA procedures. Certain problems were identified as unresolved for as many as 5 years. By 1984, Touche Ross threatened to qualify its audit opinion for Beneficial Standard because Transit's operations could not be adequately measured.

When asked about these constant warnings from reputable sources inside and outside the company, Mr. Bowie dismissed them as merely the suggestions, opinions, and concerns of auditors and people who did not understand the real business of Transit. He similarly expressed impatience and indignation with the Subcommittee's questioning of his activities as chief executive, saying that he was better qualified to judge his performance after 31 years with Transit. Showing no remorse or embarrassment over the extensive record of gross mismanagement, incompetence, and inaction during his stewardship of the company, Mr. Bowie assailed the Transit receiver for overstating the degree of the insolvency, and for not having proper qualifications to handle the enormous problems bequeathed to him by Mr. Bowie and Beneficial Standard.

The Subcommittee found Mr. Bowie's arrogant defense of his management to be instructive of the attitudes that produce such debacles, but unconvincing regarding the causes of Transit's failure. As an example, Mr. Bowie testified that he fired the first head of the Risk Management Division in 1984 because that officer could not manage the MGA and reinsurance programs. Mr. Bowie then

installed the president of Transit as head of Risk Management when he knew that gentleman was incapable of being a tough manager to run the whole company, a move which Mr. Bowie acknowledged "was not a promotion." Mr. Bowie's judgment in replacing one manager he believed to be incompetent with another he knew to be inadequate at Transit's riskiest and most troubled division defies any logical explanation, and none was offered to the Subcommittee.

For his part, Mr. Mitchell expressed total confidence in Mr. Bowie's abilities and performance, but he minimized his own role at Transit as a director and chief executive of its holding company. While the record shows his close involvement with Transit, Mr. Mitchell professed to be knowledgeable in investing rather than insurance company management, and his dumping of Transit as a bad investment when it became unprofitable certainly supports that view. Unfortunately, the state guarantee funds, policyholders, and the public have no place to dump the costs of Mr. Mitchell's sour investment which they must now bear.

ABANDONING SHIP

Transit's plunge into writing the Nation's most risky business made it "the home for the homeless," according to one former officer. However, the persons and entities responsible for that situation were not at home when the final crash into insolvency occurred. Mr. Bowie, Mr. Mitchell, and Beneficial Standard had departed after helping themselves to generous cash payments and other benefits. The Transit receiver is now trying to recover these in his $400 million lawsuit against former officers and directors.

A series of well-timed transactions and events permitted Transit's top insiders to escape in very good shape. Many of those transactions appear bogus and are probably illegal, but they had the net effect of keeping the "Titanic of insolvencies" afloat until its leaders had safely abandoned ship. The Subcommittee finds the whole episode an illuminating and discouraging example of the bankrupt management attitudes that produce financial insolvency.

The first suspect transaction was an "aggregate stop loss" agreement with the Clarendon Insurance company. This transaction was actually a loss portfolio transfer prohibited by most state regulators because there is no real transfer of risk. Completed on December 28, 1983, the aggregate stop loss deal provided for Clarendon to put $25.3 million in trust to cover future losses by Transit. In return, Transit gave Clarendon a premium of $16.8 million on January 25, 1984, which Clarendon could invest until the expected loss payments to Transit were required. This deal enabled Transit to boost its reported net income and statutory surplus for 1983 by $4.6 million just three days before the year ended.

The deal with Clarendon kept Transit's reported 1983 capital surplus essentially stable at $43.7 million, compared to the $43.9 million reported in 1982. Interestingly, the aggregate stop loss transaction could not be recognized by Beneficial Standard in its 1983 10-K annual report to the Securities and Exchange Commission, which openly stated there was no significant economic risk shifted to Clarendon. The only apparent purpose of the deal was to

artificially increase Transit's surplus for state regulators. Although examiners in at least three states questioned the transaction, it remained on the books to enhance Transit's picture of solvency.

Transit concocted an even more dubious transaction with Clarendon to inflate reported surplus for 1984. That deal, called a "surety bond agreement", was structured so that Transit paid Clarendon a premium of $8 million in return for Clarendon guaranteeing a $23.8 million shortfall in letters of credit required from Mr. Miro's company and various other unauthorized reinsurance companies. This transaction with Clarendon boosted Transit's capital surplus by $15.8 million on its 1984 annual report to regulators.

The timing and terms of the purported surety bond agreement leave little doubt as to its purpose, but do raise important questions regarding its legal implications. The agreement was not signed until April 1, 1985, but it was made effective as of November 15, 1984, in order to beat a December 1, 1984 deadline by New York regulators prohibiting such deals. On March 28, 1985, Transit unilaterally waived $14 million of Clarendon's exposure, yet the annual report filed with Missouri regulators on March 31, 1985 showed the full $23.8 million effect of the deal. Thus, Transit's 1984 regulatory report fraudulently recognized the full effect of a "bond" that had not been signed, that was shown as having been "issued" more than 4 months earlier, and that had most of its alleged coverage already waived before it was signed and reported.

When the continuing $4.6 million benefit from the 1983 aggregate stop loss transaction is added to the $15.8 million boost from the backdated surety bond agreement, it is obvious that 93 percent of Transit's reported $21.9 million capital surplus in 1984 was nothing more than an illusion based on two sham transactions. Still more curiously, Transit voided both deals to let Clarendon off the hook just a few months before Transit went into receivership. Clarendon paid back the premiums, but the receivership was denied millions of dollars more for the estate to pay policyholders. As to why Clarendon would conclude such deals with Transit, it should be noted that one of Transit's officers served on Clarendon's board of directors, there were prior business dealings and stock ownership, and certain former officers and directors of Transit went to work for Clarendon from 1983 through 1985.

Beneficial Standard had a direct interest in boosting Transit's reported capital because, under Missouri law, dividends may only be paid by an insurance company "from the surplus profits arising from their business." Transit paid Beneficial Standard dividends of $6.5 million in 1982, $5.2 million in 1983, and $4 million in 1984. The receiver told the Subcommittee that these dividends were illegal, since they were paid at times when Transit's directors knew or should have known the company was insolvent.

As Transit's financial position deteriorated, Beneficial Standard and Mr. Mitchell began to separate their good assets from Transit by a clever plan that dovetailed nicely with the events just described. In May 1984, Beneficial Standard's shareholders voted to dissolve the holding company within 1 year in order to gain favorable tax treatment. Beneficial Standard announced in June 1984 that it was ceasing all insurance activities. The holding company sold its life insurance subsidiary immediately for $130 million, but

no buyer could be found for Transit. The remaining assets were spun off into a real estate limited partnership.

The problem faced by Beneficial Standard was that its inability to sell Transit would frustrate the dissolution, and there was a distinct possibility that regulators could tie Beneficial Standard to Transit for years by placing the insurance company's operations under state control. In addition, Beneficial Standard's independent audit firm, Touche Ross, was threatening to withhold a clean audit opinion for 1984 because of the mess at Transit. The problem was resolved to the satisfaction of Beneficial Standard and Touche Ross by simply writing off the $47 million book investment in Transit. Beneficial Standard could then proceed to dissolution with a hefty loss from its Transit investment to offset the gain from selling the life insurance company, and Touche Ross was not required to include Transit in its audit opinion.

Thus, the holding company that operated Transit for over 20 years was able to free its good assets and dump the results of its gross mismanagement on the public by taking a book loss of $47 million for a company with negative liabilities projected to exceed $3 billion. The Clarendon transactions artificially propped up Transit, and helped cover the payment of $15.7 million in dividends to Beneficial Standard while the process evolved. Financial statements for the two companies reflected the anomaly of the situation, with Beneficial Standard's audited report for 1984 showing Transit as worthless, and Transit's unaudited 1984 regulatory report showing capital surplus of $21.9 million.

Mr. Bowie and Mr. Mitchell also did well personally. Beneficial Standard accelerated their stock options in 1984, giving cash payments of $647,000 to Mr. Bowie and $1.3 million to Mr. Mitchell. Mr. Mitchell told the Subcommittee that he is glad to be out of the insurance business, and has no plans to return to it. Mr. Bowie left Transit to join the law firm that served as outside counsel to Transit while Mr. Bowie ran the company, and has since represented reinsurers of Transit against the company, a situation which the receiver has called a conflict of interest. In November 1989, Mr. Bowie was indicted under Missouri law for filing false insurance reports at Transit, and has reportedly resigned from his law firm partnership.

AUDIT AND EXAMINATION PROBLEMS

The Subcommittee found several areas where the audit and examination system failed to detect, disclose, or correct Transit's problems. The most obvious was the dismal lack of internal audit, accounting, and control systems for Transit's MGA's and reinsurance activities. The company operated as a major insurance carrier without a single actuary on the staff or regular outside actuarial reviews. These errors are so glaring that it confounds the Subcommittee how Transit's board of directors or the state regulators allowed them to continue and to grow worse year after year.

Transit is a perfect example of how triennial regulatory examinations can be inadequate. The reckless expansion of the Risk Management era occurred during the 4-year interval between the 1980 examination and release of the 1983 examination in 1985.

During that time, Transit filed false and misleading regulatory reports using financial figures that could not be accurately calculated or verified, and also took improper credit for unauthorized reinsurers. Former Transit employees told the Subcommittee that management's attitude was to file the reports, and leave it to the regulators to find the errors. There is no evidence of any regulatory review that discovered the errors, but if they were found, the only penalty was to restate the information the way it should have been reported in the first place.

Because there was no requirement for Transit's annual regulatory reports to be audited independently, the audits by Touche Ross of Beneficial Standard were the sole outside check on Transit's business. The Touche Ross partner in charge of the audit made it clear to the Subcommittee that the firm's concern for Transit only extended to the material impact of such operations on the financial statements of Beneficial Standard. The audit documents reveal that Touche Ross knew about Transit's problems and communicated the firm's reservations to Transit and Beneficial Standard, however, there was no signal of anything wrong to regulators and the public until Beneficial Standard wrote off its investment in Transit at the end of 1984. A review of Touche Ross workpapers found no evidence of financial review of Transit's reinsurers, no use of an actuary to evaluate reserves, minimal checks on the controls used by MGA's, and a reliance on Transit's small net retention of business written to measure the company's ultimate exposure for losses.

CARLOS MIRO AND ANGLO-AMERICAN

The saga of Carlos Miro does not end with his fraudulent escapades at Transit. After spending a year in London, he returned to the United States in 1986 with an even bolder scheme to create, operate, and plunder a group of insurance-related companies using the name "Anglo-American". Those companies are now insolvent or inoperative, but Mr. Miro and his friends got well over 2 years of financial joyriding before state insurance authorities caught up with them.

The Subcommittee's investigation of these matters encompassed a wide range of interviews and documents, as well as hearings on March 23 and April 5, 1989. The state-appointed receiver for Anglo-American Insurance Company and his outside attorney provided valuable testimony and assistance, and have pursued various legal actions against Mr. Miro and his defunct companies. The resulting story of the rise and fall of the second Miro empire reveals new levels of personal profiteering through unprincipled manipulation of the insurance process.

Mr. Miro's first step was to receive a license for his very own insurance company in Louisiana on August 26, 1986, only 2 weeks after the Anglo-American Insurance Company was chartered and his application was filed with the state insurance commissioner in office at that time. This hasty approval was perhaps due to Mr. Miro's generosity to the insurance commissioner and other political figures in Louisiana. The Subcommittee found evidence of several Anglo-American payments, including $25,000 in laundered political

contributions to the commissioner, three payments of $18,750 each to the former Governor for unexplained "professional fees," and $132,000 for "consulting fees" to a close political associate of the former Governor and the insurance commissioner. Although it normally requires a track record of 3 to 5 years to qualify in another state, Anglo-American was licensed to do business in Georgia 6 months later.

According to the receiver for Anglo-American Insurance Company, the company was used as a "cash cow" to generate premiums that could be siphoned off to other Miro-controlled companies for Mr. Miro's personal benefit. There were three other Anglo-American entities primarily involved in this scheme to defraud, demonstrating a penchant for like-sounding names to confuse regulators and the inquisitive. More than 25 shell companies were later found in the Anglo-American files, waiting to be used when convenient.

Residing in Dallas, Mr. Miro created a series of companies in different locations to control the Louisiana insurance company, which helped to keep the company's dealings, records, and funds beyond the reach of regulators. The stock of Anglo-American Insurance Company was owned by Anglo-American Underwriters, Inc., a Texas holding company that later changed its name to Anglo-American Group. The Texas holding company was in turn owned by an entity called Anglo-American Trust Company, plc, domiciled in London, England. Anglo-American International Reinsurance Company was established in Dublin, Ireland to funnel reinsurance premiums back to Mr. Miro.

The initial $1.5 million capitalization for the Louisiana insurance company came from the Texas holding company, which obtained the money from the London parent company. A simple business plan was set forth for the insurance company: write deferred-loss casualty business as fast as possible in order to accumulate substantial cash that could be transferred to the owners before big losses developed. Anglo-American immediately began implementing this plan by writing worker's compensation and a small amount of general liability insurance in Louisiana and Georgia. Between August 1986 and January 1989, when the company was placed in rehabilitation, Anglo-American received over $56 million in premiums. The company's receiver told the Subcommittee that it is highly unusual for legitimate carriers to specialize in worker's compensation coverage because underwriting profits are so minimal, but the business is perfect for raking cash in quickly.

Mr. Miro operated his Anglo-American empire with assistance from his attorney and a few close associates, most of whom had been involved in his Transit activities. Three basic methods were used to raid the cashflow generated by the insurance company. The first was excessive personal and business expenses, the second was fraudulent reinsurance, and the third was phony transactions within the holding company structure. Combined together, these methods resulted in at least $20.8 million being improperly or illegally diverted from Anglo-American Insurance Company.

From its headquarters in a posh new Dallas office building, Mr. Miro's Texas holding company completely ran the affairs of the insurance company in return for 15 percent of the gross premiums. Anglo-American Insurance Company was nothing more than a

name, with no employees, no payroll, no office space or equipment, and no expenses. For its "management" services, the holding company received $8 million of the total insurance premiums, plus giving itself an unjustified $565,000 windfall overpayment. The office door was even adorned with a "Better Business Bureau Member" emblem.

Dating back to his Transit days, Mr. Miro has demonstrated no competence or skills relating to legitimate insurance matters, but he has truly mastered the ability to lavish vast amounts of policyholder money on himself. This pattern was repeated at Anglo-American where he was paid an annual salary of $600,000 for 1988, plus an expense allowance of $120,000. He received an additional $177,435 from Miro, Irion and Vaughn, Inc., one of the companies used to control the insurance company and milk its resources.

At Anglo-American's expense, Mr. Miro was chauffeured around Dallas in a Cadillac limousine. He joined an exclusive private club, and frequently flew to resorts and around the country on a chartered Learjet with acquaintances. In Dallas and London, Mr. Miro stayed at the finest luxury hotels. Most of Anglo-American's real estate investments were devoted to his personal comfort, including Mr. Miro's $1.4 million residence and a $1.4 million luxury condominium in Dallas that was remodelled for $600,000.

Other questionable transactions involve a $316,500 unearned MGA commission to a Miro affiliated company, a $550,000 loan for his attorney to purchase a residence in a private community, and a $60,000 loan to the exwife of a former company president. Another $155,000 unsecured loan went to a company official for his investment company. At Anglo-American's direction, he repaid the insurance company loan directly to the holding company for its benefit.

Reinsurance was a second way of looting the assets of Anglo-American Insurance Company. Mr. Miro followed his tested formula at Transit by making his Dublin captive company the primary reinsurer for the insurance company, and also using Lloyd's of London to place umbrella coverage and gain credibility. According to the Anglo-American receiver, the insurance company paid reinsurance premiums of $3.9 million directly to Anglo-American International Reinsurance Company, and another $1.1 million to the parent trust company in London. The receiver has reinsurance claims totaling $4.2 million so far, but has been unable to collect a single penny, or to determine if the Dublin reinsurance company really exists. A total of $1.95 million in premiums were paid by Anglo-American Insurance Company to syndicates at Lloyd's of London, earning commissions of approximately $150,000 for the Texas holding company.

As an unauthorized offshore reinsurer, the Dublin company was required to post letters of credit as security for payment of its claims, but none were posted. This failure took a bizarre twist when the Louisiana insurance company actually posted a $1.5 million letter of credit for the benefit of the Dublin reinsurance company. This $1.5 million was wired to the reinsurance company's London bank in June 1988, even though at the time the reinsurance company owed more than $3 million to the insurance company. Mr. Miro indicated to the receiver that the transfer of funds to London was an error, and promised the money would be returned,

but it never was. Anglo-American is the first insurance company known to the Subcommittee that has turned the letter of credit system upside-down by posting security for its reinsurer, while receiving no security for its own benefit.

As part of its investigation, the Subcommittee staff visited the purported Dublin offices of Anglo-American International Reinsurance Company during the middle of a business day in May 1989. Other than a brass nameplate on the door of an office serving many businesses, they found no personnel or business activity by the reinsurance company. The receptionist for an unrelated firm told the staff the reinsurance company manager had "been gone for months," and the secretary was "gone for the day." Irish regulatory officials knew nothing about the company.

Loans to affiliates and intercompany transactions were a third method of bleeding funds from Anglo-American Insurance Company. These were accomplished by fraudulent accounting, which was quickly discovered by the receiver when he examined the company's books and records. Many of the transactions occurred during 1988, and the efforts to hide them by cooking the books were amazingly crude.

Mr. Miro's Anglo-American empire was financed entirely with customer premiums. An amount approximating the $1.5 million initial capital infusion into the insurance company was withdrawn in January 1988, a mere 16 months after the company's formation. The funds were wired to the London bank account of Anglo-American Trust Company, and listed in the insurance company's general ledger as reinsurance premiums ceded. In March 1988, the transfer was changed to indicate a purchase of preferred stock, and in June the books were adjusted again to account for the transaction as an unsecured advance.

Finally, in October 1988, an unsecured promissory note for $1,575,000 was given to the insurance company by another Miro-controlled company, Miro Irion Ventures, Inc., to cover the money that was wired to the London parent company in January. The unsecured note purportedly represented the price paid by Miro Irion Ventures, Inc. to purchase control over the insurance company from the London parent company. In reality, this complex deal simply meant that policyholder money was used to finance a takeover of the insurance company operations by one Miro-controlled entity from another Miro entity. There have been no payments to the insurance company on the unsecured note.

By the end of 1988, unsecured loans by the insurance company to Miro-controlled affiliates exceeded $12 million, including the $1,575,000 transaction just described. Except for the unsecured note of Miro Irion Ventures, Inc., none of these advances were evidenced by a promissory note. The cash for such "loans" came from policyholder premium deposits that were supposed to be safely invested. According to the insurance company receiver, this self-dealing was covered by filing false and misleading reports with Louisiana regulatory authorities. Bank loans used to inflate the insurance company's reported capital by $9.3 million were also fraudulently hidden from the regulators. Servicing these loans drained $775,000 from the company every month.

The incredible wrongdoing by Mr. Miro and his associates was uncovered by a state regulatory examination that commenced on August 15, 1988. The new Louisiana insurance commissioner ordered an examination only a year after the first examination was completed. The examiners soon recognized the severity of Anglo-American's problems, and it was apparent that the company was insolvent. The company was placed in rehabilitation on January 25, 1989, and then into liquidation on March 20, 1989.

At the time of liquidation, Anglo-American Insurance Company had a negative net worth of more than $19 million. The receiver told the Subcommittee that losses would have been far greater if the state examination had been delayed. Mr. Miro sought approval to avoid the company's demise by infusing additional capital into the operation. State officials refused his offer when they saw the new "capital" consisted of encumbered penny stocks and thinly traded securities that were to be rented from third party investors. The present Louisiana Commissioner of Insurance has sued Mr. Miro and his various companies for $38.5 million, alleging bad faith and breach of fiduciary duty to Anglo-American Insurance Company.

MORE ON MR. MIRO

Mr. Miro's insurance career has been marked by excessive greed, megalomania, lies, and cynical abuse of the business and regulatory system. Although only 35 years old, he has personally been involved in virtually every major problem area identified by the Subcommittee, including gross mismanagement, uncontrolled MGA's, illusory reinsurance, evasive holding companies, fraudulent pricing, shell companies, conflicts of interest, self-dealing, offshore havens, and false reports. His remarkable record of unprincipled exploitation is matched by the failure of the present insurance regulatory system either to prevent or to punish Mr. Miro's multitude of wrongs, despite the notoriety of Transit and Anglo-American.

The Subcommittee's investigation and hearings have highlighted extensive evidence of numerous violations of insurance laws and regulations by Mr. Miro. In Texas, he operated as Transit's MGA without obtaining a license to perform such services or represent Transit as an agent. His violation of workers' compensation rates and filings apparently occurred in several states. In Louisiana, his sworn application to license Anglo-American contained false statements about his involvement in Transit's problems and even his education. While Mr. Miro claimed to have a masters degree in management science from the University of Texas, university officials told the Subcommittee that he attended the school less than half time for one semester, and was placed on academic probation after receiving an "F" in the course he took.

On the broader issue of fitness to operate or control an insurance business, Mr. Miro's dismal record must surely violate a host of insurance regulations requiring adequate records, secured loans, sound controls, truthful reports, prudent investments, and safe handling of premiums and claims. His "captive" offshore reinsurance companies and failure to post letters of credit were simply a mockery of the reinsurance concept. Using insurance premiums to

finance Mr. Miro's grandiose lifestyle and empire of affiliates constitutes both an illegal diversion of company assets and an affront to policyholders who work for a living. Disregarding his motives, the actual confused and incompetent management of Mr. Miro's businesses documented in audit and examination reports should be reason enough to keep him from handling policyholders' money.

The Subcommittee questions the failure of state regulators to bring any charges or take any actions regarding such obvious abuses of the insurance market in the United States. With no official sanctions to alert the regulatory system of their past conduct, Mr. Miro and his colleagues continue to operate under the accurate claim that they have never been subject to any adverse regulatory findings. If the system cannot deal with the well-publicized and obvious cases, there is little hope that more ordinary violators are being stopped.

The Subcommittee's concerns are well-founded because Mr. Miro has indeed gone back into business. While the Louisiana regulators were still trying to close down Anglo-American, Mr. Miro used the company to guarantee his lease of office space for a new venture, C.I. Miro and Company, in one of Dallas' finest new buildings. A Subcommittee inquiry to the landlord disclosed that extensive office modifications and lease credits were granted to C.I. Miro and Company, which was said to be involved in "reinsurance and insurance company management." Four months later, the landlord called to say the new Miro company had removed its furniture on a weekend and walked away from the lease, leaving the landlord with over $140,000 in unpaid bills. Recent documents indicate that Mr. Miro is starting yet another reinsurance company in the Republic of Ireland.

The Subcommittee is particularly concerned because Mr. Miro has been able to operate with impunity in the United States without being a citizen or otherwise available to appropriate government authorities in this country. He moves in and out of the United States with apparent ease to conduct his insurance schemes and send policyholder money offshore, but has remained in London, England to avoid directly responding to official inquiries regarding his business dealings. Occasionally, he issues press releases from London to express his opinions, such as a September 27, 1989 statement blaming criticism of his activities on "politics", and saying that he views events in the United States "with a sense of amusement, disbelief, horror, but mostly chagrin."

In his absence, Mr. Miro has been represented by Mr. J. Albert Kroemer of the law firm of Maloney and Smith in Dallas, Texas. Mr. Kroemer, a close friend and godfather to Mr. Miro's child, has served at various times as personal attorney, company attorney, business associate, and spokesman for Mr. Miro and his companies. During informal communications and sworn testimony before the Subcommittee, Mr. Kroemer has been vague about his own role and remarkably unfamiliar with Mr. Miro's business activities, location, and citizenship. The confusion over citizenship may perhaps result from Mr. Miro's conflicting recent claims to United States immigration officials that he is alternatively a United States citizen, a permanent resident of this country, and a foreign visitor.

The Subcommittee notes that Mr. Miro is the subject of pending investigations by the Internal Revenue Service and the Immigration and Naturalization Service. Based on its investigation and findings, the Subcommittee has requested the Attorney General of the United States to investigate and consider prosecution for any possible criminal violations of Federal laws by Mr. Miro, Mr. Kroemer, and three of their business associates. The Subcommittee will continue to monitor these efforts closely.

THE OMAHA INDEMNITY CASE

During its investigations, the Subcommittee became aware of problems at Omaha Indemnity Company that closely paralleled the situations at Mission, Transit, Integrity, and Anglo-American. The one important difference is that Omaha Indemnity, a wholly owned subsidiary of the Mutual of Omaha Insurance Company, is still solvent because its parent company has recognized a responsibility to protect policyholders and the public from the consequences of uncontrolled MGA's and inadequate operating controls. This commendable attitude contrasts sharply with other cases observed by the Subcommittee.

Omaha Indemnity has functioned since 1967 as a property/casualty insurer to offer individual homeowners and automobile insurance lines as a "door opener" for marketing other product lines offered by Mutual of Omaha companies. These personal lines were augmented by "special risks" written through MGA's as a means of spreading the company's underwriting exposure. Things were going fairly smoothly until a special risk proposal for a fronting arrangement was submitted to Omaha Indemnity in February 1982 by a unit of the Frank B. Hall Company, a large international brokerage firm.

According to documents reviewed by the Subcommittee, the initial Frank B. Hall proposal evolved into a nightmare of abuse by MGA's, dealings among related parties, excessive and complex reinsurance, elusive offshore companies, churning business for commissions, false reports, and insolvent participants. These familiar themes were exacerbated by rampant deceit, encounters with the now-defunct Insurance Exchange of the Americas, holding company dodges, and jurisdiction-hopping. The response of state regulators has been a curious blend of involvement and noninvolvement that has resulted in findings of serious misconduct and a legal "Never-Never Land" of inaction.

Omaha Indemnity's downfall began in June 1982 when the company agreed to act as fronting reinsurer for business produced by World American Underwriters Inc., an MGA based in Kansas City, Missouri. The Frank B. Hall organization was to profit from providing reinsurance brokering and underwriting services, and also was to reinsure 95 percent of that business written in Omaha Indemnity's name with Union Indemnity Insurance Company of New York, a Frank B. Hall subsidiary. Unbeknownst to Omaha Indemnity, Union Indemnity retained little of this MGA business, but instead further reinsured almost all of it with Ocaso S.A., a Spanish reinsurer, and other nonadmitted reinsurers that did not have sufficient financial resources to meet their obligations.

The key to the entire scheme was that World American would only write sound business under limitations issued by Omaha Indemnity. Although it was a subsidiary of the Financial Guardian Group, a Missouri insurance holding company complex, World American was managed by James R. Wining and Willie A. Schonacher, who had limited and questionable credentials to write the proposed business. Nevertheless, Mr. Wining and Mr. Schonacher proceeded to write prodigious amounts of high risk property/casualty business that exceeded both the limits of their MGA authority and the financial capacity of Omaha Indemnity and its reinsurers.

Like Mr. Bengston and Mr. Marsh at Mission, Mr. Wining and Mr. Schonacher soon decided to establish their own private firm to take over the Omaha Indemnity business from World American and Financial Guardian. Like Mr. Miro at Transit and Anglo-American, they chartered a complicated network of interrelated companies in the United States and offshore to take a cut of Omaha Indemnity's premiums at every step of the insurance and reinsurance process. Accordingly, they convinced Omaha Indemnity to sign an MGA agreement with their new firm, Royal American Managers, Inc. in September 1983. Mr. Wining and Mr. Schonacher continued to act as MGA for Omaha Indemnity through Royal American Managers until December 1985, when Omaha Indemnity cancelled the arrangement, and subsequently filed suit alleging fraud, breach of trust, and gross mismanagement.

With the advent of Royal American Managers, Mr. Wining and Mr. Schonacher drew Omaha Indemnity into a web of self-dealing that was truly astounding. A Frank B. Hall affiliate was initially involved as intermediary, but reinsurance for the Omaha Indemnity business was placed with a series of companies owned or affiliated with Kensu Holdings, Inc., a Delaware holding company personally owned by Mr. Wining and Mr. Schonacher. These included Interamerica Reinsurance Corporation of New York, Allied Fidelity Insurance Company of Indiana, Fielding Reinsurance Limited of Turks and Caicos in the British West Indies, and RAM Syndicate and AMS Syndicate, two poorly capitalized syndicates on the now-defunct Insurance Exchange of the Americas in Miami, Florida. Additional brokerage and management fees were earned through two related service companies, Program Administrative Services, Inc. and William Alexander Reinsurance Management, Inc.

The wrongful activities of Mr. Wining, Mr. Schonacher, and their various companies apparently involved failure to exercise underwriting controls, failure to set or accurately report loss reserves, artificially inflated capital surplus, circular reinsurance, writing excluded business, arranging reinsurance that was not negotiated at arms-length, and actually having Omaha Indemnity insure Royal American Managers against lost commission income if the MGA agreement was cancelled. To this list must be added deficient books and records, false financial statements, and reporting on a "cash received" basis that created time lags and disguised the real volume of new business being written. For example, a rental vehicle insurance program bound in late 1984 was reported to Omaha

Indemnity as generating $5 million of premiums in 1985, when the actual volume that year was almost $20 million.

These charges against Royal American Managers and other companies operated by Mr. Wining and Mr. Schonacher were confirmed by an examination commenced in March 1986 by state insurance regulatory officials in Missouri, New York, Illinois, and Nebraska. The state examiners issued a preliminary report in March 1987, and a final report in August 1987. As part of the review process, Royal American Managers objected strongly to the language and findings of both reports, and after an October 1987 meeting between the company's management and state insurance officials, the Missouri and New York regulators withdrew from the examination.

The Illinois and Nebraska regulators proceeded by revising the report as an examination of Omaha Indemnity, and submitting the new report to Royal American Managers in December 1987. After many more months of negotiations, the regulators and Royal American Managers agreed to release the revised report in December 1988 with an attached rebuttal by Royal American Managers to the report's conclusions. The Illinois and Nebraska regulators explicitly stated that they had no authority to discipline or fine the wrongdoing found, and Royal American managers vigorously attacked the two states' authority for releasing the report at all because the company is domiciled in Missouri.

The Subcommittee finds this entire sequence of events to be a disturbing example of obvious gaps in the regulatory system. When state examiners uncover serious problems affecting the solvency and integrity of insurance carriers, yet are unable or unwilling to act, the public is left without the protections it rightfully expects. The very fact that almost 2 years of negotiations were required to issue an examination report which satisfied the demands of Royal American Managers, and that two state insurance commissions dropped the inquiry along the way, sends the wrong message to those who are tempted to abuse the system. This is particularly troublesome in view of the number of insolvent companies involved, the gravity of the charges, and the fact that Mr. Wining and Mr. Schonacher continue to operate insurance businesses.

Insolvency seems to be the fate of several companies associated with the activities of Mr. Wining and Mr. Schonacher. Union Indemnity and Interamerica Reinsurance Corp. have been declared insolvent by the New York Insurance Department. Allied Fidelity is being liquidated by Indiana authorities, and RAM Syndicate, Kensu Holdings, and Fielding Reinsurance have each been found to have negative net worth by state regulators. In addition, Omaha Indemnity would have failed, except that Mutual of Omaha has contributed more than $250 million to keep its subsidiary solvent. Mr. Wining and Mr. Schonacher recently transferred much of their insurance activities to Laramie Insurance Company, a Wyoming company that was licensed under circumstances that "appeared suspicious and questionable", according to a state investigative report.

The Subcommittee notes that Mr. Wining and Mr. Schonacher have also had long and extensive relationships with Carlos Miro and his various entities, including Lafayette Reinsurance. Miro and

Associates appears to have been involved as broker in a substantial number of reinsurance deals that Mr. Wining and Mr. Schonacher made in Omaha Indemnity's name. Mr. Miro was apparently a principal architect of one horrendous insurance program which has cost Omaha Indemnity and its parent more than $80 million in incurred net losses. Omaha Indemnity's active pursuit of its legal claims for wrongdoing by Mr. Wining and Mr. Schonacher has so far resulted in an arbitration judgment of $225 million against Royal American Managers.

GENERAL ACCOUNTING OFFICE FINDINGS

Through testimony before the Subcommittee on April 19, 1989 and in subsequent reports, the General Accounting Office (GAO) has provided valuable assistance regarding the types and dimensions of problems affecting property/casualty insurance regulation. The GAO's findings confirm the Subcommittee's observations that serious weaknesses in the present regulatory system, if left uncorrected, could lead to a public financial crisis rivaling the thrift industry debacle in the United States. These findings are based on GAO's review of insurance regulatory practices involving all fifty states, the District of Columbia, and the activities of the National Association of Insurance Commissioners.

The GAO's findings and concerns can be generally summarized as follows:

1. THRIFT INDUSTRY COMPARISON

The GAO compared the failures of Mission and Transit with 26 of the largest savings and loan institution failures. Of the 11 root causes identified for the failures, ten were the same for both the insurance companies and the thrift institutions. These included multiple regulators and infrequent examinations, rapid growth in risky business areas, poor underwriting, extensive underpricing, excessive reinsurance or loan participations, bad management, and inadequate loss reserves. The only characteristic unique to insurance was the use of MGA's. In addition, there has been a fourfold increase in designated problem insurance companies from 132 in 1979 to 570 in 1988, which raises the possibility of more insolvencies.

2. PROBLEMS IN SOLVENCY EXAMINATION

The GAO found several weaknesses in the area of examining insurance companies. To detect possible solvency problems, state insurance regulators said they rely primarily on annual financial statements filed by licensed insurers and periodic field examinations done by state examiners. However, these statements are filed 2 months after the end of the accounting year and can take 6 weeks to 3 months to review, thus creating a time lag in state detection of a problem condition, and allowing insolvent companies to continue doing business for months. In addition, 35 states do not require independent CPA verification of annual financial statements filed with the state regulators.

Most states require field examinations only once every 3 to 5 years (a few states have no mandatory requirement), and such examinations can take months and sometimes years to complete. In the two largest property/casualty insolvencies of the 1980's, this time lag delayed state action in placing the insurers into receivership. Most states do not require actuarial certification of loss reserves, and half of the states do not have actuaries participating in field examinations.

The National Association of Insurance Commissioners, a voluntary association of state insurance commissioners, assists monitoring efforts with its own Insurance Regulatory Information System, but state officials give the system varied marks in terms of importance and reliability in detecting solvency problems. Insurance regulators in four of the five states visited by GAO have varied opinions as to the system's importance as compared to their own analyses. The National Association of Insurance Commissioners is seeking to improve the quality of the system and has issued a set of standards intended to improve the quality of state solvency regulation, but the results of these efforts are unknown at this time.

3. RESOURCES FOR SOLVENCY REGULATION

Some states may not be allocating sufficient resources to solvency regulation. In a recent survey by the National Association of Insurance Commissioners, 21 out of 51 insurance departments reported difficulties in obtaining adequate funding from their states for their examination staffs. The five states GAO visited had 29 staff available to analyze 6,450 annual statements. officials in two of the five states said that funding shortages prevented them from hiring needed examiners. Moreover, at least 31 states are using some examiners who are underqualified by standards established by the National Association of Insurance Commissioners.

4. INTERSTATE COORDINATION

The GAO asked state insurance regulators what information they would share with other states and the National Association of Insurance Commissioners about a problem insurer located in their state. Only a few states will fully share information and provide regular updates on a financially troubled insurer. Some state regulators told GAO they are concerned that if other states learn about a problem insurer, they might suspend the insurer's license, thus making the situation public and increasing the chances of insolvency.

The National Association of Insurance Commissioners has recently increased its efforts to improve coordination and cooperation among states, but it cannot require states to participate in its activities or make use of its facilities. While three states participated in more than 100 Association-sponsored multistate field examinations from 1984 through 1987, 28 states participated in fewer than 10 examinations.

5. ACCOUNTING PROBLEMS

The GAO said that audit guides used by independent auditors to measure the financial soundness of thrift institutions and property/casualty insurance companies were outdated by many years, and that needed revisions were moving slowly. The failure to show complete exposure for reinsurance on a company's balance sheet was also noted.

6. REINSURANCE

The GAO found that its attempts to measure and evaluate the reinsurance market were greatly hampered by lack of data. This problem was exacerbated by defining what transactions actually constitute reinsurance, as well as the fact that much reinsured business is further reinsured (retroceded) one or more times in ways that are not disclosed in public reports. Reinsurance remains an area where significant additional study is needed.

THE REGULATORY SYSTEM

The Federal government does not presently regulate the activities and solvency of insurance companies. Congress delegated this function exclusively to the states through the McCarran-Ferguson Act of 1945, but current problems could give rise to reconsidering that delegation. During the course of its inquiry, the Subcommittee has had numerous contacts with state insurance commissions and regulatory officials regarding specific insolvencies and general procedures. Almost without fail, state regulators have been very patient and cooperative in providing the Subcommittee with requested information and explanations. This assistance is very much appreciated, and forms the basis for additional cooperative efforts to improve the regulatory system and protect the public.

The Subcommittee has observed a number of serious weaknesses with solvency regulation in the United States. Some of these appear to be inherent in a system which divides the regulation of insurance companies among the governments of fifty states and the District of Columbia. Others seem to derive from inadequate and misallocated resources, as well as an inability or unwillingness to regulate solvency effectively. Some industry participants believe solvency regulation is simply outmoded and overwhelmed by current demands.

Under the present system, each state has an insurance regulatory agency headed by one or more commissioners who are either elected or appointed to office. Insurance commissioners are the government officials responsible for licensing insurance companies, monitoring their activities, and acting as the state-appointed receiver when companies become insolvent. They are also responsible for licensing and regulatory requirements affecting agents, brokers, and other intermediaries associated with the sale and performance of insurance products.

An April 1988 study of insurance departments by the Consumer Insurance Interest Group and the National Association of Professional Insurance Agents concurred with GAO's findings that states are not adequately funding insurance regulation. The study said

that state governments are allocating an average of only .063 percent of their total budgets to regulating insurance, while the average consumer spends nearly one-fifth of disposable income on insurance. Premium taxes on insurance companies are major revenue sources for the states, yet states allocated an average of a mere 5.37 percent of premium taxes received from insurance companies to insurance regulation, down from a seven percent average in 1985. The study recommended that at least 10 percent of premium taxes should be devoted to effective insurance regulation, and pointed to inadequate staffing, low salaries, and deficient examinations as the negative results of poor funding.

Regulatory requirements generally vary according to a company's authorization to do business within a particular state's jurisdiction. Authorized insurance companies are licensed, examined, and file annual financial reports with the state insurance department. A company may be authorized to do business in more than one state by meeting each state's licensing and regulatory requirements, but primary regulation and periodic solvency examinations are handled by the state where a company is legally chartered and domiciled.

Unauthorized companies are neither licensed nor directly regulated by a state, and are restricted to dealing with other insurance companies and writing commercial property/casualty coverages not readily available through the regulated marketplace. Such unauthorized companies may be located in the United States or foreign countries, and they play a major role in reinsuring the business of companies licensed within a state. With no direct regulation of unauthorized insurance companies, states must rely upon financial bonding through letters of credit to guarantee a company's ability to pay claims.

INADEQUATE LICENSING PROCEDURES

Certain procedures for licensing insurance companies are clearly outdated. Initial capitalization requirements, often established by statute, can be very low and easily met. For a few hundred thousand dollars in some states, a company can be licensed to sell a full range of insurance products to the public. The Subcommittee was told that at least one state has permitted nonliquid and inflatable assets such as land to be counted as capital. Thus, a relatively small investment in an insurance company can literally lead to a license to steal, or at least a golden opportunity to reap millions of dollars in immediate cash from a trusting public.

Background checks on the character and competence of persons applying for an insurance license seem inadequate or, in many cases, nonexistent. During its investigations, the Subcommittee corresponded and talked with officials of several state commissions regarding their procedures for verifying the qualifications of applicants. Most of them rely on biographical information submitted by the applicants themselves, which then may be checked with the commission's own records of insurance violators. As one commission candidly noted: "For proposed domestic companies, resumes of each officer is [sic] submitted with the application. As long as there is no derogatory information in it, no investigation will be under-

taken." This system of blanket acceptance obviously does nothing to catch the lies, omissions, and misrepresentations of the types encountered by the Subcommittee in its review of the licensing process.

Checking the record of known violators within a state will often prove fruitless anyway, because very few persons engaged in wrongdoing appear to be sanctioned or prosecuted by regulators to the point where a violation would be recorded. Some regulators view the issue of punishment or adverse findings as moot once a company and its officers cease doing business within that state. One official acknowledged that his commission only checks and records "insurance-related" violations, so disbarred lawyers, stock swindlers, and other persons of dubious character would not be revealed. Prosecution and recording of wrongdoing would also require investigations, hearings, and use of resources that may not seem worthwhile at commissions where budgets are limited. The end result is that checking official records of violations to discover dishonest or incompetent applicants for insurance licenses is simply not effective, as evidenced by the fact that not a single person involved in the debacles investigated by the Subcommittee has been cited by state regulatory authorities for any infraction at all, and just one has been indicted by law enforcement authorities. A search of their records would disclose nothing.

In the absence of recorded offenses, the Subcommittee inquired about informal contacts among regulators to discuss suspected and known problem individuals who have no regulatory sanctions or convictions. The general response was that such contacts are limited due to a fear of libel litigation against regulators by wrongdoers. A convicted insurance fraud felon told the Subcommittee that he would routinely sue troublesome regulators individually to intimidate them and distract them from performing their duties. This lack of open communication among state officials regarding recognized offenders, coupled with a failure to take recorded actions against such persons, has encouraged a "Bonnie and Clyde" attitude, where certain individuals move across state lines to escape detection and continue their fraudulent activities.

The licensing process is also hampered by conflicting responsibilities in states hoping to develop more competition through admitting new insurance companies, while trying to enforce solvency regulations that might reduce the number of participants in the marketplace. Furthermore, there seems to be little willingness to deny an insurance license on the grounds of demonstrated incompetence through association with a prior insolvent company as a senior officer or director. The apparent presumption is that a person submitting an application showing acceptable industry experience (with little or no independent checking by regulators) is entitled to receive an insurance license, unless the state regulator can prove by recorded criminal or regulatory infractions that the applicant is unfit beyond a reasonable doubt.

Every state contacted by the Subcommittee has statutory authority to deny a license on the basis of discretionary judgments relating to the integrity and fitness of the applicant. In practice, it appears that regulators have the burden of proving that a person is unfit, rather than the applicant proving that he or she is fit to take

money from the public by running an insurance company. This twist of regulatory responsibility took a bizarre turn when two state commissions actually requested the Subcommittee to provide a letter recommending denial of a license for certain persons on the grounds of misconduct, so that the commissions would have written evidence to refuse licensing the applicants. Their unwillingness to use existing authority and act independently is surprising and disturbing.

Even where there is a will to regulate strongly, the way may be blocked by failure to ask the right questions. For example, the application filed by Carlos Miro with the Louisiana commission for licensing Anglo-American asked whether he had ever been an officer, director, or controlling owner of an insurance company which became insolvent while he held such a position. Although his fraudulent activities at Transit led to litigation and an eventual settlement against him of $9 million, Mr. Miro accurately answered "no" to the question because his Transit business was conducted in his role as an agent and broker, rather than an officer or director of the company.

DEFICIENT MONITORING

Monitoring the ongoing affairs of existing insurance companies has been another problem area for regulators. The problems begin with the quality of information used to determine the financial health of companies. That information is basically provided by the companies themselves through annual financial reports filed with insurance commissions in states where the firms are licensed. In 35 states, the quality of those reports is only as good as the honesty of the people submitting them because there is no requirement for independent audits.

Many of the annual regulatory reports examined by the Subcommittee were materially false and misleading as a result of lies, unsupported assumptions, and a complete lack of adequate books and records upon which to prepare financial statements. If there was any routine review of such reports by state regulators at all, it was not enough to discover the scope and depth of the companies' deterioration. Misstating and underreporting loss reserves by truly gargantuan proportions has been the biggest problem, yet at least 33 states do not require that reserves of property/casualty companies be certified by a qualified actuary. The Subcommittee views this astonishing fact against an equally astonishing revelation that many large property/casualty companies, including Transit and Integrity, have been operated with no actuaries at all.

The major advance in routine solvency surveillance during recent years has been the development of the Insurance Regulatory Information System by the National Association of Insurance Commissioners. This computer system is programmed to spot potential solvency problems by calculating key financial ratios, however, the data input for the system comes from the mostly unchecked annual reports filed by regulated insurance companies. The dependability of the system is based upon the reliability of the information in the annual reports, and companies such as Mission, Transit, and Integrity were apparently not identified earlier because their financial

reports did not reflect the gravity of their problems. Over the course of many investigations into financial fraud and mismanagement in various industries, the Subcommittee has always found that the persons committing such deeds are equally willing and committed to misrepresenting the results of their activities, which negates the effectiveness of any monitoring system using information provided by those persons.

Scheduled regulatory examinations by state officials are the primary independent check on the solvency of licensed insurance companies under the present system, but infrequency and scope limitations have plagued the usefulness of this monitoring tool in the real problem cases. In an age where instantaneous wire transfer of funds is commonplace, examinations every 3 to 5 years that measure a company's financial condition the previous year will not even begin to prevent the types of insolvencies observed by the Subcommittee. In fact, the horrendous mismanagement that led to the failures of both Mission and Transit occurred during the multiyear intervals between their scheduled regulatory examinations.

Scope limitations have also marred the effectiveness of examinations. The focus of examinations is on the soundness of the primary insurance company which is licensed by the state, with no review of the MGA's, holding companies, and other affiliated entities that surround the insurance company and determine its ultimate well-being. Those related entities are often the sources of the bad management and worse business dealings that can kill a regulated company, as well as being the recipients of the commissions, management fees, service contracts, dividends, loans, and associated largesse that bleeds away necessary cash and incentives to act prudently. By the time the results of greed, fraud, and tomfoolery by MGA's and corporate affiliates show at the regulated insurance company, it is usually too late to prevent insolvency.

Industry sources have complained to the Subcommittee that many examination procedures are misdirected and wasteful. They say too much emphasis is put on relatively minor details such as confirming serial numbers on bonds, while insufficient attention is given to the "big picture" of whether a company's business practices endanger its solvency. Criticism from regulated companies which must pay for their examinations is to be expected, but the Subcommittee's own inquiry confirms that valid questions can be raised about the way solvency examinations are conducted in the United States. Not the least of these is the coordination of examinations and jurisdiction over multistate companies, as demonstrated by the four-state examination of Royal American Managers and Omaha Indemnity.

PROBLEMS WITH REINSURANCE

Reinsurance is the "black hole" of solvency regulation. Basically, reinsurers are not regulated directly because the focus of regulation is on the primary insurance company that writes a policy for a customer. Although that policy coverage may be reinsured several times in the United States and overseas, the regulatory system operates on the presumption that an insurance company controls the

reinsurance process, and will arrange sound reinsurance for itself. That presumption is clearly false for a number of reasons.

Many primary insurance companies are not soundly managed regarding the business they write or the manner in which such business is reinsured, as demonstrated by Mission, Transit, and Integrity. The managements of problem companies are more concerned with short-term profits than long-term stability. To rely on their judgment in arranging reinsurance that will be available later to pay claims is simply unrealistic. Even reinsurance judgments of well-managed insurance companies are complicated by the sometimes poor quality of information on reinsurers available to them. In addition, there may be further reinsurance transactions by reinsurers on the same business which are often unknown to the primary company.

The present regulatory system backs its reliance on the judgment of insurance company managers with a requirement that adequate security, primarily bank letters of credit, be posted by unauthorized reinsurers to cover expected losses. This letter of credit requirement has failed abysmally to protect primary companies, policyholders, and the public from the consequences of bad reinsurance in cases observed by the Subcommittee. Available letters of credit to pay claims have been woefully inadequate because they have been based upon greatly understated loss projections. Policing the reinsurance process through primary insurance companies has also been ineffective, as the information provided by problem insurance companies may be fraudulent, unsupported, and outdated.

Offshore reinsurers present even greater difficulties for the present system. Once the premiums have left United States jurisdiction, the likelihood of recovering substantial assets in foreign countries is remote, time-consuming, and expensive. This is particularly true in countries with weak insurance regulation that harbor shell companies in a cloak of secrecy. Conflicts of interest, miscommunication, fraud, and irresponsibility have also been evident in far too many cases.

Reinsurance is an essential function for spreading risk and expanding capacity in the insurance marketplace. This legitimate concept must be a reliable part of an open and competitive international market, yet the Subcommittee has received more complaints and requests for assistance from industry participants, regulators, and state legislators on reinsurance matters than on any other issue. These complaints have included insufficient jurisdiction by states, improper activity, inadequate information, "white lists" that favor certain reinsurers, poor capitalization, illusory capacity, and slow payment that threatens the fragile chain of financial stability in reinsurance relationships.

ENFORCEMENT FAILURES

When state insurance laws and regulations are violated, or when companies become insolvent, there is very little apparent investigation and enforcement to punish offenders and act as a deterrent. State regulators do not aggressively look for the causes of wrongdoing and gross mismanagement, or issue sanctions and penalties when they are found. State law enforcement authorities also seem

lax in prosecuting insurance violations, perhaps because such cases are difficult to document and prove. Federal law enforcement efforts are greatly restricted because looting an insurance company is not itself a Federal crime, and the 5-year statute of limitations on mail and wire fraud has often run before a case can be successfully developed.

Available penalties also seem out of step with the needs of today. For example, Carlos Miro and Transit failed to comply with the licensing laws of Texas in several major aspects, but the laws only provide penalties for violating a few relatively minor sections. Even for those sections, Texas law states that an offender "shall be guilty of a misdemeanor, and on conviction in a court of competent jurisdiction, shall be punished by a fine of not less than One Dollar ($1.00) nor more than One Hundred Dollars ($100.00)." Without adequate enforcement and suitable penalties, there is little reason for potential violators to follow the law.

The persons causing insurance company insolvencies usually face only the prospect of civil litigation for monetary damages arising from their breach of duty, and those suits, even when brought, are hampered by problems of proof and documentation. As a deterrent against wrongdoing, civil litigation has limited effect because many defendants are protected by officers and directors liability insurance, and assets subject to recovery are often quite minimal. Ironically, the funds wrongfully taken from policyholders, shareholders, and the public are used to shield the perpetrators of insolvency from the consequences of their actions.

While civil litigation may be commenced by customers, investors, creditors, and business associates, the primary plaintiff is normally the state-appointed liquidation receiver who has a legal responsibility to maximize the recoverable assets of a failed insurance company's estate. The receiver has a priority claim on assets, control of the company's books and records, and cash resources gleaned from the top of the estate which can be used to pursue rights of action against former officers, directors, agents, and other parties involved with the failure. Information developed during the course of such litigation can help to determine the causes of insolvency, but the major purpose is to recover money, and most cases are settled without finally resolving the question of ultimate responsibility for a company's demise.

LIQUIDATION PROBLEMS

There is also a conflict between a receiver's goal of recovering maximum assets for an insolvent company's estate and finding that former officers and directors committed fraud or other wrongdoing. As an example, the receiver for Mission refused to acknowledge that the noxious management behavior at Mission observed by the Subcommittee constituted fraud, and he might well have ruined his civil actions to recover $2.2 billion from Mission's reinsurers if he had admitted that fraudulent behavior occurred. With no real incentive to discover management fraud, and with a strong financial reason not to find it, the receiver is not in a position to issue a credible determination regarding the existence of fraudulent activity by senior management at Mission, yet he is the only

state official assigned to investigate the insolvency. Marshalling assets and pursuing wrongdoers are both important public functions when an insurance company fails, and those two distinct tasks should not be combined in a manner that prevents one or both of them from being faithfully performed.

Policyholder losses arising from insolvencies are covered to some extent by state guarantee funds which are financed by assessments on solvent insurance companies. There are, however, state-by-state limits on the types of insurance and amounts of losses that the guarantee funds will pay. The growing costs of insolvencies are passed to the public through increased rates, tax credits on guarantee fund assessments, and unpaid claims. The Subcommittee is concerned that current assessments on the industry do hot recognize the gross liabilities of guarantee funds, and that annual capacity limits on assessments are already being reached in some states. In addition, losses are paid by the guarantee fund in the state where a particular policy was written, so the failure of an insurance company domiciled in California or Missouri can be very costly to state governments and the public in many states where policies were sold, but which had little or nothing to do with regulating the failed company.

The National Association of Insurance Commissioners has tried to improve the present regulatory system through model laws and periodic meetings among state insurance commissions. Many of the system's weaknesses noted by the Subcommittee have been the subject of such joint recommendations for action, but implementation of those recommendations has been uneven because the National Association of Insurance Commissioners is a voluntary organization with no authority to compel state legislatures or regulators to adopt its model laws and regulations. For example, most states have not adopted important recommendations to require independent audits and use of actuaries in setting reserves. Also, international reinsurance problems seem beyond the effective jurisdiction and capabilities of state insurance commissions.

The Subcommittee found other areas of turmoil and concern plaguing the present regulatory framework. These include charges of mishandled receiverships such as Transit, where a 17-month period of inaction by the first state-appointed receiver greatly exacerbated the collection problems of the present receiver. In addition, lengthy liquidations and large estates of companies like Mission and Transit have generated millions of dollars in fees paid from the estates for certain law firms, accounting firms, and consultants, resulting in a perception that insolvent companies are more valuable dead than alive for those with a financial stake in the process of carving up the carcass. Also, political turmoil and allegations of wrongdoing and incompetence have affected state insurance commissions in California, Texas, Missouri, Wyoming, Louisiana, and Florida. Any serious proposals for improving the solvency regulatory system must take into consideration the climate in which such changes must be implemented.

INTERNATIONAL CONSIDERATIONS

The business of insurance is international in scope, particularly in the area of reinsurance. With this in mind, the Subcommittee has approached its review of regulatory and business practices recognizing the national and international impact of those practices. This has included discussions with representatives of several international insurance and reinsurance companies, both in the United States and overseas. Visits have also been conducted thus far with insurance regulators in Ireland, Switzerland, and Great Britain.

The Subcommittee strongly believes that every company wishing to do business in this country must meet adequate solvency requirements. These include strong capitalization, effective regulation, accurate and complete reporting, and available assets in the United States to pay claims. Any insurer or reinsurer failing to meet such requirements should not be permitted to have any involvement at all in receiving premiums from policyholders in the United States.

Some people have told the Subcommittee that attempts to require higher solvency standards will reduce available market capacity and raise insurance rates, but this argument is both unconvincing and misleading. It is unconvincing because a sound and well-run market will reduce financial risks and create equal opportunities and responsibilities for legitimate insurance providers who wish to participate in the world's largest source of premiums. It is misleading because insurance that does not deliver is no insurance at all. Much of the insurance and reinsurance "capacity" observed by the Subcommittee was nothing more than an illusion that failed to perform as promised.

Illusory offshore "capacity" is a particular problem when premiums are solicited, but claims are not paid. In such cases, losses fall on the American public through unpaid claims and state guarantee fund assessments, resulting in a direct drain on domestic financial resources. These situations add no real capacity to the United States insurance market, and actually diminish the market by the amount of premiums sent offshore. Legitimate foreign insurance sources have been willing to meet proper regulatory and solvency standards in this country, and the United States can very well do without the so-called "capacity" offered by companies domiciled in countries where effective regulation, reporting, and capital requirements are nil.

THE INSURANCE COMPANY OF IRELAND

The Subcommittee's contacts with foreign insurance professionals and regulatory authorities revealed much useful information. Interestingly, the problems noted at Mission, Transit, Integrity, and Omaha Indemnity are not indigenous to the United States. The Insurance Company of Ireland followed a similar recipe for disaster with the same inevitable results.

Started in 1935, the Insurance Company of Ireland was well-established as that country's premier insurer with a large branch network and the cream of Ireland's business. Trouble began in the early 1980's when the company's management turned to using MGA's and excessive reinsurance to expand rapidly. The commis-

sion-driven MGA's produced a horrendous book of business that was 90 percent reinsured, and management accepted the familiar refrain that minimal retention of business meant minimal risk for the Insurance Company of Ireland. This relatively small company with no sophisticated controls was taking a lead position of 50 percent to 100 percent on individual risks, and even joined the notorious reinsurance pools run by Pacific Re on behalf of Mission.

A reckless plunge into the London insurance market dealt a lethal blow to the solvency of the Insurance Company of Ireland. The company's London office, headed by a brash salesman, doubled its business each year for more than 3 years, growing from 25 percent to 70 percent of gross premiums of the entire company. No effective management controls were exercised over the London operations, and the company had no actuaries to establish proper loss reserves.

Just over 1 year prior to its collapse, the Insurance Company of Ireland was purchased by the Allied Irish Bank. When the severity of the insurance company's problems threatened the solvency of Allied Irish Bank, one of that country's major financial institutions, the Irish government bought the Insurance Company of Ireland for a nominal sum. Since March 1985, the company has operated under government control at a cost to Irish taxpayers of approximately $400 million. The government plans to pay all claims, return the company to profitability, and then sell it to recover as much as possible.

In the wake of the Insurance Company of Ireland fiasco, the Irish government strengthened its regulatory system, which depends on annual independent audits, rather than government examinations, to spot solvency problems. A new law passed in early 1989 requires independent audit firms to provide Irish regulators with any information requested regarding the activities of an insurance company, and to alert regulatory authorities immediately whenever the auditor resigns, proposes to qualify its audit opinion, or has reason to believe there are material business or financial problems. The government-appointed administrator is also suing Ernst & Whinney, the former auditor of the Insurance Company of Ireland, for negligence in failing to note the company's gross risk exposure and its deficient incurred-but-not-reported loss reserves.

According to Irish authorities, the insurance regulators in Great Britain were responsible for checking the adequacy of incurred-but-not-reported loss reserves at the company's London branch. British regulators told the Subcommittee that deficiencies in the London operations of the Insurance Company of Ireland were not found sooner because of time lags in the filing and review of the company's reports. Apparently, regulatory coordination problems are not unique to the United States, and that situation might be expected to grow worse in Europe when regulatory barriers are dropped for members of the European Community.

REGULATORY COMPARISONS

In general, the Subcommittee's inquiry into European solvency regulation so far has revealed practices that are similar in many ways to those in the United States, but there are fundamental dif-

ferences. The primary difference is that European countries are geographically much smaller, their insurance markets are more centralized, and entrance to their markets is more restricted. Regulatory officials and industry participants say these factors mean that reputations of individuals and companies are better known, and exchange of significant information is easier. They point to their limited number of reported insolvencies as proof that their regulatory systems work.

Ireland and Great Britain rely upon independent auditors to check insurance company reports for accuracy, while Switzerland uses government examiners to perform that task. Both Ireland and Great Britain have legal requirements for auditors to report important problems directly to government regulators, and actuaries in Great Britain have a professional responsibility to report such problems, even if they are company employees. The United States currently has no equivalent requirements for actuaries and independent auditors. Great Britain also has useful provisions for prior regulatory approval of key executives and shareholders, as well as restrictions on reentering the insurance industry for senior company officials associated with prior insolvencies.

Another difference in Great Britain is the existence of self-regulating insurance markets such as Lloyd's of London and the Institute of London Underwriters. These organizations enable many participating entities to operate in a centralized marketplace using common support functions. They are generally supervised by British regulators, but have important self-regulatory mechanisms intended to assure the solvency of their markets. Efforts to establish similar organizations in New York and Miami have failed.

Lloyd's is best known as an exclusive market where selected brokers and underwriters are permitted to write insurance and reinsurance coverages in a free-form atmosphere. Specific risks are insured by separate syndicates representing groups of Lloyd's "names", who are wealthy individuals pledging their full assets to satisfy claims taken on by the syndicates. As a market, Lloyd's is one of the world's largest reinsurers and has an impressive record of solvency and dependability, but a few notable problems have arisen in recent years.

Lloyd's has experienced fraudulent and incompetent behavior by some syndicate managers and brokers, as well as resistance to paying large claims by syndicate members whose personal fortunes are threatened. The process of screening "names" for good character and financial worth has not included strong background checks or regular financial reports on individual syndicate members, and has not prevented persons such as Carlos Miro from using his status as a Lloyd's "name" as an advertisement of his respectability. Industry participants have also complained to the Subcommittee that Lloyd's syndicates are becoming very slow in paying legitimate claims presented to them.

The Institute of London Underwriters is another exclusive market organized to permit its members open negotiation and joint participation in insurance coverages. Unlike Lloyd's, the Institute of London Underwriters' members are actual insurance companies operating in the London market, many of which are affiliated with large international companies. They use the organization to facili-

tate the writing of purely marine and aviation business. Although much newer than Lloyd's, the Institute of London Underwriters has achieved success in securing a solvent market through initial screening and regular monitoring of member companies.

The challenge for the United States is to strengthen its own system of solvency regulation, while determining which foreign regulatory systems are worthy of recognition and reliance in regard to solvency matters. This must be accompanied by an acknowledgment that United States and foreign regulatory bodies, like the companies they regulate, vary widely in terms of size, resources, competence, and commitment to the public. The key to resolving solvency problems may well lie in placing more reliance on those who deserve it, while more closely monitoring and restricting those who do not meet appropriate standards.

Regulating international insurance entities and transactions requires international cooperation and coordination, which seems lacking under the present system. A lot can be learned and copied from successful foreign regulatory efforts, but the United States is a geographic giant with decentralized markets and an economic culture based on open entry and competition. There must be better balance among the insurance industry's solvency needs, the unavoidable realities of the United States market, and present tendencies to let everyone participate equally and freely under ineffective rules. The existing regulatory system treats Lafayette Re the same as Munich Re, and Great Britain the same as the Cayman Islands. This dissipates limited resources and ignores obvious differences.

The Subcommittee plans further inquiry into foreign regulatory and business practices, particularly in the area of reinsurance. Solvency and reliability are common international objectives, but the Subcommittee has also noted common international weaknesses, such as failure to control MGA's, failure to require actuaries for establishing property/casualty loss reserves, and too little focus on the activities and solvency of reinsurers. If the reform efforts of concerned government regulators, self-regulatory organizations, and industry participants can be promoted and coordinated, there could be a real opportunity to substantially improve international solvency regulation for the mutual benefit of everyone involved. The Subcommittee looks forward to working with all interested parties in developing a system that is more rigid in addressing solvency requirements, and more flexible in recognizing where and how such requirements should be implemented.

ISSUES TO BE ADDRESSED

The Subcommittee's inquiry into solvency issues thus far has documented many problems and weaknesses in the present regulatory framework, some of which fundamentally affect the well-being of the system. The inquiry has been conducted with an open attitude for seeing and describing things the way they really are, but with no preconceived agenda of solutions for correcting problems found by the Subcommittee. The focus of the inquiry will continue to be on understanding the causes of insolvency, and finding work-

able solutions with an open mind regarding what is needed to improve the regulatory system.

From the start of its efforts, the Subcommittee has been pleased to receive advice, assistance, and encouragement for its efforts from state regulators and industry participants who share concerns that insolvency is a major threat to the integrity and health of the insurance industry. Trade associations such as the National Association of Insurance Brokers, the National Association of Independent Insurers, and the National Association of Professional Insurance Agents should be commended for devoting their resources to researching the causes of insolvency and seeking solutions. The dire plight of the savings and loan industry illustrates what can occur when honest and competent people ignore blatant dishonesty and incompetence practiced by others in the industry.

The next priority for the Subcommittee will be additional hearings regarding the findings and issues raised by this report. These will be coupled with ongoing investigations and hearings on specific problem cases. This process will provide Congress, the states, the public, and the insurance industry with the information and recommendations needed to make important choices regarding how solvency should be regulated in the United States.

The following important issues, among others, will be addressed by the Subcommittee as its inquiry continues:

1. ADEQUATE CAPITALIZATION

The threshold issue for solvency regulation is the amount of capital needed to operate a sound insurance company. Regulatory capital requirements observed by the Subcommittee generally seemed too low, and were readily subjected to abuse. Real capital surplus should be easily measured, liquid, and fully dependable as a cushion against insolvency. How should capital surplus be measured? What restrictions should be placed on surplus, and how much capital is enough to protect policyholders and the public?

A collateral issue is the type of operating license granted for certain levels of capitalization. At present, a single license appears to permit a property/casualty company to write all types and amounts of such insurance and reinsurance, subject only to state solvency requirements that are checked by regulators well after the business is written. Different license classifications based on capital amounts, company history, types of policies that can be issued, growth rates, reinsurance amounts, and other factors might prevent a company from expanding beyond its technical abilities and capitalization limits before problem business is placed on its books. Are license classifications feasible? How should they be applied and enforced?

The nature of investments is also a key measure of adequate capitalization for insurance companies. At a minimum, junk bonds, penny stocks, and risky real estate investments should be strictly monitored because a long-term promise to pay claims must be matched by investments that will provide necessary short-term liquidity and long-term stability. Should investments in a company management's personal ventures, residences, and affiliated companies be prohibited? What types of investments are appropriate for

insurance companies of different sizes and abilities? How can sound investment policies be monitored and enforced?

2. AGENTS, BROKERS, AND INTERMEDIARIES

How should the activities of agents, brokers, and other intermediaries be regulated? The Subcommittee found that many agents effectively performed every function of the insurance companies they represented, yet these agents have not been regulated in any meaningful way. State examiners have even failed to include the activities of agents when evaluating an insurance company's financial condition, although the fate of the company may well depend directly upon the integrity, skills, and procedures followed by those agents.

Managing general agents (MGA's) have been a particular problem in the property/casualty industry. How can a responsible company justify completely turning over its essential management decisions to an agent who prospers from earning commissions on the volume of business produced? Should the use of MGA's in such circumstances be prohibited or restricted? Should they be permitted to reinsure the business they write, or to deal with an affiliated company? The Subcommittee found conclusive evidence that MGA's can kill a property/casualty company like Mission or Transit, but the regulatory system has not yet responded with adequate safeguards.

Brokers and intermediaries provide a useful service in bringing together customers and insurance providers, but what responsibilities should brokers have for the transactions they arrange? The Subcommittee observed active broker participation in some of the worst deals taken by Mission and Transit, yet the brokers involved denied responsibility for either the consequences of those deals, or for inquiring into the real identities and financial condition of the parties involved. Respectable brokers have said their duty of inquiry extends only to checking company solvency ratings published by the A.M. Best service. However, they admit such ratings are not dependable solvency guides because they are based essentially on unverified information published by insurance companies themselves.

How should the regulatory system deal with the dealmakers? Should they be allowed to own insurance companies or place business with such companies? Brokers are compensated by commissions, which are sometimes adjusted on the basis of loss experience. Should brokers be required to check the integrity of the people and records which determine ultimate premiums and losses charged on a policy? Are brokers bound by any ethical considerations other than completing a deal where the parties raise no objections?

3. REINSURANCE

Reinsurance abuse has been a key factor in every insolvency studied by the Subcommittee. The level of reinsurance has been excessive, the quality has been poor, and controls on reinsurers have been minimal or nonexistent. Conflicts of interest in arranging reinsurance have been fairly common, and reinsurance problems seem to grow geometrically with the number of reinsurers in-

volved. In addition, letters of credit have not worked to guarantee the performance of these reinsurers, and foreign reinsurers appear beyond the effective reach of state regulators, especially when they are domiciled in countries where regulation is weak.

The Subcommittee was told many times that reinsurance is not being properly regulated, and that Federal government involvement will be necessary to correct the problems. Is that assertion true? How should reinsurance be regulated in the United States? Should there be limits on the amounts of reinsurance allowed on a single risk, or on an insurance company's gross liabilities? How many reinsurers are too many? Should the capital surplus credits given for reinsured business be restricted?

What should be done about insurance coverage that is "retroceded", or reinsured more than once? Can this process be monitored effectively to assure the reinsurance chain will pay as promised? How can "circular reinsurance", where a company ends up reinsuring itself, be prevented? How many times can a policy be reinsured before intervening commissions and fees leave the last reinsurer with insufficient premium income to cover the risk assumed?

Several industry participants have complained that the reinsurance chain has weakened as reinsurers more and more resort to slow payment or litigation to avoid meeting their responsibilities. Is this a major problem that threatens the solvency of insurance companies? How far should independent auditors, actuaries, government regulators, and other third parties be expected to go in checking the adequacy and solvency of reinsurance?

To what extent can regulatory authorities in the United States rely on solvency regulation in other countries to assure that foreign-based reinsurers will be solvent and will meet their responsibility to pay legitimate claims? Would bilateral agreements between United States and foreign regulators or self-regulatory organizations be a practical way to establish adequate solvency regulation, collection, and enforcement standards? Should reinsurers based in countries without adequate solvency regulation simply be banned from doing business involving the United States? What should be the requirements regarding the amounts and types of assets available in the United States to pay reinsurance claims? Should foreign companies be required to provide the same reports using the same accounting rules followed by companies in the United States?

4. REPORTING REQUIREMENTS

False and misleading financial reports have been a major contributing factor to every insolvency and problem company observed by the Subcommittee. These falsehoods have been prevalent in reports to regulators, internal company reports, and reports to reinsurers, investors, customers, and the public. One industry source said the annual yellow financial report booklet filed by insurance companies with state commissions is often called "the yellow peril" because of its dubious reliability.

The Subcommittee found that false reporting was easily accomplished for the simple reason that independent checks on the information presented by company managements is not widely required.

Errant managements are free to omit information, misstate facts, and manipulate reserves with little fear that they will be caught, or that they will be punished. The problem is compounded by late reporting and failure to file required reports.

The National Association of Insurance Commissioners has recommended that state regulators require independent audits of financial reports and certification of loss reserve estimates by qualified actuaries. Incredibly, the GAO found that 35 states have not implemented the independent audit recommendation, and 33 states do not require actuarial certification of reserve adequacy. Without such basic safeguards, how can those states have any confidence in their regulatory judgments on the financial condition of companies doing business within their borders? The infrequency of regulatory examinations would seem to make mandatory use of independent auditors and actuaries even more imperative as a tool for monitoring solvency. Should actuarial certifications and independent audits be required for every reporting company?

The negative impact of false and misleading reports extends far beyond the regulatory system. The A.M. Best Company, a widely known industry rating service, uses regulatory filings to determine its solvency ratings on individual companies, which are then relied upon for business decisions by agents, brokers, and insurance companies around the world. What good are such ratings if they are based on wrong information, and help companies like Mission and Transit to fool the industry? Standard and Poor's Ratings Group has developed a sophisticated solvency rating system that probes deeply into an insurance company's real condition, but this system only rates companies subscribing for the service, which means that problem companies most surely will avoid being rated. Should in-depth rating reviews of the type offered by Standard and Poor's be required through regulation or accepted business practice?

One major industry leader has decried the lack of balance sheet discipline resulting from present accounting rules for insurance companies. Financial reports that do not recognize the current value of investments, that ignore gross liabilities by reporting net business retention, and that substantially restate loss reserves year after year can mislead regulators, customers and the public. Some companies even fool themselves with improper reporting. Should accounting and auditing rules for insurance companies be changed to reflect financial conditions more accurately? Do regulatory accounting principles and Generally Accepted Accounting Principles work together adequately in measuring solvency?

The Federal securities laws provide a framework for informed decisionmaking based on fair and complete disclosure of important facts. These laws apply to publicly held insurance companies, but not to mutual companies and closely held companies. Should all insurance companies be covered by the Federal securities laws? Are there other ways to improve reporting by insurance companies?

5. HOLDING COMPANIES AND AFFILIATES

The Subcommittee observed numerous abuses of the relationship between insurance companies and their holding companies or affiliated companies. At Mission, the separation of the holding company

and its operating subsidiaries obscured lines of management responsibility and the overall effects of individual incompetence and fraudulent activities. At Transit, the holding company was used to insulate and deny management responsibility for the insurance company's demise, while spinning off good assets and walking away from a multibillion dollar loss. Carlos Miro, his Anglo-American empire, and his offshore reinsurance companies provide textbook examples of self-dealing, intercompany sham transactions, illusory reinsurance, gross incompetence, and deliberate confusion to mask Mr. Miro's extravagant living with policyholder's money.

Are new rules needed to limit intercompany dealings involving loans, dividends, management contracts, and investments? Should officers and directors of insurance companies, holding companies and affiliates be presumed to be fully liable for insurance company insolvencies and self-dealing in the absence of proof to the contrary? Do interrelated corporate networks prevent adequate access by regulators and liquidation receivers to books and records affecting an insurance company's business? Can holding companies and management contracts be used to disguise the real identities of persons running an insurance company?

The Subcommittee is concerned over reports that excessive financial leveraging is being proposed in takeovers of insurance companies. With substantial assets for use as collateral in leveraged buyouts, insurance companies are attractive targets for takeovers. However, leveraging the ownership capital of companies that are by nature already highly leveraged poses extreme risks regarding solvency and the actual margin of capital available to pay losses. What should be done to prevent insurance companies from becoming overleveraged and controlled by persons whose primary goal is not sound underwriting for the long term?

6. STATE REGULATION

Under the present regulatory framework, state insurance departments are responsible for regulating insurance company solvency, and administering the liquidation of insolvent companies. The Subcommittee found numerous weaknesses and breakdowns in this system, including lack of coordination and cooperation, infrequent examinations based on outdated information, insufficient capital requirements and licensing procedures, failure to require use of actuaries and independent audits, and improper influence on regulators. Inadequate staffing and regulatory resources is also a serious problem, yet state governments collect twenty times more from premium taxes than they spend on insurance regulation. Realistically, can the present system correct these problems when 50 state legislatures and insurance commissions are involved?

The National Association of Insurance Commissioners has been the vehicle for addressing solvency issues at the national level by developing model laws and regulations, but most states have not adopted the Association's recommendations on important matters such as auditing and actuaries. Even when model recommendations are widely adopted, there is no guarantee of uniformity because the National Association of Insurance Commissioners has no compulsory enforcement powers. Are there ways to make the National

Association of Insurance Commissioners more effective in solvency regulation? Is it the right organization to do the job? Could it or another appropriate organization of regulators or insurance companies be established as a compulsory self-regulatory organization with authority to set and enforce uniform national solvency standards?

If the system of 50 separate insurance commissions continues, how can the regulatory process be improved within the present framework? Should resources be allocated to better target the root causes of insolvencies? Does it make sense to base the regulatory system almost entirely on the activities of primary insurance companies? Are regulatory examinations once every 3 to 5 years sufficient?

The Subcommittee noted severe problems that can occur from rapid and uncontrolled business expansion, particularly when more than one regulatory jurisdiction is involved. How can a single state monitor and control the national and international activities of insurance companies, brokers, and agents? Should there be different classifications of insurance company licenses to restrict the types and amounts of business written before it is placed on the books? Is the selling of excess and surplus lines of insurance adequately regulated?

There have been recommendations for augmenting the regulatory system by incorporating the special skills and knowledge of actuaries and independent auditors. Should the reports, observations, and recommendations of actuaries and auditors be made concurrently to both regulators and company managements? Should actuaries and auditors have an affirmative duty to report serious wrongdoing and solvency problems to regulators, as is required in Great Britain and Ireland? What can be done to enhance solvency regulation outside the government regulatory framework?

When an insolvency occurs, the state-appointed liquidator seems to be the only official charged with investigating the circumstances causing the failure. In the Mission situation, the Subcommittee observed an obvious conflict between the receiver's efforts to prevail in civil litigation against reinsurers and his willingness to investigate fraud and mismanagement by former Mission officers and directors. That conflict between maximizing recoverable assets and investigating wrongdoing will always exist when a single official is responsible for performing both functions. Should liquidation receivers be relied upon to pursue both tasks? Are the skills and attitudes needed to do each job compatible? Should a separate enforcement investigation be required to determine the causes of insolvency and take appropriate action, without the inquiry restrictions common in civil litigation?

State guarantee funds are responsible for paying policyholder claims of insolvent companies, however, the amounts and types of claims covered vary significantly from state to state. Except for New York, these guarantee funds are financed on a pay-as-you-go basis by assessments on solvent insurers, with a cap on the amount that can be assessed each year. Is the present state guarantee fund system adequate? Does the process of assessing current payments provide sufficient funding for paying claims promptly and covering future claims? Should the types and amounts of claims paid depend

on where the claimant lives? To preserve the goals and resources of the guarantee funds, is there a need to restrict their coverages in order to provide more incentive for large commercial policyholders to analyze better the financial condition of their insurers?

7. ENFORCEMENT

Enforcement of insurance laws and regulations is one of the weakest links in the present regulatory system. States apparently are not collecting adequate information, investigating wrongdoing, or taking legal action against the perpetrators of insolvency. Statutory penalties and remedies also seem out-of-step with the realities of today's insurance market. With little fear of meaningful administrative sanctions or criminal prosecution, there is no effective penalty for wrongdoing and no real deterrent. Inadequate enforcement was a major factor in the scandals and gross incompetence that accompanied the collapse of the savings and loan industry.

Prosecution, conviction, and incarceration have proven to be very effective in deterring white collar crime, yet most people involved with obvious wrongdoing at insolvent insurance companies simply walk away with no real investigation of their activities. Many of them continue to be active in the insurance business. Are criminal statutes and penalties adequate to deal with fraudulent activity? Are sufficient resources being devoted to criminal enforcement? How can criminal investigation and prosecution be encouraged?

At present, Federal criminal enforcement is restricted because plundering an insurance company is not a Federal crime. Mail and wire fraud statutes are the primary way to attack insurance fraud, but these Federal antifraud laws have a 5-year statute of limitations, which often expires before a criminal investigation can be completed. Should there be a specific Federal criminal statute to deal with fraudulent behavior at insurance companies? Should the statute of limitations be extended to allow more time to complete investigations and bring criminal charges?

Administrative sanctions could also be made more effective in removing wrongdoers from the insurance industry, and creating a formal record to prevent their reentry. Are administrative resources, procedures, and penalties adequate to deal with people who abuse insurance companies and cause insolvencies? When a company goes insolvent, should the burden of proof be shifted so that mismanagement will be presumed unless a director or officer establishes that he or she is free from fault? Should senior officers and directors of an insolvent insurance company or an organization controlling an insolvent insurer be automatically barred from holding a similar position in the insurance industry for a period of time, and then be required to prove their fitness to serve? Are the broad interests of the public in having a solvent industry being fairly balanced with the individual interests of persons who want a license to take money from policyholders?

Civil litigation can serve an important function in enforcing solvency regulation and recovering money from those who abuse the system. Are any changes needed to improve civil litigation in performing such a role? Is the Federal Racketeer-Influenced and

Corrupt Organizations Act useful as an enforcement tool in the area of insurance company insolvencies?

Insurance is truly an international business, and abuse of insurance companies has also become international in scope. Moving money offshore, basing companies in foreign countries, and evading enforcement jurisdiction are standard elements in cases observed by the Subcommittee. Are changes needed to assure that foreign governments are not harboring perpetrators of insurance fraud, and that the United States does not act as a haven for violators wanted in other countries? Should all foreign participants in the United States market be required to have a designated agent for accepting legal process in this country? Are there unnecessary international barriers that hamper or even prevent enforcement investigations and actions from going forward? What can be done to promote international coordination on enforcement matters?

8. FEDERAL ROLE

What role, if any, should the Federal government play in regulating the solvency of insurance companies? Many industry participants, as well as state regulators and legislators, have told the Subcommittee that Federal assistance will be essential in establishing uniform national standards, coordinating regulatory efforts, and resolving reinsurance problems. The Federal government has an immediate interest in promoting a sound insurance industry, and a longer term interest in avoiding a financial crisis in the industry that could lead to calls for a Federal bailout, as occurred with the savings and loan industry, Penn Central, Chrysler, and Lockheed.

There have been a variety of suggestions for Federal involvement in solvency regulation. The most farreaching would have the Federal government completely supersede state regulatory authority in matters affecting solvency. Opponents of this idea point to the savings and loan industry fiasco as evidence of Federal regulatory incompetence in the financial sector.

In addition to the generally favorable results of Federal involvement in banking, investment, and securities regulation, the Subcommittee notes that its own investigations and hearings on thrift industry problems in 1985 demonstrated that Federal incompetence, by itself, was not the root cause of that industry's solvency crisis. By granting Federal deposit insurance coverage to state-chartered thrift institutions without a corresponding requirement for minimum capitalization and investment restrictions equivalent to Federally chartered institutions, the Federal regulatory structure bet the system's solvency on the adequacy of state standards. The system went bankrupt when Federal insurance was required to cover massive losses in states such as California, Texas, and Florida where regulatory standards were exceedingly low.

Other proposals for improving solvency regulation in the insurance industry would have the Federal government establish minimum national standards for state regulators to follow within the present system, or would create the option of Federal chartering and regulation for insurance companies that choose to deal with a single regulator at the national level. If Federal involvement occurs, do these proposals make sense? Are there better ways to

benefit solvency regulation through Federal participation? How would any of these proposals be implemented?

Clearly, Federal legislation and involvement would be required to implement changes that are beyond the legal authority and practical reach of state insurance commissions. One such possibility would be negotiating bilateral agreements with individual foreign governments or self-regulatory organizations to recognize and accept companies based in countries where solvency is well-regulated. This would ease regulatory barriers for sound companies, while permitting more resources to be devoted to regulating weak companies. It would acknowledge the reality that all regulatory systems are not equal, and might encourage substandard countries to raise their level of solvency regulation in order to be accepted in the United States.

Another possibility would be a Federal law to empower a national association of state regulators or insurance companies to act as a self-regulatory organization with compulsory authority to establish and enforce adequate solvency standards. This approach has worked well in the securities industry. Federal grants of legal immunity for legitimate exchanges of information among regulators regarding the business activities of known or suspected wrongdoers might also be a useful possibility.

Additional areas where Federal legislation might be necessary include clarifying solvency regulation for risk retention and purchasing groups. These groups of insurance purchasers are prime targets for the types of fraud and mismanagement observed by the Subcommittee, but there have been questions about the jurisdiction of state insurance commissions to regulate them. Establishing a Federal agency as the designated agent for serving legal summons on foreign nationals doing business in the United States also deserves legislative consideration.

The Subcommittee will look into all issues and proposals which offer promise for resolving problems associated with the solvency of individual insurance companies and the industry as a whole. Although no conclusions have yet been reached regarding the desirability of specific changes or the involvement of the Federal government, the Subcommittee is open to considering ideas that make sense and address the very real problems discussed in this report. The time to begin implementing needed improvements in the present regulatory system is now, before the problems identified during the Subcommittee's inquiry grow to crisis proportions.

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