The Florida Senate

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Committee on Banking and Insurance Senator Rudy Garcia, Chairman

INSURANCE COMPANY SOLVENCY REGULATION

SUMMARY

Insurer insolvency results in increased costs for Florida policyholders, the investors and creditors of insurers, the State, and the insurance industry in Florida as a whole. The Department of Financial Services (Department or DFS) regulates the insurance industry via the Office of Insurance Regulation (Office or OIR), whose responsibility it is to ensure that insurers transacting business in Florida remain solvent. If an insurer becomes insolvent, then the Division of Rehabilitation and Liquidation (Division or DRL) assumes control of the insurer and the insurer either enters rehabilitation or liquidation.

Although the number of insolvencies in the state has decreased in recent years, a close examination of the insurers currently in receivership and Florida's statutes and rules that regulate insurer solvency reveal potential problems that current deficiencies and inefficiencies in regulation fail to resolve. There are four issues that could be targeted by the Legislature to increase the effectiveness and efficiency of solvency regulation and thus benefit policyholders and the insurance industry in Florida.

A lack of reporting requirements involving the transactions that insurance companies make with their affiliates has made it possible for an insurer to enter into transactions that are not in the best interest of the insurer, avoid regulation, and shield assets in the event of an insolvency.

Insurers transacting business in Florida must be prepared to pay for damages resulting from hurricanes. Over $20 billion dollars in losses have been reported as a result of the four major hurricanes to strike Florida during the 2004 hurricane season. However, Florida does not specifically require an insurer to maintain the reserves necessary to pay for damages resulting from a catastrophic storm. Insurers that lack the assets to pay claims resulting from such a storm are likely to become insolvent, creating further strain on the property and casualty market in Florida.

The Office monitors the financial condition of insurers using detailed financial reports and periodic on-site examinations. A determination of whether an insurer is solvent is largely based on whether the insurer's loss reserve is adequate, and loss reserve amounts are also used in setting the insurer's rates. The September 2004 Auditor General's operational audit of OIR procedures for monitoring insurer solvency recommended that the OIR obtain independent actuarial certifications of an insurer's reported loss reserve.

Finally, for most Florida domiciled insurers the OIR conducts an on-site financial examination every 3 years. Representatives from the Office have expressed a desire to switch to a 5-year interval between exams, which they say would better allow them to focus their resources on troubled insurers.

Based on the findings in this report, committee staff recommends that in order to protect Florida's consumers and strengthen the insurance market in Florida, the following changes be made to Florida insurance company solvency regulation:

1. Enact additional reporting requirements for affiliated transactions involving an insurer.

2. Require that property and casualty insurers maintain reinsurance and reserves necessary to cover losses resulting from a 100-year probable maximum storm loss.

3. Mandate that insurers obtain independent actuarial certifications of their reported loss reserve.

4. Change the on-site financial examination requirement for insurers that are found to clearly be in strong financial condition from a minimum 3-year interval to a 5-year interval.

BACKGROUND

State Regulation of Insurer Solvency

Insurance companies are regulated primarily by the states.[1] The state of domicile[2] serves as the primary regulator for insurers. Solvency regulation is designed to protect policyholders[3] against the risk that insurers will not be able to meet their financial responsibilities.[4] Ensuring the solvency[5] of insurance companies is a primary responsibility of state regulators. Solvency regulation includes the requirements for starting and operating an insurance company,[6] monitoring the financial health of insurers through examinations and audits, and procedures for the administrative supervision,[7] rehabilitation,[8] or liquidation[9] of an insurance company if it is in unsound financial condition or insolvent.

In Florida, the Department of Financial Services regulates the insurance industry. The Office of Insurance Regulation[10] is primarily responsible for ensuring that insurers remain solvent, obey applicable laws, and sell policies at a fair rate for both the insurer and the public. To monitor the financial condition of insurers in the different lines of business, the Office is divided into three bureaus.[11] The Division of Rehabilitation and Liquidation is the court appointed receiver[12] of insurers once they become financially unsound or insolvent. Once an insurer enters receivership,[13] the Division will either attempt to rehabilitate the insurer, or will gather the insurer's assets, distribute them to policyholders and creditors, and liquidate the company.

Although each state regulates the insurance industry within its borders, many states often voluntarily join together to create and enact uniform solvency legislation. The National Association of Insurance Commissioners (NAIC) is a voluntary association of insurance regulators from all 50 states.[14] The NAIC was created to coordinate regulation of multi-state insurers, provide a forum for addressing major insurance issues, and promote consistent laws among the states. The NAIC also has a national accreditation program of reviewing state insurance departments,[15] serves as a national insurer information clearinghouse, provides a structure for interstate cooperation in examining multi-state insurers, and develops model laws.[16]

Aspects of Insurer Solvency Regulation

A wide array of insurer practices is regulated by the state to ensure that domestic insurers remain solvent and in healthy financial condition. Solvency regulation

[1] 15 U.S.C. s.s. 1011-1015 (McCarron-Ferguson Act).
[2] The state of domicile is the state in which the insurance company is chartered.
[3] Insurance companies are generally regulated more closely than most other companies because a contractual relationship is created between the policyholder and the insurance company, whereby the insurer is obligated under contract to make the policyholder whole.
[4] Robert W. Klein, *The Growing Sophistication of Solvency Policing Tools*, JOURNAL OF INSURANCE REGULATION, Winter 2000, Vol. 19 Issue 2, pg. 235.
[5] An insurer is solvent if all the assets of the insurer would be sufficient to discharge all its liabilities, and the insurer is able to pay its debts as they become due in the usual course of business. See s. 631.011(14), F.S.
[6] s. 624.411-s. 624.414, F.S.
[7] Administrative supervision allows the Department of Financial Services to supervise the management of a consenting troubled insurance company in an attempt to cure the company's troubles rather than close it down.
[8] In rehabilitation, the DFS is authorized as receiver to conduct all business of the insurer in an attempt to place the insurance company back in sound financial condition.
[9] In liquidation, the DFS is authorized as receiver to gather the insurance company's assets, convert them to cash, and distribute them to various claimants, and shut down the company.
[10] s. 624.302, F.S.
[11] The OIR is divided into the Bureau of Property and Casualty Insurer Solvency, the Bureau of Life and Health Insurer Solvency, and the Bureau of Specialty Insurers.
[12] BLACK'S LAW DICTIONARY 1268 (6th ed. 1990). A receiver is the person appointed by a court for the purpose of preserving property of a debtor or using the property to satisfy creditor's claims when there is the danger that the property will be lost, removed or injured.
[13] BLACK'S LAW DICTIONARY 1269 (6th ed. 1990). A receivership is a proceeding in which a receiver is appointed for an insolvent corporation, partnership or individual to preserve its assets for the benefit of affected parties. In this context it is the placement of an insurer under the receiver's control pursuant to a delinquency proceeding under Chapter 631, F.S.
[14] Also includes the District of Columbia and four U.S. territories.
[15] Florida was the first state to be accredited by the NAIC and has since been reaccredidated twice.
[16] Florida has enacted via statute a number of NAIC model acts, either in part or in whole. Examples of model acts adopted by Florida include NAIC Model Act 315—Risk Based Capital (RBC) For Insurers Model Act and NAIC Model Act 440—Insurance Holding Company System Regulatory Act.

includes establishing capitalization requirements for insurers,[17] examining the financial condition of insurers,[18] the approval and pricing of insurance products,[19] requiring minimum insurance company reserve and surplus requirements,[20] and regulating the ways in which an insurer can invest[21] its money. The reinsurance contracts that insurers enter into are regulated to ensure that when an insurer purchases reinsurance to cover certain policies, the reinsurer will assume responsibility for the payment of claims on policies assumed by the reinsurer.[22] If the insurance company has affiliates or is set up in a holding company system, transactions between affiliates are regulated to attempt to provide that the transactions are beneficial to the insurer.[23]

State Examination of Insurers

State insurance regulators monitor the financial condition of insurers using detailed financial reports and periodic on-site examinations. Insurance companies are required to file annual financial statements in each state where they are licensed. This information is then analyzed using tests developed by the NAIC, that look at whether the insurer's financial condition is at an unacceptable level, possibly leading to immediate regulatory action if the problems are sufficiently severe.

The OIR monitors the financial condition of each insurer in Florida. The Office reviews quarterly and annual financial statements of insurers using criteria developed by the NAIC in its Financial Analysis Handbook. As a result of a financial analysis, the OIR may require additional reporting from the insurer, require the insurer to develop a plan to correct deficiencies, conduct a targeted examination of the insurer, or even restrict, suspend or revoke the insurer's Certificate of Authority to conduct business in Florida.[24]

In addition to constantly monitoring insurers, the OIR also conducts more in-depth on-site examinations of each insurer in the state. The Office is authorized to examine[25] each insurer authorized to do business in Florida[26] as often as is warranted for the protection of policyholders and the public interest.[27] Generally, each insurer must be examined a minimum of once every 3 years.[28] An insurer that has been authorized by Florida for over 15 years without a change in ownership need only be examined once every 5 years.[29] Insurers who have been authorized to conduct business in Florida for less than 3 years[30] must be examined once each year.[31] After completion of the examination, the OIR publishes a report of its findings.[32]

The adequacy of an insurer's capital is primarily examined using the risk based capital[33] (RBC) system, which uses a formula to determine a company's minimum necessary capital level by evaluating the risk level of an insurer's underwriting, investments, and other factors depending on the lines of business the company writes.[34] If the insurer's actual capital level falls below certain levels when compared with the minimum capital level, the statute authorizes the DFS

[17] See s. 624.407, F.S.
[18] See s. 624.316, F.S. .
[19] See Part I of Chapter 627, F.S. (The "rating law" for property and casualty insurances.
[20] See s. 625.081, F.S. (Reserve requirements for health insurers); s. 625.051, F.S. (Unearned premium reserve requirements); s. 624.408, F.S. (Surplus requirements for insurers. Insurers must maintain a minimum surplus in order to maintain a certificate to transact insurance.); FLA. ADMIN. CODE r. 69O-143.047(2), (2003) (Criteria used to determine sufficiency of insurer's surplus).
[21] See Part II of Ch. 625, F.S. (Investment requirements for domestic and commercially domiciled insurers; includes requirements for diversification of investments.).
[22] See s. 624.610, F.S.
[23] See s. 624.310, F.S. ; FLA. ADMIN. CODE r. 69O-143.047(1) (2003).
[24] s. 624.418-s.624.421, F.S.
[25] In lieu of making its own examination, the OIR may accept an independent certified public accountant's audit report prepared according to the requirements of the Florida Insurance Code. However, OIR staff indicates that very few companies choose this option because it is much more expensive than opting to have state employees conduct the audit.
[26] For foreign insurers (insurers domiciled in a United States state, territory, commonwealth or district other than Florida) the OIR may accept a full report of the last recent examination certified to by the insurance supervisory official of another state. See s .624.316(2)(c) F.S.
[27] See s. 624.316 F.S,
[28] See s. 624.316(2) (a) F.S,
[29] See s. 624.316(2) (f) 2., F.S,
[30] See s. 624.316(2) (f) F.S,
[31] The yearly examination must be conducted by the OIR and the insurer cannot be charged more than $25,000 per year. See paragraph 1.c. of of s. 624.316(2) (f) F.S. .
[32] See s. 624.319, F.S.
[33] See s. 624.4085, F.S.
[34] The risk based capital system is now used instead of fixed capital standards such as a minimum surplus because it provides a more comprehensive measure of the financial needs of each individual insurer than a uniform requirement.

to take action to require the insurer to rectify the shortfall or begin receivership proceedings.[35] The RBC system examines whether insurers have met minimum financial requirements. The overall financial strength of insurers is analyzed by various rating agencies.

State Control of Financially Troubled Insurers

When an insurance company domiciled in Florida becomes insolvent[36] in Florida, the DFS has the authority to petition the Leon County Circuit Court to place the insurance company in rehabilitation or liquidation, with the Division acting as receiver. In both rehabilitation and liquidation the receiver suspends all powers of the company's directors, officers and managers.

If an insurance company is insolvent and placed in receivership, often an attempt will be made to rehabilitate the company. In rehabilitation, the receiver/Division is authorized to conduct all business of the insurer, including managing all the property and assets of the insurer, directing the actions of employees, and hiring or firing employees. If the rehabilitation is successful, then control of the company is turned back over to private sector ownership. If, however, the insurer is insolvent and there is no realistic chance that the company can be rehabilitated, then the Division will petition the court to place the company in liquidation. In a liquidation, the receiver takes possession of all the insurer's assets, marshals them, and eventually uses them to pay claimants to the extent possible and then dissolves the corporate existence of a domestic insurer.

[35] The risk-based capital requirements include various action levels if an insurer's capital falls below certain levels. If the insurer's actual capital is 200% or greater than the minimum level, no action is needed. From 100%-200% the insurer must take corrective action to increase the company's capital. From 70% to 100%, the DFS may take control of the insurer, and if the company falls below 70% then the DFS must take control of the insurer.

[36] The Florida Statutes defines "insolvency" as when 1) all the assets of the insurer would be insufficient to discharge all its liabilities, or; 2) the insurer is unable to pay its debts as they become due in the usual course of business. Also, insolvency can occur when an "impairment of capital" exists, meaning that the minimum required surplus is dissipated and the insurer lacks assets equal to greater than its liabilities. Finally, insolvency can occur when an insurer has an "impairment of surplus" by failing to comply with the surplus requirements of s. 624.408, F.S.

Hurricanes and Insurer Solvency

Florida's susceptibility to hurricanes presents additional challenges to the State's goal of ensuring the solvency of property and casualty insurers. On average, a severe hurricane (category 3 or higher) hits landfall in Florida once every four years. Hurricane Andrew (a category 5 storm) struck south Florida with over 150 mph winds, killed 39 people, caused $20-$30 billion dollars in damages, and forced the insolvency of 11 insurers.

In the aftermath of Hurricane Andrew, the Florida legislature created the Florida Hurricane Catastrophe Fund[37] (FHCF) to provide additional reinsurance capacity and thus enable insurers to continue to write residential property insurance in Florida. By providing an additional source of reinsurance to what is available in the private market, the law enables insurers to write more residential property insurance in the state than could otherwise be written. Because reinsurance purchased from the FHCF is significantly less expensive than private reinsurance, it also acts to lower residential property insurance premiums for consumers.

During the 2004 hurricane season, hurricanes Charley, Frances, Ivan and Jeanne pounded the west coast, east coast, central Florida and the panhandle. The 2004 hurricane season is expected to result in more dollar losses than Hurricane Andrew, with the residential market alone suffering damages in the range of $11 to $15 billion.[38] One insurer, American Superior Insurance Company, has been placed in receivership due to damages incurred during the hurricane season. American Superior insures approximately 60,000 policyholder's statewide, accounting for approximately 1% of the market statewide.

The High Cost of Insurer Insolvency

When an insurance company becomes insolvent, the result is costs for the State, the insurance industry, and ultimately policyholders in the State of Florida. Florida has established three guaranty funds[39] to avoid

[37] See s. 215.555, F.S.

[38] As of November 12, 2004, over $20 billion dollars in estimated gross property losses had been reported by insurers. However, this includes loss amounts under the deductible.

[39] See s. 631.55 and s. 631.57, F.S. (Florida Insurance Guaranty Association—handles claims against insolvent property and casualty insurers); s. 631.715 and s. 631.717, F.S. (Florida Life and Health Insurance Guaranty

financial loss to claimants or policyholders because of the insolvency of an insurer.[40] When an insurer or HMO goes insolvent, the various state guaranty funds are left to pay claims against those entities. Guaranty funds are funded via assessments against insurance companies and HMOs, with the result being that the rest of the market ends up paying for the failures of insolvent insurers.[41] Investors and creditors of insolvent insurers also often lose money in an insolvency, with such losses likely to lead to diminished confidence among investors.

Most importantly, the costs of insurer insolvencies are passed on to Florida consumers. When insurers become insolvent, it diminishes the overall capacity of the insurance market. This sometimes forces customers to purchase coverage from a state insurer of last resort that is required by statute to charge higher rates than private insurers.[42] Insolvencies also decrease competition within the insurance market, which gives consumers less options and likely increases costs. Plus, statutory limits are placed on the payments that state guaranty funds make to policyholders, thus some Floridians do not make a full recovery when their insurer goes insolvent.

METHODOLOGY

Staff reviewed the current solvency requirements for insurers in Florida and compared these requirements to model laws adopted by the National Association of Insurance Commissioners and to laws in other major states. Staff also interviewed personnel at the Office of Insurance Regulation and the Division of Rehabilitation and Liquidation in an attempt to determine the causes of insolvency for insurers that have been placed in liquidation or rehabilitation in recent years, generally since 1997. Legislative proposals related to insurance solvency, insurance trade publications, and insurance credit rating agency reports were also researched on this issue.

FINDINGS

A review of the insurance market in Florida shows that while the number of insolvencies in the state has decreased in recent years, the current Florida solvency laws could be strengthened to prevent certain insurer practices likely to lead to insolvency or ensure that insurers have the funds necessary to pay claims. Additionally, there are inefficiencies in insurance regulation that should be resolved to ensure that the monitoring of insurance companies focuses more intently on the insurance companies in the market that are in weaker financial condition.

A review of data provided by the Division shows that 30 insurance companies have entered receivership from the start of 1998 to November 2004. Eighteen of the insurers (60%) to enter receivership during this period are property and casualty insurers,[43] with HMO insurers being the second most common insurer to become insolvent (20%). Of the 18 property and casualty insurers to become insolvent, 10 of these companies (56%) are auto liability insurers. Of the ten insurers to become insolvent from 2001 to the present, half of these insurers are auto liability insurers, primarily in the "non-standard" auto insurance market that writes higher risk drivers.

A study by A.M. Best, examining the property and casualty market from 1969 to 2002 concluded that every insolvency—other than catastrophic losses—is caused by some form of mismanagement.[44] The study states that inadequate reserves, inadequate pricing, overly rapid growth, and fraud are historically the prime causes of insolvency. Stock insurers were four times more likely to become financially impaired than mutual insurers. Given the primacy of mismanagement in causing insolvencies in the property and casualty

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Association—handles claims dealing with health insurance, life insurance, annuity contracts and supplemental contracts); s. 631.911 and s. 631.913, F.S. (Florida Workers Compensation Insurance Guaranty Association—handles claims against workers' compensation insurers).

[40] The state has also established the Florida Health Maintenance Organization Consumer Assistance Plan to protect Floridians by assuring payment for services under covered subscriber contracts for up to 6 months after the HMO goes insolvent and to help subscribers of the insolvent HMO to find coverage. See Part IV of Ch. 631, F.S.

[41] See s. 631.57(3), F.S. (Authority for FIGA to assess insurers); s. 631.64, F.S. (Permits insurers to pass along the costs of a FIGA assessment to consumers in their rates and premiums). Insurers are also permitted to consider the cost of an assessment in ratemaking for life and health policies. See s. 631.718(7), F.S.

[42] Such as Citizens Property Insurance Corporation and the Florida Worker's Compensation Joint Underwriting Association.

[43] Since 1965, the percentage of property and casualty insurers in receivership is 61%, almost identical to the ratio of such insurers currently in receivership.

[44] Brendan Noonan, *Lessons From Past Highlight Insolvency Report*, BEST WEEK, (2004).

market, a focus on preventing clear practices of mismanagement by insurers should help reduce the possibility of a company becoming insolvent.

When insurance companies enter the receivership process in Florida, the most likely result is that they will be liquidated. Twenty-four of the thirty insurers that have entered receivership since 1997 have entered the liquidation process. Only one insurance company has been successfully rehabilitated and discharged from receivership in that time period, though five companies are currently in the rehabilitation process.

The OIR and the Division of Rehabilitation and Liquidation outlined for committee staff a number of insurer practices that often lead to insolvency. The practices involve transfers with affiliates of the insurance company, reinsurance agreements that do not transfer risk, a failure to follow company guidelines, and mismanagement.

Transactions with Affiliates

According to representatives with the OIR and the Division, insurance companies quite frequently establish affiliated entities[45] to provide services to the insurer. The services provided may include claims servicing, policy administration, premium collection, premium financing, investment management services, accounting services, or other administrative or management services. Specific disclosure requirements and guidelines as to the agreements between insurers and affiliated parties are necessary, according to these representatives, to ensure that the affiliated entities are not unjustly enriched for the services they provide and to preserve and protect the assets of the insurer. Specific requirements are also needed for officers, directors, and stockholders of insurers to comply with affiliated party transactions.

Four problematic practices were identified dealing with transactions between an insurer and its affiliates. First, some insurers have improperly paid for the expenses of an affiliated company or made improper "loans" to affiliates. In a similar vein, some insurers enter into contracts with affiliates that provide excessive compensation to the affiliate and are not in the best interest of the insurer. A third problem is the failure of an affiliated Managing General Agent to remit premiums to the insurer. Finally, insurers simply do not report their transactions with affiliates.

The non-standard auto liability insurance market provides an example of the vulnerabilities in the regulation of transactions with affiliates. Non-standard auto insurers sell coverage to drivers that most auto insurers are reluctant to insure, such as drivers with DUI charges or a history of speeding tickets. Insurers in the non-standard automobile insurance market have struggled financially in recent years. For the three non-standard insurers that have entered receivership since 2000, the causes of their financial troubles appear to have been created by a combination of outside forces and self-inflicted wounds.

Auto-insurance fraud[46] by policyholders has been a major cause of insolvency in Florida, particularly in the south Florida market.[47] However, many of these insurers that entered receivership did so because of their own actions. Some of the non-standard auto insurers in receivership are part of a holding company system in which the insurance company contracts with affiliated management or claims processing services to the insurance company, which in and of itself is perfectly legal. Perhaps because of the financial pressures caused by fraud, a downturn in the market, or simple dishonesty, insurers entered into bad financial agreements with their affiliates, resulting in excess amounts of money being sent outside of the insurance company, with the result being that the insurer lacked the resources to set adequate reserves.

An excellent example of the potential problems related to the affiliate party agreements with insurers is found in the insolvency and later liquidation of Aries Insurance Company.[48] Aries had a number of affiliated companies including a managing general agent, an adjusting company, multiple premium finance companies, a computer services company, and a

[45] s. 624.310(1)(a), F.S. An affiliated party is any person who directs or participates in the affairs of an insurance licensee and who is a director, officer, employee, trustee, committee member or controlling stockholder of the licensee. Exempted from the definition is 1) a controlling stockholder that is a holding company or 2) an agent of a licensee or a subsidiary or service corporation of the licensee.

[46] During the 2003 legislative Special Session A, the Legislature passed CS/SB 32A, which created and enhanced criminal penalties for PIP insurance fraud in order to reduce the level of fraud occurring in the auto insurance arena. See Chapter 2003-411, L.O.F.

[47] John Finotti, *Risky Business*, FLORIDA TREND, August 2001, at 44.

[48] Aries was placed in rehabilitation on May 9, 2002 and subsequently declared insolvent and placed in liquidation on November 14, 2002.

collections company. When Aries was placed in liquidation, millions of dollars were owed to the company by its affiliates. Entities which were not reported by Aries to OIR as affiliates asserted that in fact, they are affiliates. The example of Aries and other insurers in this segment of the market reveals that this is a potential avenue for any insurer that is facing financial pressures to attempt to shield many of its activities and assets from being monitored and closely regulated by the OIR.

Reserve Requirements

The 2004 hurricane season showed that insurers doing business in Florida must be prepared to pay for sometimes devastating losses resulting from damages caused by hurricanes. Reported gross loss estimates from the four major hurricanes are at over $20 billion dollars. An insurer that lacks the reserves, via their assets or reinsurance, to pay claims that result from a severe hurricane is likely to become insolvent. A review of Florida law reveals that there is no requirement that an insurer maintain and secure the assets and reinsurance necessary to establish a reserve that will enable the insurer to pay for claims that result from a catastrophic storm. Interviews with representatives from the insurance industry indicated that many insurers maintain reinsurance and reserves that will enable them to cover two 100-year probable maximum loss (PML)[49] storms or a 250-year probable maximum loss storm. Private insurance agencies, such as A.M. Best, typically require insurers to demonstrate that they maintain such reinsurance and reserves in order to obtain an acceptable or superior rating. When questioned by staff about the wisdom of establishing a reserve requirement on property and casualty insurers that mandates the ability to cover a single 100-year PML, representatives from the OIR indicated that such a standard would be wise given the real threat of severe storms in Florida.

Financial Analysis Reviews and Examinations

The OIR conducts financial analysis reviews and examinations for over 120 Florida domiciled (domestic) insurance companies currently in the state. A recent operational audit of the OIR by the Auditor General found that the current design of the financial analysis reviews and the financial condition examination processes are both sufficient for the office to accomplish examination objectives.

In the September 2004 Auditor General's operational audit of OIR procedures for monitoring insurer solvency, a recommendation was made that the OIR obtain independent actuarial certifications of an insurer's reported loss reserve. A loss reserve is the insurer's estimate of liabilities the insurer faces based on an actuarial determined estimate of the value of all claims. A determination of whether an insurer is solvent is largely based on whether the insurer's loss reserve is adequate, which is also used in approving the insurer's rates. A loss reserve report must have an actuarial certification according to NAIC requirements. Current Florida law and the NAIC requirements allow the certification to be done by an actuary or loss reserve specialist employed by the insurer making the report. A 1990 Government Accounting Office report stated that, "given the importance of sufficient reserves…we believe that, ideally, this loss reserve certification should be independently verified and certified."[50] The Auditor General's office made a similar recommendation in a 1997 audit report. The OIR has stated that it supports having the authority to require an independent certification of a loss reserve report.

Representatives from the Office of Insurance Regulation have expressed their desire to change the maximum time between financial examinations from 3 to 5 years for all insurers that have been certified in Florida for more than 3 years. These representatives claim that many insurers are in sound financial condition and that requiring all insurers to be examined every 3 years diverts resources and personnel from directing more time and effort to monitoring and examining insurers that are in more troublesome financial condition. Office personnel report that by going to a 5-year interval, Florida will be able to join in the examination process of multi-state insurers who currently are only examined once every 5 years by the state in which they are domiciled. The 5-year interval is the maximum time permissible to maintain accreditation with the NAIC.

[49] A 100 year probable maximum loss event is the probable loss resulting from a storm that is likely to strike with a probability of once every 100 years.

[50] GOVERNMENT ACCOUNTING OFFICE, INSURANCE REGULATION—THE INSURANCE REGULATORY INFORMATION SYSTEM NEEDS IMPROVEMENT, (1990); See FLORIDA AUDITOR GENERAL OPERATION AUDIT, OFFICE OF INSURER REGULATION—INSURER SOLVENCY, Report No. 2005-033, pg. 4-5 (Sept. 2004).

RECOMMENDATIONS

Based on the findings contained in this report, committee staff presents the following recommendations for the purposes of protecting Florida's consumers and increasing the effectiveness and efficiency of Florida's solvency regulations:

1. Enact additional guidelines, restrictions and reporting requirements that must be followed when insurance companies enter into transactions or agreements with affiliated parties.

2. Require that all property and casualty insurers transacting business in Florida maintain reinsurance and reserves sufficient to pay obligations incurred as a result of a 100-year probable maximum loss event.

3. Require that insurers provide an independent actuarial certification of the reported loss reserve that the insurer presents to the Office of Insurer Regulation.

4. Change the maximum interval between financial condition examinations from 3 to 5 years if the Office of Insurance Regulation finds the insurer to be in sound financial condition based upon audits and examinations of the finances of the insurer, financial strength ratings, risk-based capital levels, and other criteria. For insurers not meeting this threshold, the exam interval would remain at 3 years, and all insurers would be subject to an on-site examination at any time if the Office determines one is necessary.