Insurance & Banking Focus

Section I Insurance and Banking

CHAPTER 1 Insurance Sales in Banks

This first section of the course provides information for insurance professionals with information about the risks, controls and supervision of national banks' insurance activities. The information and guidance on the appropriate risks to national banks from insurance activities is provided along with a process that may be used in planning and conducting risk assessments. An important concept is the idea of functional regulation activities, where the Office of the Comptroller of the Currency defers regulatory supervision of the bank's insurance function to the state department of insurance in which the bank is located. From a banking perspective, the Federal Office of the Comptroller of the Currency (Comptroller's Office) does not consider debt cancellation contracts, debt suspension agreements, and fixed and variable rate annuities as insurance products within the scope of the guidance and policies that are to be discussed in this section of the book. Because of the complexity and importance of the legal requirements associated with insurance activities, this course also contains considerable legal information.

Overview

National banks have conducted insurance sales activities since the early 1900s. The types of insurance products and services offered and the associated distribution systems are changing significantly as this business line evolves. In recent years, national banks have engaged in insurance activities as a means to increase profitability mainly through expanding and diversifying fee-based income. Banks are also interested in providing broader financial services to customers by expanding their insurance product offerings. The Gramm-Leach-Bliley Act of 1999 (GLBA) is important legislation that addresses a number of significant issues affecting both national banks and the examination process. Among its provisions, GLBA reaffirms the authority of national banks and their subsidiaries to sell insurance. The law also clarifies the regulatory structure and product offerings related to national bank insurance activities. GLBA establishes a functional regulatory framework that reaffirms the states' authority to regulate insurance activities conducted within banks and through a functionally regulated affiliate (FRA). An FRA is an affiliate (including subsidiary) of a bank that is regulated by the SEC, CFTC, or a state insurance regulator, but generally does not include a bank holding company, savings and loan holding company, or a depository institution. FRAs can be either bank affiliates or bank subsidiaries. Additionally, GLBA reaffirms the OCC's responsibility for evaluating the consolidated risk profile of the national bank. This evaluation includes determining the risks posed to the bank from insurance activities and the effectiveness of the bank's risk management systems, including compliance with banking laws and applicable consumer protection requirements. This course examines the OCC's process for assessing risks to the national bank from insurance activities. This risk assessment process is consistent with

GLBA's functional regulation requirements and is conducted at the bank level. It is anticipated that the OCC's examinations of FRAs will be infrequent.

National Bank Insurance Powers

Both federal and state laws may govern national bank insurance activities. A national bank is authorized to engage in insurance agency activities under 12 USC 92. Under 12 USC 92, a national bank that is "located and doing business in any place the population of which does not exceed five thousand "may . . act as the agent for any fire, life, or other insurance company."

Under this authority, a national bank may sell *most* types of insurance from an agency located in a "place of 5,000" or fewer inhabitants. An area designated as a "place" by the Census Bureau is acknowledged as a "place" by the Comptroller's Office for 12 USC 92 purposes. The Census Bureau defines "place" to include both incorporated places and census designated places.

There are no geographic restrictions on the bank's ability to solicit and serve its insurance customers. National banks are not, however, authorized to sell title insurance under 12 USC 92. National banks' authority to sell title insurance is based on GLBA section 303 (15 USC 6713). See "Permissible National Bank Insurance Activities" section of the handbook for a discussion of a national bank's authority to sell title insurance under GLBA. National banks also may engage in various insurance agency activities under 12 USC 24(Seventh). This law authorizes national banks to engage in the "business of banking," and to exercise "all such incidental powers as shall be necessary to carry on the business of banking." Although an insurance product sold under this authority could also be sold under 12 USC 92, there are no geographic "place of 5,000" limits under 12 USC 24(Seventh). National banks also may engage in insurance agency activities without geographic restriction through their financial subsidiaries established under GLBA section 121 (12 USC 24a). A financial subsidiary is any company that is controlled by one or more insured depository institutions, other than a subsidiary that:
Engages solely in activities that national banks may engage in directly and that are conducted subject to the same terms and conditions that govern the conduct of these activities by national banks; or
A national bank is specifically authorized to control by the express terms of a federal statute, and not by implication or interpretation. Financial subsidiaries of banks may engage in activities that are not permissible for the parent bank, as long as the activities are financial in nature. (12 CFR 5.39. Insurance Activities Comptroller's Handbook)

National banks are authorized under GLBA section 302 (15 USC 6712) to provide insurance as principal (underwriter or reinsurer) for any product the Comptroller's Office had approved for national banks prior to January 1, 1999, or that national banks were lawfully providing as of January 1, 1999. Refer to the "Permissible National Bank Insurance Activities" section of this book for a discussion of a national bank's authority to provide insurance as principal under GLBA.

Applicability of State Laws

In 1945, Congress passed the McCarran-Ferguson Act, granting states the power to regulate most aspects of the insurance business. The McCarran-Ferguson Act (15 USC 1012(b)) states that "no act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of

insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." Therefore, under the McCarran-Ferguson Act, a state statute enacted for the purpose of regulating the business of insurance preempts a conflicting federal statute, unless the federal statute specifically relates to the business of insurance. As a result of this law, national banks must be cognizant of the potential applicability of state law requirements. The extent to which states could regulate national bank insurance activities authorized by federal law was clarified in 1996 by preemption principles that were applied by the U.S. Supreme Court in *Barnett Bank of Marion County, NA v. Nelson*, 517 U.S. 25 (1996). Under Barnett and the substantial body of law upon which the Barnett Court relied, state laws that prevent, impair, impede, or hamper the exercise of national bank powers, or that discriminate against national banks, are preempted. As a result of GLBA, the standards for determining when state laws are preempted became more complex. Under GLBA, state laws generally cannot "prevent or restrict" insurance activities conducted by national banks and their subsidiaries. For insurance sales, solicitations, and cross marketing, however, state laws cannot "prevent or significantly interfere" with bank and subsidiary insurance activities, in accordance with the legal standards for preemption set forth in Barnett (The summary follows).

BARNETT BANK OF MARION COUNTY v. NELSON, ___ U.S. ___ (1996)

No. 94-1837.

Argued January 16, 1996
Decided March 26, 1996

A 1916 federal law (Federal Statute) permits national banks to sell insurance in small towns, but a Florida law (State Statute) prohibits such banks from selling most types of insurance. When petitioner Barnett Bank, a national bank doing business in a small Florida town, bought a state licensed insurance agency, respondent State Insurance Commissioner ordered the agency to stop selling the prohibited forms of insurance. In this action for declaratory and injunctive relief, the District Court held that the State Statute was not pre-empted, but only because of the McCarran-Ferguson Act's special insurance-related anti-pre-emption rule. That rule provides that a federal law will not pre-empt a state law enacted "for the purpose of regulating the business of insurance" - unless the federal statute "specifically relates to the business of insurance." 15 U.S.C. 1012(b) (emphasis added). The Court of Appeals affirmed.

Held:

The Federal Statute pre-empts the State Statute. Pp. 4-17.

(a) Under ordinary pre-emption principles, the State Statute would be pre-empted, for it is clear that Congress, in enacting the Federal Statute, intended to exercise its constitutionally delegated authority to override contrary state law. The Federal and State Statutes are in "irreconcilable conflict," Rice v. Norman Williams Co., 458 U.S. 654, 659 , since the Federal Statute authorizes national banks to engage in activities that the State Statute expressly forbids. Thus, the State's prohibition would seem to "stan[d] as an obstacle to the accomplishment" of one of the Federal Statute's purposes, Hines v. Davidowitz, 312 U.S. 52, 67 , unless, as the State contends, Congress intended to limit federal permission to sell insurance to those circumstances permitted by state law. However, by providing, without relevant qualification, that national banks "may . . . act

as the agent" for insurance sales, 12 U.S.C. 92, the Federal Statute's language suggests a broad, not a limited, permission. That this authority is granted in "addition to the powers now vested . . . in national [banks]," ibid. (emphasis added), is also significant. Legislative grants of both enumerated and incidental "powers" to national banks historically have been interpreted as grants of authority not normally limited by, but rather ordinarily pre-empting, contrary state law. See, e.g., First Nat. Bank of San Jose v. California, 262 U.S. 366, 368-369. Where, as here, Congress has not expressly conditioned the grant of power upon a grant of state permission, this Court has ordinarily found that no such condition applies. See Franklin Nat. Bank v. New York, 347 U.S. 373 . The State's argument that special circumstances surrounding the Federal Statute's enactment demonstrate Congress' intent to grant only a limited permission is unpersuasive. Pp. 4-11.

(b) The McCarran-Ferguson Act's anti-pre-emption rule does not govern this case, because the Federal Statute "specifically relates to the business of insurance." This conclusion rests upon the Act's language and purposes, taken together. The word "relates" is highly general; and in ordinary English, the Federal Statute - which focuses directly upon industry-specific selling practices and affects the relation of insured to insurer and the spreading of risk - "specifically" relates to the insurance business. The Act's mutually reinforcing purposes - that state regulation and taxation of the insurance business is in the public interest, and that Congress' "silence . . . shall not be construed to impose any barrier to [such] regulation or taxation," 15 U.S.C. 1011 (emphasis added) - also support this view. This phrase, especially the word "silence," indicates that the Act seeks to protect state regulation primarily against inadvertent federal intrusion, not to insulate state insurance regulation from the reach of all federal law. The circumstances surrounding the Act's enactment also suggest that the Act was passed to ensure that generally phrased congressional statutes, which do not mention insurance, are not applied to the issuance of insurance policies, thereby interfering with state regulation in unanticipated ways. The parties' remaining arguments to the contrary are unconvincing. Pp. 11-17.

43 F.3d 631, reversed.

(End of Summary)

Insurance Law as Relevant to Financial Institutions and the Gramm-Leach-Bliley Act

The American Bankers Insurance Association (“ABIA”) had hoped that the Supreme Court’s decision in the *Barnett Bank* case and the codification of that decision in the Gramm-Leach-Bliley Act (“GLBA”) would end state efforts to regulate banks engaged in the sale of insurance. Instead, the Independent Insurance Agents and Brokers of America (“IIAA”) and the National Association of Insurance Commissioners (“NAIC”) sought to re-litigate the *Barnett Bank* case and re-interpret GLBA to allow States to take action against banks engaged in the sale of insurance.

The IIAA and NAIC undertook this effort on multiple fronts, including through a federal lawsuit that challenged a preemption opinion issued by the Office of the Comptroller of the Currency (“OCC”) regarding certain provisions of West Virginia’s insurance sales law. The IIAA and NAIC argued that the OCC has misread the *Barnett Bank* case and GLBA, and, as a result, has applied the wrong preemption standard. According to the

IIAA and NAIC, the "prevent or significantly interfere" preemption standard that appears in the *Barnett Bank* case and GLBA should be read narrowly and applied sparingly.

ABIA maintains that it is the IIAA and NAIC who have misread the decision in the *Barnett Bank* case and GLBA. The "prevent or significantly interfere" standard established in the *Barnett Bank* case and codified in GLBA should be read to override any action by a State that obstructs, hinders, impedes or frustrates the ability of a bank to engage in the sale of insurance.

The importance of this attempt to re-litigate the *Barnett Bank* case and re-interpret GLBA cannot be overstated. The *Barnett Bank* case was a watershed for the banking industry. It recognized the public benefits associated with national bank entry into insurance sales, and it stopped other discriminatory State insurance laws aimed at national banks. Congress subsequently codified the *Barnett Bank* decision in GLBA, and applied the *Barnett Bank* standard to all depository institutions and their affiliates.

I. The *Barnett Bank* Case, Including its Supporting Rationale, Defines when a State Law is Preempted.

In the 1996 *Barnett Bank* case the U.S. Supreme Court held that a federal banking law that permits national banks to sell insurance from small towns preempted a Florida insurance law that prohibited affiliations between financial institutions and insurance agencies. To determine whether preemption was appropriate, the Court examined the authority for national banks to sell insurance. The Court said that the authority was "a broad, not a limited, permission." The Court then said that the Florida statute is preempted, because it stood as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress" in permitting national banks to sell insurance. Further, the Court said that a state may not "prevent or significantly interfere" with a national bank's authority to sell insurance. The Court did not leave the meaning of the phrase "prevent or significantly interfere" solely to the imagination. Instead, the Court placed that phrase within the context of several other preemption cases previously decided by the Supreme Court. In those cases, the Supreme Court said that state laws that "unlawfully encroach", "destroy", "hamper", or "impair" the operation of a national bank are subject to preemption. Thus, when the phrase – "prevent or significantly interfere" – is read in conjunction with the entire decision, it is clear that this "*Barnett Bank* preemption standard" is a broad and flexible one intended to override any state law that stands as "an obstacle" to the exercise of a national bank's legitimate powers.

II. The GLBA Codified the *Barnett Bank* Decision in its Entirety.

In response to the discriminatory regulatory treatment of banks engaged in insurance sales by the States, Congress codified the decision in the *Barnett Bank* case in GLBA — including all favorably cited preemption standards — not just four words taken from the case. The relevant provision of GLBA provides that —

In accordance with the legal standards for preemption set forth in the decision of the Supreme Court of the United States in Barnett Bank of Marion County N.A. v. Nelson, 517 U.S. 25 (1996), no State may . . . prevent or significantly interfere with the ability of a depository institution . . . to engage . . . in any insurance sales, solicitation, or crossmarketing activity. (emphasis added)

The terms used in the introductory clause of this provision clearly indicate that Congress intended to codify the entire decision in the *Barnett Bank* case, not just the phrase "prevent or significantly interfere." The word "accordance" means "conformity" or "agreement." Therefore, the phrase "prevent or significantly interfere" must be read to conform or agree with the "decision" in the *Barnett Bank* case. The word "decision" is commonly understood to mean the entire opinion of a court, not just one part of the opinion, or just certain words taken from an opinion. The introductory clause also includes a citation to the decision in the *Barnett Bank* case. That citation is to the entire decision, not a portion of the decision.

The extensive legislative history of the GLBA supports this reading of the statute. Congress actively debated and voted on GLBA between 1997 and 1999. Over the course of those three years, the text of the preemption standard for State insurance sales laws evolved from a "prevent or restrict" standard to the codification of the entire decision in the *Barnett Bank* case. This occurred through the addition of what are now the introductory clause, the substitution of the phrase "prevent or significantly interfere" for the phrase "prevent or restrict," and the insertion of a rule of construction. That rule of construction provides that "Nothing in this paragraph shall be construed . . . to limit the applicability of the decision of the Supreme Court in Barnett Bank of Marion County N.A. v. Nelson, 417 U.S. 25 (1996). . . ."

Furthermore, as the text of GLBA was refined to codify the entire *Barnett Bank* decision, the Committee Reports accompanying the bill expressly linked the preemption standard for State insurance sales laws with the decision in the *Barnett Bank* case. Three statements from those reports are illustrative. First, in a November 1997 report, the House Committee on Commerce reported that even the phrase "prevent or restrict" was intended "to be *parallel to the analysis* of the United States Supreme Court in Barnett Bank of Marion County, N.A. v. Nelson, 116 S. Ct. 1103 (1996)..." (emphasis added) That Report also noted that the "prevent or restrict" standard "does not intend, by implication or otherwise, *to expand or narrow* the scope of the Barnett ruling." (emphasis added)

Second, a Senate Banking Committee Report in 1999 supporting the preemption language in the final bill states that the preemption standard for State insurance sales laws is a codification of the *Barnett Bank* decision and all of the case law embodied in that decision:
There is an extensive body of case law related to the preemption of State law. For example, in Barnett Bank of Marion County, N.A. v. Nelson, 116 S. Ct. 1103 (1996), the U.S. Supreme Court noted that Federal courts have preempted State laws that "prevent or significantly interfere" with a national bank's exercise of its powers; that "unlawfully encroach" on the rights and privileges of national banks; that "destroy or hamper" national banks' functions or that "interfere with or impair" national banks' efficiency in performing authorized functions.

Finally, the Conference Report accompanying GLBA acknowledged that the House and Senate had "parallel" provisions related to the operation of State law, and stated that the preemption standard for State insurance sales laws was the *Barnett Bank* case:

With respect to insurance sales, solicitations, and cross-marketing, States may not prevent or significantly interfere with the activities of depository institutions, *as set forth*

in Barnett Bank of Marion County N.A. v. Nelson, 517 U.S. 25 (1996). . . . (emphasis added)

These statements leave no doubt that Congress intended to codify the entire *Barnett Bank* case in GLBA and to apply that entire case to all banks and their affiliates engaged in the sale of insurance.

III. Federal Courts have Accepted a Broad Reading of *Barnett Bank*.

Recent litigation in which *Barnett Bank*'s "prevent or significantly interfere" standard played the central role supports a broad reading of the preemption standard in the *Barnett Bank* case. In *Association of Banks in Insurance (ABI) v. Duryee,* the Federal District Court of the 5th District of Ohio said that preemption under *Barnett Bank* is not limited to state laws that prohibit bank-affiliated insurance agencies from engaging in an authorized insurance agency activity, but also is warranted when the statute harms bank operations; increases a bank's costs of operating; requires a bank to operate inefficiently; or places obstacles in front of banks – all principles it derived from the *Barnett Bank* case. In other words, according to the court, preemption is appropriate where a state requirement prevents a bank from operating like a bank – that is, a profit-making enterprise.

The United States Court of Appeals for the Sixth Circuit fully affirmed this broad reading of *Barnett Bank*'s preemption standard, noting that the phrase "prevent or significantly interfere" means much more than what the intervenors in that case had argued:

The intervenors' attempt to redefine "significantly interfere" as "effectively thwart" is unpersuasive, however. . . . The intervenors are asking this court to interpret "significantly interfere" in a way that would render the two prongs of the *Barnett Bank* standard redundant. Moreover, immediately after laying out the "prevent or significantly interfere" standard, the *Barnett Bank* opinion cited two cases that do not support the intervenors' interpretation of the standard. *See McClellan v. Chapman,* . . . (considering whether state statute would "impair the efficiency of national banks" or would "destro[y]" or "hampe[r]" national bank's functions); *First Nat'l Bank v. Kentucky*, . . . (considering whether state law would "interfere with or impair [national banks'] efficiency in performing the functions by which they are designed to serve [the Federal] government"). (emphasis added)

It is this reading of the *Barnett Bank* preemption standard that is incorporated fully into GLBA as the Section 104 preemption standard and upon which the OCC has relied in its preemption opinion letters.

IV. Since Passage of GLBA, the States have been on Notice that Their Bank-Insurance Sales Laws are Subject to Preemption Under *Barnett Bank* and GLBA.

Following enactment of GLBA, only a few states responded to eliminate or revise discriminatory State insurance sales laws. For example, two months after enactment of the GLBA, the Texas Department of Insurance issued a bulletin describing interim guidelines temporarily suspending enforcement of several insurance agent licensing statutes pending legislative action. The Department recognized that "[b]ased on provisions of the [GLBA], several provisions of the Texas Insurance Code are preempted as applied to depository institutions and other affiliated entities who wish to

exercise powers granted under federal law to engage in the business of insurance in Texas." The Michigan Insurance Bureau issued a similar letter last year.

The NAIC also recognized the need for action. It established a working group to amend the NAIC's model Unfair Trade Practices Act to recognize the GLBA preemption standards, and invited banking interests, insurance interests, and the OCC to participate in the process. That collaborative effort was designed to ensure that any amendments to the model act that might later be adopted by a state were consistent with GLBA. The result was a final product that all parties agreed provides the states with a useful template to guide them in the enactment of state insurance sales laws that will clearly be protected from federal preemption. Moreover, in the two preemption opinion letters it has issued, the OCC made it clear that it would not preempt state laws consistent with the NAIC model.

Additionally, ABIA has provided the NAIC with a list of laws in 30 states that are inconsistent with GLBA. In its letter to the NAIC, ABIA asked the NAIC to encourage those states to remedy those laws. ABIA also noted that while there are three avenues available for resolving noncompliant state laws – state administrative/legislative action; federal regulatory action (preemption opinions); and litigation – ABIA preferred state administrative/legislative action.

In spite of these efforts, most states have not eliminated or revised offending laws, and despite the urging of the ABIA, the NAIC has expended no further efforts to encourage States to do so. This has left the banking industry with no choice but to ask the OCC for preemption opinions. It is state inaction; therefore, not the OCC's eagerness to "act unilaterally," that has led to the OCC's preemption letters in West Virginia and Massachusetts.

Moreover, it should be emphasized that the OCC's preemption letters are merely opinion letters. As stated in the OCC's preemption letters, "Federal courts, rather than the OCC, are the ultimate arbiters of whether Federal law preempts State law in a particular case."

Gramm-Leach-Bliley Act- (*Gramm-Leach-Bliley Financial Services Modernization Act)* This was enacted November 12, 1999. It repealed part of the Glass-Stegall Act of 1933. It opened up competition among banks, securities companies and insurance companies. Commercial banks are now permitted to own insurance companies and engage in securities underwriting through federally regulated subsidiaries. A complex piece of legislation, the act marks the culmination of efforts dating to the early 1980s to modernize the U.S. Financial services industry.

Glass-Stegall Act- A Federal law enacted by Congress in 1933 forcing a separation between commercial banking and investment banking. This act required commercial banks to dispose of their securities affiliates. Since then, the name Glass-Steagall has been more commonly used when referring to the four sections of the banking act (Sections 16, 20, 21, and 32) pertaining to underwriting and sale of securities.

Summary

The entire framework for State "functional regulation" of bank-insurance sales activities as set forth in GLBA is based upon a delicate balance between two principles: the preservation of state insurance regulatory powers and the establishment of limits on

those powers to ensure that states cannot unfairly discriminate against banks engaged in the sale of insurance. To achieve that balance, Congress included in GLBA a preemption standard based upon the entire *Barnett Bank* decision. The statutory text of GLBA and the supporting legislative history lead to no other conclusion. The IIAA and the NAIC are seeking to turn that balance on its head by re-litigating the *Barnett Bank* case and, thereby, effectively amending GLBA. The states have been on notice since enactment of GLBA in November 1999 that not only was *Barnett Bank* the law of the land, but that its application has been broadened to all depository institutions.

The OCC has not rushed to judgment in issuing its recent preemption letters. It has issued them within the legal authority and spirit of the GLBA. Working through the NAIC, the OCC has given the states ample time and consultation to address preemption issues relating to existing laws and laws yet to be enacted. At some point, however, states should no longer be able to delay addressing noncompliant state laws and should be put on formal notice – through a preemption opinion issued by a federal regulator – that noncompliant laws are subject to Federal preemption. In West Virginia and, subsequently, in Massachusetts, the OCC has taken that action. The OCC has the authority to do so, and its interpretation of the preemption standard to be applied is consistent with GLBA.

CHAPTER 2 State Regulation and Safe Harbors

GLBA provides 13 areas or "safe harbors," within which the states can regulate insurance sales, solicitation, and cross marketing practices of banks and their subsidiaries and affiliates. Those 13 safe harbors cover advertising practices, licensing requirements, various notices and disclaimers, tying, restrictions on paying fees to non-licensed employees, and other potentially coercive sales practices. A state law concerning insurance sales, solicitation, and cross-marketing activities that does not fit within the safe harbors is treated in one of two ways, depending on when the law was enacted. The traditional *Barnett* preemption principles apply to all state laws for insurance sales, solicitation, and cross-marketing activities that do not fit within one or more of the safe harbors. State laws regulating those activities enacted on or after September 3, 1998 are subject to the *Barnett* preemption principles and a new antidiscrimination standard.

State Regulation Safe Harbors

Application of those principles can create novel and complex legal issues that the Comptroller's Office reviews case by case. In October 2001, the Comptroller's Office published its first opinion letter, analyzing whether a state's insurance sales laws would be preempted pursuant to the *Barnett* standards as incorporated in section 104 of GLBA. The letter can be found at 66 *Federal Register* 51502 (Oct. 9, 2001). That letter contains a comprehensive discussion of how the standards apply. Until the law in this area becomes settled, however, questions about whether particular provisions of state insurance sales laws apply to national banks will continue to be address by the Office of Comptroller of the Currency.

Permissible National Bank Insurance Activities

Questions periodically arise concerning the permissibility of national banks to engage in specific insurance activities. Banks should consult with the OCC's Law Department or

their own legal counsel if any questions arise. Examples of insurance activities permissible for national banks and their subsidiaries include:

Insurance Activities as Agent

• *Selling insurance as agent from a "place of 5,000" consistent with 12 USC 92*. A national bank may act as a general insurance agent and sell most types of insurance from any office located in a community of 5,000 or less. No geographic restrictions limit the bank's ability to solicit and serve its insurance customers. A national bank is not generally authorized to sell title insurance under 12 USC 92, but may sell title insurance to the extent permitted under GLBA, as discussed later. In some states, insurance agency activities authorized under 12 USC 92 may be characterized as managing general agency (MGA) activities.

• *Selling title insurance, as authorized under GLBA*. Under GLBA, a national bank or its operating subsidiary may sell title insurance in a state where a state bank is permitted to sell title insurance, but only in the same manner and to the same extent as the state bank. Also, a national bank and its subsidiary may conduct title insurance activities that the national bank or the subsidiary was actively and lawfully conducting before November 12, 1999. Neither a national bank nor its operating subsidiaries may offer, sell, or underwrite title insurance, if a state law was in effect before November 12, 1999 that prohibits those activities in that state. Although financial subsidiaries are not subject to those title insurance sales restrictions, they may not underwrite title insurance.

• *Selling crop insurance, as authorized under 12 USC 92 and 12 USC 24a*. A bank's sales of crop insurance are permitted from a "place of 5,000" consistent with 12 USC 92. Under 12 USC 24a, a national bank is authorized to sell crop insurance as agent through the bank's financial subsidiary.

• *Selling insurance as agent without geographic limitation through a financial subsidiary, as authorized under 12 USC 24a*. Financial subsidiaries of a national bank are authorized under 12 USC 24a to act as an insurance agent for all types of insurance, in any state.

• *Selling credit-related insurance as agent under 12 USC 24(Seventh)*. Pursuant to 12 USC 24(Seventh), national banks or their subsidiaries may sell credit-related insurance products, including:

- *credit life insurance* (as defined in 12 CFR 2.2(b));
- *involuntary unemployment insurance* (protects the bank if the borrower becomes involuntarily unemployed);
- *vendors single interest insurance* and *double interest insurance* (insures the bank or the bank and the borrower, respectively, against loss or damage to personal property pledged as loan collateral);
- *mechanical breakdown insurance* (protects a loan customer against most major mechanical failures during the loan's life); and,
- *vehicle service contracts* (protects the value of loan collateral from mechanical breakdown for the term of the contract).

Insurance Activities as Principal

• *Providing insurance as principal (underwriter or reinsurer).* GLBA permits national banks and their subsidiaries to provide insurance as principal (underwriter or reinsurer) for any product that the Comptroller's Office had approved for national banks prior to January 1, 1999, or that national banks were lawfully providing as of January 1, 1999.

Included among the various types of insurance that national banks and their subsidiaries may provide as principal are credit-related insurance, municipal bond insurance, safe deposit box insurance, self insurance of business risk insurance, and private mortgage insurance.

Insurance Activities as Finder

A national bank may act as a finder to bring together potential purchasers and sellers of insurance. As a finder, a national bank may receive a fee to identify potential parties, inquire about interest, introduce or arrange meetings of interested parties, and otherwise bring parties together for a transaction that the parties themselves negotiate and consummate.

Acting as finder. Insurance finder activities are authorized for national banks under 12 USC 24(Seventh) as part of the business of banking. Some state laws may treat finder activities as activities that constitute acting as an insurance agent under state law. Where a state law characterized finder activities as activities of an insurance agent, national banks must comply with the applicable state insurance licensing and other requirements. The Comptroller's Office has also permitted banks acting as finders to provide extensive billing services to process insurance forms.

Bank Structures for National Bank Insurance Activities

A national bank may structure its insurance activities using one or a combination of legal entities. These include conducting insurance activities through the bank directly, a related insurance entity, or an unaffiliated third party. Each structure has certain benefits and efficiencies; a bank's choice will likely depend upon its resources and strategic preferences. Each of these structures must comply with appropriate legal requirements. Certain variable life insurance products are securities registered with the Securities Exchange Commission (SEC). These products are sold through broker/dealers whose functional regulator is the SEC. The SEC may use self-regulatory organizations, such as the National Association of Securities Dealers Regulation (NASDR) and the New York Stock Exchange (NYSE), to fulfill its regulatory responsibility.

Bank Direct Sales

In many states, a national bank must obtain a license — that is, the bank is the "licensed agency," and individuals working in the bank are licensed agents. Other states may require only that the individual be licensed. A bank that conducts its own insurance sales or operations may be able to exercise more control over the insurance activities than it would if it used a separate corporate or third-party structure. No formal application with the Comptroller's Office is required, if insurance activities are conducted directly through the bank.

Investment in an Insurance Entity

A national bank may choose to invest in an insurance entity, either through a controlling interest in an operating subsidiary or a financial subsidiary or a non-controlling interest in another enterprise. A bank's investment in an insurance entity may involve acquiring an existing entity or starting up a *de novo* entity. National banks planning to invest in an

insurance entity should consult 12 CFR 5 for the appropriate corporate filing procedures with the OCC. A national bank may also use a holding company affiliate to offer insurance products and services to its clients. Several factors may influence a bank's decision to invest in an insurance entity. Establishment of a separate corporation for insurance activities may minimize the potential legal liability to the bank from financial losses arising from the subsidiary's insurance activities. In addition, in the event that the bank purchases an existing insurance entity, the necessary expertise and an existing customer base can be acquired immediately.

Operating Subsidiary

National banks are authorized to conduct insurance activities in an operating subsidiary. A national bank's operating subsidiary may be structured as a corporation, a limited liability company, or a similar entity. The parent national bank must own more than 50 percent of the voting (or similar type of controlling) interest in the operating subsidiary, or may hold 50 percent or less if the parent bank otherwise controls the subsidiary and no other party controls more than a majority interest in the subsidiary. See 12 CFR 5.34 for additional information.

Financial Subsidiary

GLBA permits national banks to own financial subsidiaries that may engage in many activities financial in nature or incidental thereto, including insurance agency activities. Financial subsidiaries are authorized to act as an insurance agent for all types of insurance, including title insurance, from any location, and are not confined to a "place of 5,000." See 12 CFR 5.39 for additional information.

Non-controlling Investment

In 12 CFR 5.36, it provides that national banks may own, either directly or indirectly, a *non-controlling* interest in an enterprise. The enterprise may be a corporation, limited partnership, limited liability company, or similar entity. A non-controlling investment represents another structural option that banks may consider as a vehicle to offer insurance products and services. National banks that make non-controlling investments must meet the following four part test;

- Activities of the enterprise must be part of, or incidental to, the business of banking, or otherwise authorized for a national bank.
- The bank must be able to prevent the entity from engaging in activities that do not meet this standard or otherwise be able to withdraw its investment.
- The bank's loss exposure must be limited with no open-ended liability.
- The investment must be convenient or useful to the bank in carrying out its business and may not be a mere passive investment unrelated to the national bank's business.

Holding Company Affiliate

Some banking organizations structure their insurance activities directly under the holding company. GLBA permits a broader range of insurance activities under this structure including broader insurance underwriting authority. A national bank may contract with the holding company affiliate to offer insurance products and services to its

client base. Such transactions between a bank and a holding company affiliate must comply with the standards of Section 23B of the Federal Reserve Act. In other words, such transactions must be on terms and under circumstances that are substantially the same, or at least as favorable to the bank, as those prevailing at the time for comparable transactions with or involving other nonaffiliated companies; or in the absence of comparable transactions, on terms and under circumstances that in good faith would be offered to or would apply to, nonaffiliated companies. Generally, this requirement means that the transactions must be conducted on an arm's-length basis, and the bank must receive at least fair market value for any services it provides to its affiliate.

Arrangements with Unaffiliated Third Parties

Banks may elect to enter into agreements with third parties that have no affiliation with the bank. These arrangements can provide banks with expertise and services that otherwise would have to be developed in-house or purchased. Depending upon the type of insurance being sold, the expected volume of business, and the size of the bank, banks may find that using unaffiliated third parties to be more advantageous than establishing bank-direct or bank-affiliated insurance programs. Additionally, some banks may elect to offer more specialized products through an arrangement that may or may not involve common ownership or affiliation.

Distribution Methods

Within the authorized structures, banks may use various methods to distribute their insurance products. The sales force could involve fully dedicated agents or part-time agents. Part-time agents generally are part of a bank's platform program and may be authorized to sell bank and insurance products. These agents may have multiple employers, which may include the bank, an insurance agency, and a securities broker. Distribution methods may include face-to-face customer meetings, seminars, telemarketing, direct mail, referrals, the Internet, and other electronic media.

Agency Activities and the Role of the Insurance Agent

No one in the insurance business deals more closely with the public than insurance agents. Consumer confidence in the insurance industry depends on the demonstrated knowledge, experience, and professionalism of the insurance agent with whom a customer chooses to do business. An agent is someone who has been authorized by an insurance company to represent it. The insurance company (or insurer) underwrites and issues policies. The agent's role includes:

Describing the insurance company's policies to prospective customers.
Soliciting applications for insurance.
Providing service to prospects and policyholders.
Collecting premiums (when authorized) from policyholders and applicants.

Agents are most commonly described in terms of the contractual relationship between the agent and an insurance company. An *exclusive* agent is an individual who represents only one insurance company and is often, but not always, an employee of that insurer. A *general* agent is usually contractually awarded a specific geographic territory for an individual insurance company. General agents build their own agency and usually represent only one insurer. Unlike exclusive agents, who usually receive a salary in addition to commissions, general agents are paid by commissions only. An

independent agent can work alone or in partnership or corporate affiliations. Under a contractual agreement, independent agents represent many different insurers in the life, health, and property and liability fields. All of their compensation is from commissions.

Managing General Agency (MGA) and the Role of an MGA

An MGA is a wholesaler of insurance products and services to insurance agents. An MGA receives contractual authority from an insurer to assume many of the insurance company's functions. The MGA may provide insurance products through local insurance agents. The MGA may also provide diversified services, including marketing, accounting, data processing, policy maintenance and service, and monitoring of claims. Many insurance companies prefer the MGA distribution and management system for the marketing and underwriting of their insurance products, because it avoids the high cost of establishing a branch office. Most states require that an MGA be licensed.

Finders Activities and the Role of the Finder

A national bank may act as a finder to bring together potential purchasers and sellers of insurance. As a finder, a national bank may receive a fee to identify potential parties, inquire about interest, introduce or arrange meetings of interested parties, and otherwise bring parties together for a transaction that the parties themselves negotiate and consummate.

Reinsurance and the Role of the Reinsurer

Reinsurance is insurance for insurers. As individuals and businesses purchase insurance as protection from the consequences of loss, so do insurers. Reinsurance allows an original insurer, also called the direct writer or ceding company, to reduce its underwriting risk by transferring all or part of the risk under an insurance policy or a group of policies to another company or insurer, known as the reinsurer. The original insurer may retain only a portion of the risk and reinsure the balance with a second company. The reinsurer then assumes that portion of the risk and receives a portion of the premium. In establishing a reinsurance arrangement, the insurer should seek a reinsurer that shares its underwriting discipline and that operates under comparable standards. The same is true for reinsurers seeking partners among insurers. Banks that have captive reinsurance subsidiaries that reinsure all or part of private mortgage insurance for real estate loans also must conduct their activities in compliance with the requirements of the Real Estate Settlement Procedures Act (RESPA), 24 CFR 3500.

Regulation and Supervision

The Office of the Comptroller of the Currency is responsible for supervising the safety and soundness of the national banking system. This responsibility encompasses evaluating the consolidated risk profile of the national bank, including determining the potential material risks posed to the bank by the functionally regulated activities of a national bank's subsidiaries and affiliates. The Comptroller's Office will assess the risks posed to the bank from its insurance related activities by using a risk assessment process that is consistent with GLBA's functional regulation requirements. The assessment is integrated into the OCC's normal supervisory process and embraces the supervision by risk approach in determining the necessity, frequency, and depth of the analysis. The assessment is conducted at the bank level, and it is anticipated that the

OCC's examinations of FRAs will be infrequent. This section contains information on the OCC's supervisory process involving functionally regulated activities. It identifies the risks and significant legal requirements applicable to national banks' insurance activities. The OCC's assessment process is detailed in the "Risk Assessment Process" section of this booklet.

Functionally Regulated Activities

The Gramm-Leach-Bliley Act (GLBA) codified the concept of "functional regulation," recognizing the role of the state insurance commissioners, the Securities and Exchange Commission (SEC), and the Commodities Futures Trading Commission as the primary regulators of insurance, securities, and commodities activities, respectively. As the primary regulator of national banks, the Comptroller's Office has the responsibility for evaluating the consolidated risk profile of a bank. This responsibility includes determining the potential material risks posed to the bank by functionally regulated activities conducted by the bank or by a Functionally Regulated Affiliate (FRA), such as an affiliate insurance agency. A key component of this assessment is evaluating a national bank's systems for monitoring and controlling risks posed by functionally regulated activities conducted in the bank or an FRA. The Comptroller's Office is also responsible for determining compliance with applicable legal requirements under the OCC's jurisdiction.

The state insurance regulators are responsible for enforcing individual state's laws on the insurance companies and their associated agencies and agents doing business in the state. States regulate, among other things, licensing insurance agents or agencies, the financial stability of insurance companies, marketing and trade practices, the content of insurance policies, and the setting of premium rates. Each state has its own legal requirements and supervisory methods. State insurance regulators refer to the National Association of Insurance Commissioners (NAIC) model laws for guidance in drafting state regulations. The NAIC consists of principal insurance regulatory authorities from each state and its primary function is to develop uniform standards for the insurance industry. State insurance regulators have discretion in implementing the NAIC's recommendations given the NAIC has no authority over its individual members.

The assessment of risk at individual national banks must adhere to GLBA requirements that limit the OCC's authority to obtain reports directly from and examine an FRA, unless certain conditions exist. GLBA does not limit the OCC's authority to obtain reports from or examine the national bank itself. If the risk assessment identifies potential significant risk to the bank from the FRA's insurance activities, the Comptroller's Office will seek additional information or reports from the appropriate functional regulator. If such information or report is not made available, the Comptroller's Office may seek to obtain it from the FRA if the information or report is necessary to assess:

- A material risk to the affiliated national bank;
- Compliance with a federal law the Comptroller's Office has specific jurisdiction to enforce with respect to the insurance entity; or
- The system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank.

GLBA does not, however, limit the OCC's authority to seek information on an FRA in the possession of the bank or from sources other than the FRA to the extent needed to evaluate the risks an FRA poses to the bank.

OCC Limits

GLBA also imposes limitations on the OCC's ability to directly examine insurance activities conducted by FRAs. The Comptroller's Office may directly examine the FRA only when:

- There is reasonable cause to believe that the company is engaged in activities that pose a material risk to the affiliated national bank;
- After reviewing relevant reports, a reasonable determination is made that an examination of the company is necessary to adequately inform the Comptroller's Office of the system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank; or
- Based on reports and other information available, there is reasonable cause to believe that the company is not in compliance with federal law that the Comptroller's Office has specific jurisdiction to enforce against the company, including provisions relating to transactions with affiliates, and the Comptroller's Office cannot make such determination through examination of the national bank.

Before an examiner requests information from or conducts an examination of an FRA or an unaffiliated third-party insurance provider. Although GLBA limits on bank regulators' ability to examine and obtain reports technically apply only to affiliated entities, the Comptroller's Office will generally apply the same principles when seeking information from an unaffiliated third-party insurance provider.

GLBA functional regulation limitations on obtaining reports and examinations do not apply to insurance activities conducted directly by the bank. In those arrangements, the state insurance regulator is responsible for functional regulation of the bank's insurance activities. The Comptroller's Office is responsible for supervising the safety and soundness of those insurance activities and for evaluating compliance with banking law requirements. Effective functional supervision places a premium on close cooperation and coordination among the various regulators. The Comptroller's Office has entered into information sharing agreements with many state insurance departments to assist in this coordination and is working toward entering into agreements with all states.

Large bank EIC's and ADC's with portfolio responsibilities maintain open channels of communication with their state insurance regulatory counterparts and work directly with them on institution-specific issues. These efforts can result in strengthening regulatory oversight and reducing the burden of overlapping jurisdiction on the regulated entities. This includes the coordination of supervisory activities, communication of critical issues, and exchange of necessary information. The Comptroller's Office might receive a request for information from another functional regulator, in which case a response can be given or forwarded to another, more appropriate, functional regulator for information.

Regulatory Risk Assessment

The OCC's primary supervisory focus, with respect to a bank's insurance activities, is assessing the material risks that those activities may pose to the national bank and the effectiveness of the bank's oversight systems for monitoring and controlling those risks. The bank's insurance activities can pose direct risks to the bank's earnings, capital,

liquidity and reputation, if not properly managed. The risk assessment by the OCC takes into consideration items discussed in this course under the sections, “Applicable Legal and Regulatory Requirements,” “Risks,” and “Risk Management Processes.” The OCC’s risk assessment process is consistent with GLBA functional regulation requirements. Also, this business line risk assessment conforms to the OCC’s supervision by risk approach and is integrated into the bank’s normal supervisory process for evaluating the bank’s overall risk profile. The risk assessment process consists of a preliminary risk assessment that determines whether the insurance activities pose a material risk to the bank and what, if any, additional supervisory efforts are warranted in making this risk determination. If additional supervisory efforts are necessary, the OCC examiner selects the appropriate steps from the “Additional Risk Assessment” section. The risk assessment process anticipates that the OCC’s examinations of an FRA or unaffiliated third-party insurance provider will be infrequent; nevertheless, the process does establish protocol in the event such an examination is considered. The risk assessment of the bank’s insurance activities generally will include a bank level evaluation of the nature of the activities, strategic plans, financial significance to the bank’s earnings, capital and liquidity, risk management systems, and compliance with banking laws. Comptroller’s Office examiners use sources, such as routine meetings with bank management, regular reviews of existing bank reports, information obtained from state insurance regulators, and any applicable Comptroller’s Office reports to aid in the development of the consolidated bank assessment of risk. Comptroller’s Office examiners review and update data on the OCC’s electronic information systems during the bank’s normal supervisory cycle or as requested. The “Risk Assessment Process” section of this book contains more information on how the risk assessment is conducted.

Applicable Legal and Regulatory Requirements

Potentially relevant statutory, regulatory, and Comptroller’s Office policy requirements may apply to a national bank when insurance activities are conducted through the bank, FRAs, or unaffiliated third parties. The Comptroller’s Office risk assessments of insurance activities encompass evaluating national banks’ risk management functions. This includes determining the effectiveness of banks’ systems for ensuring compliance with applicable legal and regulatory requirements. Following is a summary of these requirements that add to the statutory provisions discussed in the “National Bank Insurance Powers” section.

Insurance Customer Protections - 12 CFR 14

National banks must comply with the OCC’s insurance consumer protection rule published under 12 CFR 14, which implements section 305 of GLBA. This regulation applies to retail sales practices, solicitations, advertising, or offers of any insurance or annuity product by a depository institution or any person engaged in such activities at an office of the institution or on behalf of the institution. Refer to the section “Bank Insurance Activities- Insurance Customer Protections” for a more detailed discussion of this regulation.

Privacy Rule - 12 CFR 40 and the Fair Credit Reporting Act

A national bank and its financial and operating subsidiaries that provide insurance to consumers must comply with the privacy provisions under Title V of GLBA. Pursuant to

the requirements of GLBA, the OCC, the Federal Reserve Board, the Federal Deposit Insurance Corporation, and the Office of Thrift Supervision have issued an interagency rule that governs the privacy of consumers' nonpublic personal information. National banks are subject to the OCC's privacy rule. However, functionally regulated financial and operating subsidiaries that offer insurance to consumers are not covered by the OCC's privacy rule, but must comply with state privacy requirements. The interagency privacy rule implements the provisions of GLBA that require each bank (and other types of financial institutions, including insurance agents and insurance underwriters) to notify its customers about the bank's privacy policies and to provide consumers with an opportunity to opt out of information sharing between the bank and certain nonaffiliated third parties. Similarly, a bank's insurance subsidiary would have to provide its customers with its own privacy and opt out notices, although the rule would permit a company-wide notice where it accurately reflects each institution's practices. The rule requires that these privacy and opt out notices be provided to individual consumers who establish a customer relationship with the bank, generally not later than the time the customer relationship is established. Unless an exception applies, these notices also must be provided to any other consumer, even if not a "customer" of the bank, before the bank discloses that consumer's nonpublic personal information to a nonaffiliated third party. While the privacy rule applies to the sharing of information by a bank with nonaffiliated third parties, affiliate sharing of certain consumer information is subject to the Fair Credit Reporting Act (FCRA). In general, if a bank wants to share with its insurance subsidiary information from a credit report or from a consumer application for credit (such as assets, income, or marital status), the bank must first notify the consumer about the intended sharing and give the consumer an opportunity to opt out of it. The same rules would apply to an insurance company that wants to share information from credit reports or from applications for insurance. Failure to provide notice and opt out may turn the bank or insurance company into a consumer reporting agency. Affiliate sharing notices should be included in the bank's or insurance company's privacy notice.

Consumer Reporting Agency

As stated above, the failure of a bank or its affiliate insurer to provide notice and opt-out information may cause the entity to morph into a consumer reporting agency. Here are the rather serious ramifications of becoming one of those.

Federal Prohibitions on Tying - 12 USC 1972

Tying the availability of credit from the bank to the purchase of insurance offered by the bank or a bank affiliate is illegal. Under 12 USC 1972, a bank is prohibited (subject to certain exceptions) from requiring a customer to obtain credit, property, or services as a prerequisite to obtaining other credit, property, or services. This standard applies whether the customer is retail or institutional, or the transaction is on bank premises or off. The Comptroller's Office has extended these protections to cover national bank operating subsidiaries

Restrictions on Transactions with Affiliates - 12 USC 371c, 371c-1

A national bank is subject to certain quantitative and qualitative restrictions on transactions with affiliates as prescribed by sections 23A and 23B of the Federal

Reserve Act, 12 USC 371c and 371c-1. These legal restrictions apply to transactions between a bank (or its subsidiaries) and affiliates conducting insurance activities. They also apply to transactions between a bank and its own financial subsidiary. The principal requirements of 12 USC 371c are as follows. The statute provides that for any one affiliate, the aggregate amount of covered transactions may not exceed 10 percent of the bank's capital stock and surplus. For all affiliates, the aggregate amount of covered transactions may not exceed 20 percent of the bank's capital stock and surplus. In addition, an extension of credit to an affiliate and a guarantee, acceptance, or letter of credit issued on behalf of an affiliate, must meet specific collateral requirements. Further, under section 371c any covered transaction must be made on terms and conditions that are consistent with safe and sound banking practices. Section 371c also prohibits the purchase of low-quality assets by a bank (or its subsidiaries) from an affiliate. Generally low-quality assets are defined as substandard, doubtful, loss, other assets especially mentioned, or delinquent.

The principal requirement of 12 USC 371c-1 is that transactions covered by that statute must be on terms and under circumstances that are substantially the same, or at least as favorable to the bank, as those prevailing at the time for comparable transactions with or involving other nonaffiliated companies; or in the absence of comparable transactions, on terms and under circumstances that in good faith would be offered to or would apply to, nonaffiliated companies. Generally, this requirement means that the transactions must be conducted on an arm's-length basis, and the bank must receive at least fair market value for any assets it sells, or services it provides, to its affiliate. A covered transaction under 12 USC 371c is an extension of credit to an affiliate; a purchase of, or investment in, affiliate securities; a purchase of assets from an affiliate; the acceptance of affiliate securities as collateral for a loan to any borrower; or the issuance of a guarantee, acceptance, or letter of credit on behalf of an affiliate. Transactions covered by 12 USC 371c-1 include covered transactions under 12 USC 371c, the sale of securities or other assets to an affiliate, including assets subject to an agreement to repurchase, and the payment of money or the furnishing of services to an affiliate under contract, lease, or otherwise.

Advisory Letter 96-8, "Guidance on Insurance and Annuity Sales Activities"

Certain standards from Office of Comptroller of the Currency Advisory Letter 96-8 under the "Risk Management" section are mentioned in this book. Other portions of Advisory Letter 96-8 were superseded by GLBA's requirements on the applicability of state laws, customer privacy, and customer protections. Advisory Letter 96-8 has since been rescinded by the OCC.

Risks

The Comptroller's Office assesses banking risk relative to the potential that events, expected or unanticipated, may have an adverse effect on the bank's earnings and capital. The primary risks associated with insurance activities are **transaction, compliance, strategic, reputation, and credit** risk. These are separate risks from those normally associated with insurance underwriting and reinsurance risks, such as mortality risk, adverse selection, excess capacity, and poor underwriting results that affect an insurer's success in business. All of these risks can pose direct risks to the bank's franchise value if not managed properly. For example, inferior product delivery, ineffective controls, and poor planning can result in potential legal costs and loss of

business. The following is a more detailed discussion of the primary risks associated with a bank's insurance activities.

Transaction Risk

Transaction risk is the risk to earnings or capital arising from fraud, error, and the inability to deliver products and services, maintain a competitive position, and manage information. Increasing or high transaction risk exists in a bank whose ability to transact business is impeded by inefficient operating systems or poor internal controls. Ineffective operating systems can result in poor product delivery, including unacceptable levels of errors and exceptions or general systems failures. Banks with low transaction risk typically have efficient delivery systems, including capable staffs, strong information systems and processing, viable backup systems, and appropriate insurance coverage for errors and omissions.

A bank's insurance activities, which may include the issuance of binders and policies, the forwarding of premiums, the filing of claims, and electronic product delivery, pose transaction risk to the bank if they are not performed efficiently and accurately. Transaction risk is elevated for banks that internally process premium payments and loss claims, including the potential liability for late or non-remittance of payments to the underwriter. For insurance sales, underwriting, or reinsurance activities, examiners assess transaction risk by evaluating the adequacy of the bank's risk management over insurance application, processing, and delivery systems and controls. They consider the volume and type of policies issued, the capabilities of systems and technology in relation to current and prospective volume, contingency preparedness, and exposures through the claims and payment processing systems.

Compliance Risk

Compliance risk is the risk to earnings or capital arising from violations of or noncompliance with laws, rules, regulations, internal policies and procedures, or ethical standards. Compliance risk exposes a bank to the possible loss of business, fines, payment of damages, and voidance of contracts. The regulatory framework for bank insurance activities is complex, consisting of both federal and state legal requirements. Banks, particularly those with multi-state programs, must research carefully and understand fully the compliance requirements for each state in which they conduct insurance activities. Moreover, this regulatory framework addresses both safety and soundness and consumer protection provisions. It is crucial that banks comply with all applicable regulatory requirements. Banks without adequate policies, training, management information systems, and audit/compliance programs are subject to high compliance risk, because of the lack of effective systems for self-regulating this business line.

Significance of Complaints

A pattern of complaints is a lagging indicator of compliance problems. Conversely, banks that clearly incorporate authority and responsibility into their risk management programs and develop strong compliance systems are likely to exhibit low compliance risk. OCC Examiners assess compliance risk by evaluating the comprehensiveness of a bank's compliance program relative to the complexity of the bank's insurance activities.

Examiners consider the volume and nature of complaints received, violations of law cited, and enforcement actions taken by banking and functional regulators, and the quality and effectiveness of the audit/compliance program.

Strategic Risk

Strategic risk is the risk to earnings or capital arising from adverse business decisions, improper implementation of decisions, or lack of responsiveness to industry changes. Strategic risk in insurance activities may be high in banks that, in an effort to remain competitive, rapidly and aggressively introduce new products and services without fully performing due diligence reviews or implementing the infrastructure to support the activity.

Culture Club

A culture that focuses almost exclusively on production and income can motivate undesirable sales and underwriting practices if appropriate risk management systems are not in place. Conversely, banks with low strategic risk would likely exhibit a corporate culture that includes appropriate planning, due diligence, implementation, delivery networks, and risk management systems.

Management's knowledge of the economic dynamics and market conditions of the insurance industry, including the cost structure and profitability of each major insurance line, can help limit strategic risk. The bank's structure and managerial talent must support its strategies and degree of innovation in offering new or nontraditional products. Strategic risk may vary depending on whether the bank acquires an existing insurance agency, underwriter, or reinsurer with established systems and controls or starts a new one. Examiners assess strategic risk by determining whether bank management: has performed adequate due diligence reviews of the insurance companies whose products will be offered, underwritten, or reinsured; evaluated the feasibility and profitability of each new insurance product and service before it is offered; and established appropriate systems and controls. Examiners also assess the adequacy of the bank's infrastructure to support agency, underwriting, and reinsurance activities.

Reputation Risk

Reputation risk is the risk to earnings or capital arising from negative public opinion that can affect the bank's ability to establish new business and retain existing relationships. Reputation risk associated with insurance sales can arise from inappropriate sales recommendations, deficient underwriting and reinsurance practices, poor service, violations of law, or litigation. Also, adverse events surrounding the insurance companies whose products are sold or underwritten through the bank may increase reputation risk. Reputation risk can be minimized by appropriate implementation and policing of the bank's insurance activities, to include effective due diligence in selecting products and their providers, as well as adequate policies, procedures, training, audit, and management information systems. Banks that are entering into or expanding insurance activities without acquiring the necessary expertise or implementing the necessary risk management systems may experience high or increasing reputation risk.

High Anxiety

A focus on production and an anxiety for income may motivate undesirable sales or underwriting practices without the necessary systems and controls. Inappropriate sales recommendations or deficient underwriting or reinsurance practices, and violations of law could subject the bank to significant reputation risk and litigation, including class-action lawsuits which can give rise to significant potential liability. Banks with low or stable reputation risk are typically those that exercise caution in introducing new insurance products and services, or those that have been in insurance activities for some time and expand their product line gradually and only after performing the appropriate due diligence review. Examiners assess reputation risk by evaluating the quality of the bank's risk controls including the due diligence process and oversight functions for ensuring appropriate sales, underwriting, and reinsurance practices. Examiners also consider any current or pending litigation and analyze customer complaint information.

Credit Risk

Credit risk is the risk to earnings or capital arising from an obligor's failure to meet the terms of any contract with the bank or to otherwise fail to perform as agreed. Credit risk is found in all activities for which success depends on counterparty, issuer, or borrower performance. Banks relying on third parties to facilitate their insurance activities are exposed to credit risk, if the vendor is unable to meet the contractual requirements. Credit risk exists in credit-related insurance sales, underwriting, and reinsurance activities, if the insurance carrier fails to honor a claim. The insurance carrier's claims paying ability depends on its financial strength and willingness to pay. In many credit-related insurance sales, the bank is named as the beneficiary to receive insurance proceeds for debt repayment in the event of the borrower's death, unemployment, or disability. If the insurance company fails to pay benefits under the credit-related policy, the bank's credit risk exposure increases as debt repayment becomes uncertain. Banks involved in underwriting credit-related insurance and reinsurance are exposed to credit risk from the probability that claims will be presented for payment or will not be honored by another underwriter. The credit quality of the primary insurance company and duration of the contracts are key variables. Before establishing a relationship with a primary underwriter or a reinsurer, the bank should conduct an independent financial analysis and review of the insurance carrier's ratings. Credit risk may be reduced partially by the support provided by state insurance guaranty associations or funds. Examiners assess credit risk in the bank's insurance activities by evaluating the significance of exposures, loss experience, and controls over the associated activities. The OCC examiner of insurance activities coordinates with the examiner responsible for assessing credit underwriting standards when determining risk exposures.

CHAPTER 3 Risk Management Processes

This section describes how national banks should manage the risks associated with insurance activities. It is what the federal government looks for in the case of banks selling insurance- procedural practices. This is a primer on risk audit standards and the examination of risk structure at a bank. The board and senior bank management should develop and implement effective risk management processes that effectively assess,

control, and monitor the risks emanating from a bank's insurance activities. An effective risk management system is characterized by a board and senior management that are actively involved in the development and maintenance of effective supervision and sound risk management processes. Evaluating the effectiveness of the bank's risk management processes is a key component of the OCC's risk assessment.

Program Management Plan

A bank's board of directors is responsible for overseeing insurance activities conducted directly by the bank or through contractual arrangements with third parties, including bank subsidiaries, affiliates, or unaffiliated providers. In carrying out this responsibility, the board should adopt an appropriate program management plan to guide the bank's insurance activities. Aspects of the plan may be articulated in the bank's strategic plan for insurance activities or in other board-approved directives. The comprehensiveness of the plan should be commensurate with the complexity of the bank's insurance activities. This plan should articulate the board's risk tolerance and establish the necessary systems for controlling the program's risks. Annually, the board should reevaluate the plan for appropriateness and effect any necessary changes. At a minimum, the plan for insurance activities should address:

Program objectives, strategic direction, and risk tolerance standards. The bank board of director's plan should address the insurance program's objectives and establish the strategies for achieving them. The plan should describe the insurance program, including risks associated with the activities, and the board's risk tolerance levels.

Organizational structure and authority. The plan should establish the organizational structure for insurance activities and clearly delineate program authority, responsibility, and accountability. Depending upon the size of the bank, this structure may be an individual, a group of individuals, or a committee.

Policies and procedures. The plan should require establishing appropriate policies and procedures commensurate with the structure and complexity of insurance activities. These guidelines should ensure that the program's objectives are met without compromising customers' best interests.

Risk management system. The plan should reflect the board's commitment to risk management and a sound internal control system. It should outline a comprehensive risk management system that is appropriate for the bank's structure, complexity, and diversity of operations. A risk management function should include, as appropriate, senior managers, line managers, and personnel from compliance, audit, legal operations, human resources, information systems, and product development.

Management information systems (MIS). The plan should establish the appropriate MIS necessary for the board to oversee properly the bank's insurance activities. Board MIS should provide sufficient information to evaluate and measure the effect of actions taken. Also, the plan should provide for appropriate senior management MIS that may include sales volumes and trends, profitability, policy exceptions, customer complaints, and other data outlining compliance with laws and policies.

Bank Risk Assessment

The board and senior management must have processes in place to identify the risks associated with the bank's insurance activities. These processes should also determine how those risks will be measured and what controls and monitoring systems are needed. The bank should clarify the risk measurement and reporting processes it expects from bank managers and third-party providers. Over time, risks may vary

because of changes in the bank's strategies, product lines, personnel, or economic environment. The bank's risk assessment should adapt to the changes and adequately address the risks. Internal and independent risk assessment should be comprehensive. Staff assigned to manage risk should identify the types of risk and estimate the levels of risk created by the bank's insurance activities. The assessment should consider the differences in bank direct activities and third-party relationships.

Risk Identification

Depending upon the size of the institution, a risk management function may have responsibility for identifying the risk in insurance activities. This function (or person in a smaller institution) should be independent and objective. When insurance activities are performed exclusively by third parties, bank management should ensure that the third-party activities are consistent with the bank's corporate strategic goals. The bank should identify the strategic purposes and risks associated with the third-party activity to ensure that the standards are consistent with those employed by the bank and to ensure that they are within the bank's risk tolerance levels.

Risk Measurement

Management must decide what measurement system is appropriate for gauging the risks in insurance activities. Models may be used in quantifying the risks. Management could incorporate insurance risks in existing models measuring credit and operational risks. A model is only as good as the quality of its data and the expertise of its users. Banks must continually assess and validate models used in this process. Office of the Comptroller of Currency's Office Bulletin 2000-16, "Risk Modeling," provides guidance on validating computer-based financial models. For third-party relationships, management should receive sufficient information and reports that allow for effective measurement of risk.

Risk Monitoring

For both third-party and bank direct activity, bank management should be accountable for understanding the insurance products offered and the sales process and for assuring compliance with insurance laws, regulations, and rules. A control self-assessment program should be implemented. This program should include identification of performance criteria, internal controls, reporting needs, and contractual requirements. The bank may want to use internal auditors, compliance officers, and legal counsel to help analyze the risks associated with third-party relationships and establish the necessary control and reporting structures.

Risk Controls

A function of insurance is to eliminate risk for individuals and businesses. Unpredictable events which put individuals at risk are a predictable expense for the population as a whole. Through insurance coverage, a risk of loss is pooled with similar risks and converted to a regular expense for the individual or business by means of payment of premiums.

There are many examples of risk; a homeowner faces a large potential for variation associated with the possibility of economic loss caused by a house fire. A driver faces a potential economic loss if his car is damaged. A larger possible economic risk exists

with respect to potential damages a driver might have to pay if he injures a third party in a car accident for which he is responsible. Historically, economic risk was managed through informal pooling agreements. Over time, these agreements were replaced by the insurance function. The cooperative concept became formalized in the insurance industry. Under a formal insurance arrangement, each insurance policy purchaser pools his or her risk with all other policyholders. An insurance contract covers a policyholder for economic loss caused by a peril named in the policy. The policyholder pays a known premium to have the insurer guarantee payment for the unknown loss. In this manner, the policyholder transfers the economic risk to the insurance company. Risk is the variation in potential economic outcomes. It is measured by the variation between possible outcomes and the expected outcome: the greater the standard deviation, the greater the risk.

By extension, the same applies to the risks faced by banks. Risk controls, including policies, procedures, processes, and systems, are necessary to maintain risk at levels consistent with the bank's risk tolerance levels. The bank should have a comprehensive set of controls for managing the insurance-related risks affecting the national bank.

Adequate Policies and Procedures

Policies and procedures should be developed and implemented that comprehensively address the bank's insurance activities. The level of detail contained in a bank's policies and procedures will depend on the structure and complexity of the bank's program. For example, an insurance program involving nationwide product distribution and heavy sales volumes will require more elaborate policies and procedures than a bank's program that is limited credit life insurance sales to its loan customers.

Effective Due Diligence Processes

A third-party provider (affiliated or unaffiliated) may perform many of a national bank's insurance activities. Before entering into a relationship with a third party, a bank should establish a comprehensive program for managing the relationship. The program should be documented and should include appropriate due diligence for selecting providers, products, and services, and ongoing oversight of the relationship. The relationship should be supported with binding written agreements, and bank counsel should review all contracts before entering into a third-party relationship. If the relationship is with a third-party provider that is an affiliate, the relationship must be consistent with the requirements of sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1. The requirements of sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1, are summarized under the "Restrictions on Transactions with Affiliates - 12 USC 371c, 371c-1" section of this study guide.

Processes for Identification and Selection of Third Parties

Selecting a competent and qualified third-party provider is essential to managing third-party risk. An effective due diligence process should be used to identify and select a third party that will help the bank achieve its strategic goals. The bank should obtain information, as appropriate, on the firm's investment and business approaches, professional resources, financial strength, historical performance, regulatory history,

personnel turnover, and other relevant factors. The due diligence process normally will consider the following factors:

- *Background*. When the third party was established, its ownership and affiliation, the history of regulatory actions, personnel turnover, and other relevant factors.
- *Financial strength*. The provider's current, past and projected financial performance, financial audits, credit ratings and analyses issued by nationally recognized independent credit rating agencies.
- *Experience*. The provider's capability to render the necessary expertise, operational and technical support for the products and services under contract, and management depth and quality, and training support for all employees. Consider any subcontractors used and their effects on the prime provider's capabilities.
- *Reputation*. The provider's business reputation, complaint records and methods of resolving complaints, commission structure, product pricing, the payment of claims, and the current regulatory/litigation environment.
- *Business strategies and goals*. The provider's business strategies and goals and whether they complement the bank's philosophies and risk appetite. Consider the provider's human resource policies, customer service philosophies, policies for managing costs and improving efficiency, and ethics.
- *Effectiveness of risk management processes*. The provider's policies and procedures, diversification guidelines, concentration limits, internal compliance and audit programs, contingency planning and disaster control systems, and the internal control environment.
- *Written plans*. The provider's written business resumption, recovery, continuity, and contingency plans; and whether they meet the bank's expectations and requirements.
- *Management information systems (MIS)*. The provider's MIS capability in meeting the bank's information needs in a timely and comprehensive manner. MIS should cover client data, sales activity, product performance, financial, compliance, and complaint information.
- *Products and services*. Whether the variety of offerings meet the bank's criteria for its client base, products' underlying insurance underwriters possess the financial strength for paying claims, and product pricing is reasonable compared with similar product offerings from other vendors. Bank management should review a sample of marketing materials, particularly those using the bank's name, to ensure materials are appropriate.

Guidelines for Written Contracts

Bank management should ensure that expectations and obligations of each party are clearly defined within a binding written agreement or contract with each third-party provider. The document should address the following issues:

- *Scope of the relationship*. The types of insurance products or services that will be provided, software support and maintenance, training of employees, and customer service guidelines.
- *Activities provided*. Agency or other insurance related activities that will be provided and whether they will be conducted on or off bank premises. The contract should describe, as applicable, the terms governing the use of the bank's space, compensation, human resources, and equipment. When dual employees are used, responsibilities and duties should be articulated clearly.

- *Expectations and responsibilities*. The means for monitoring ongoing performance and measuring the success of the third-party arrangement, including compliance with legal requirements.
- *Management information reports*. The types, frequency, and materiality of management information reports expected by bank management.
- *Compensation and costs*. Full descriptions of compensation, fees, and calculations for services provided, including charges based upon the volume of activity and fees for special requests. The contract should state clearly who is responsible for paying legal, audit, and examination fees associated with the insurance activity. The cost and responsibility for purchasing and maintaining hardware and software should be addressed.
- *Indemnification*. Provisions that release the bank from any potential liability. Such provisions can reduce the likelihood that the bank will be held liable for claims citing negligence of the third party. The bank may also consider limiting the third party's liability. If so, management should determine whether the proposed limit is in proper proportion to the amount of loss the bank might experience from the third party's failure to perform.
- *Insurance coverage*. Requirements for insurance coverage. The third party should maintain adequate insurance, including appropriate errors and omissions coverage, and should notify the bank of material changes to coverage.
- *Dispute resolution*. The process (arbitration, mediation, etc.) for resolving problems between the bank and the third party.
- *Default and termination*. What constitutes default, identity of remedies, and allowance for opportunities to cure defaults. The contract should include a provision that enables the bank to terminate the contract upon reasonable notice and without penalty, in the event the Comptroller's Office or another regulator formally objects to the third-party arrangement. The contract should state termination and notification requirements with timeframes to allow for the orderly conversion to another provider. It should also provide for timely return of the bank's data and other resources.
- *Customer complaints*. Identity of the person(s) responsible for responding to and resolving complaints. The third party should forward to the bank copies of any complaints it receives from the bank's customers and copies of all follow up correspondence on those complaints.

Guidelines for Qualifications and Training

Banks should have knowledgeable, experienced, and qualified personnel to ensure that insurance activities are carried out in a manner that provides customers with competitive products, sound advice, and accurate information. Personnel should be familiar with the bank's policies and procedures to ensure compliance with its internal guidelines and applicable legal requirements. Timely and regularly scheduled training can keep personnel aware of the latest innovations in financial products, changes in bank policies, and developments in applicable laws or regulations. To achieve these goals, management should:

- Clearly define responsibilities of personnel authorized to sell insurance products and the scope of the activities of any third party involved in the sales program.
- Verify that sales personnel are licensed and in good standing under applicable state and federal laws.
- Ascertain whether individuals have been subject to any disciplinary action.
- Ensure that continuing education requirements are met.

- Limit the involvement of tellers and individuals not qualified to sell insurance to directing customers to qualified personnel who can provide authoritative information.

For third-party relationships, the bank should ensure that the vendor has processes in place to meet qualification and training requirements.

Guidelines to Prevent Inappropriate Recommendations or Sales

Customers interested in purchasing insurance products may have particular needs based on their financial status, current insurance coverage, or other circumstances. Customers inexperienced in dealing with financial products, particularly those products involving an investment risk, may also require more detailed information about the products offered. Sales programs should have effective guidelines to prevent inappropriate recommendations or sales. For example, management should communicate clearly to its sales personnel that it is unacceptable to recommend and sell new or replacement insurance policies to customers on the basis of commissions to the seller rather than on the benefits of the policy. Such “twisting” is inappropriate and a violation of most states’ laws. For bank direct activities, the bank is responsible for day-to-day supervision of the sales practices and management including the appropriateness of products for each customer. In arrangements with third parties (bank subsidiaries, bank affiliates, and unaffiliated entities), the bank oversees the third party and ensures that the vendor has policies and procedures to prevent inappropriate recommendations and sales. Day-to-day supervision of third-party sales practices is the responsibility of the third party.

Appropriate Employee Compensation Programs

Incentive compensation is commonly used to sell insurance and may increase customer awareness of the availability of the products offered by a bank. The sales program should have a compensation structure in place that does not encourage inappropriate sales practices. Sales should reflect the customer’s best interest and the policy’s benefits, not the commission derived from the transaction. Management should communicate clearly to the bank’s sales personnel that it is unacceptable to engage in high-pressure sales tactics, sell duplicative or unnecessary insurance, or recommend and sell new or replacement insurance policies to customers for reasons other than the customers’ benefit. Sales personnel who engage in such practices should be penalized, either through the compensation program or by termination, as appropriate. The bank is responsible for day-to-day supervision of the bank’s employee compensation programs. For third-party relationships (bank subsidiaries, bank affiliates, and unaffiliated entities), it is the bank management’s task to ensure that the vendor has policies and procedures in place to ensure that its employee compensation programs are appropriate. Any performance-based compensation should be:

- Conformed to applicable legal requirements.
- Approved by appropriate legal counsel.
- Addressed in a governing document or contract.

These documents should discuss formally the performance-based compensation, including the basis of calculation and circumstances under which the fees will or will not be payable.

Any bank employee referral program should meet applicable legal requirements. For example, under 12 CFR 14, certain bank employees, including tellers, may receive a one-time nominal fee of a fixed dollar amount for each customer referred for insurance products. The payment of this referral fee cannot depend on whether the referral results in a transaction.

Risk Monitoring

Risk monitoring is necessary to evaluate the performance of the bank's risk strategies and control processes over insurance activities. Bank management responsible for risk monitoring should perform frequent, independent reviews of compliance with risk policies, procedures, and control systems. Noncompliance with established policies and procedures should be addressed through fully documented corrective action plans and communicated to affected persons. The frequency of monitoring should be determined based on the nature, complexity, and diversity of insurance activities and operations.

Ongoing Oversight of Third-Party Relationships

After entering into an arrangement with a third party (bank subsidiary, bank affiliate and unaffiliated entities), management should monitor the third party's activities and performance. Management's oversight program should be documented properly to facilitate the monitoring and management of the risks associated with third-party relationships. Management should dedicate sufficient staff with the necessary expertise to oversee the third party. The extent of a bank's oversight activities will vary depending on the nature of the arrangement. At a minimum, the bank should monitor the third party's financial condition, its controls, and the quality of its service and support. The monitoring of these areas may include:

- *Evaluation of the third party's financial condition*. Perform a comprehensive financial analysis at least annually, and more often depending upon the complexity of the third-party arrangement. Significant relationships with third parties should require audited financial statements.
- *Financial obligations to subcontractors*. Ensure that the third party's obligations are met in a timely manner.
- *Insurance coverage*. Review adequacy of the third party's coverage.
- *Review audit reports*. Review audit (e.g., internal audits, external audits, security reviews) and examination reports, if available, and follow up on any deficiencies noted.
- *Policies relating to internal controls and security*. Ensure that these policies continue to meet the bank's minimum guidelines and contract requirements.
- *On-site quality assurance reviews*. Perform reviews, targeting adherence to specified policies and procedures, when practicable and necessary.
- *Coordinated audits and reviews*. Coordinate with user groups.
- *Compliance*. Review compliance with applicable banking laws, including consumer protection legal requirements.
- *Third party's business resumption contingency planning and testing*. Review to ensure that all bank services can be restored within an acceptable time. For many critical services, annual or more frequent tests of the contingency plan are typical. Review any results of those tests and ensure that recovery times meet bank requirements.
- *Third-party personnel*. Monitor changes in key personnel allocated to the bank.

- *Reports documenting the third party's performance*. Review service level agreements regularly. Determine whether contractual terms and conditions are being met, and whether any revisions to service-level agreements or other terms are needed.
- *Performance problems*. Document and follow up on performance problems in a timely manner.
- *Bank's strategic plan and goals*. Evaluate the third party's ongoing ability to support and enhance its strategic plan and goals.
- *Training*. Ensure that adequate training is provided to bank employees.
- *Customer complaints on the products and services*. Review those provided by the third party and any complaint information available from the OCC, and the resolution of those complaints.
- *Customer satisfaction*. Consider using mystery shopper, customer callback, or other customer satisfaction programs.
- *Periodic meetings with contract parties*. Discuss performance and operational issues.
- *Documentation and records maintenance*. Document and maintain records on contract compliance, revision, and dispute resolution.

Customer Complaints

Even the most well-managed insurance program can be subject to customer complaints. Both customers and the bank will benefit, if the bank has an orderly process for assessing and addressing customer complaints and resolving compliance issues. A process that keeps track of customer complaints also helps the bank to identify and monitor any systemic problems in its sales program that could harm its franchise. This process should include maintaining records on the number, nature, and disposition of customer complaints received by a bank, subsidiary, or affiliated or unaffiliated third party. Management should also ensure that an effective process exist through which it receives information about complaints or other concerns about the bank's insurance sales, so that it may implement corrective measures. The bank's systems must be sufficient to monitor compliance with its policies, applicable federal and state laws, and Comptroller's Office guidance.

Compliance and Audit Programs

Banks develop and implement policies and procedures that ensure that insurance activities are conducted in compliance with applicable laws and regulations, internal policies and procedures, and guidelines. Compliance procedures also provide for a system to monitor customer complaints and their resolution. When applicable, compliance procedures should call for verification that third-party sales are being conducted in a manner consistent with the governing agreement with the bank. Personnel performing the audit or compliance review of the bank's insurance activities must be qualified and should have the necessary expertise to perform the assigned tasks. Audit and compliance personnel engage in ongoing training to keep abreast of emerging developments in banking, securities, and insurance laws and regulations. There should be an independent review of the insurance program. Independence may be established, if the audit or compliance personnel: determine the scope, frequency, and depth of their own reviews; report their findings directly to the board of directors or an appropriate committee of the board; have their performance evaluated by persons

independent of the insurance activity; and receive compensation that is not connected to the success of insurance product sales. An audit and compliance function is essential to effective risk management and internal control monitoring. Any deficiencies in internal controls and risk management processes should be addressed through written corrective action plans and monitored effectively for adequate follow-up and resolution.

CHAPTER 4 Insurance and Risk Review

The following risk assessment process is applicable when the risks of a national bank's insurance activities are evaluated. Whether conducted by the bank directly or through affiliated or unaffiliated third parties, the purpose of the review is to determine whether the bank's insurance activities pose a material risk to the bank. The review is normally based on supervisory information obtained during routine meetings with bank risk managers or during the Office of the Comptroller of the Currency's regularly scheduled monitoring of bank information reports. The risk assessment conforms to the OCC's supervision by risk approach and is generally integrated into the normal supervisory process for evaluating the bank's overall risk profile. The risk assessment process consists of a preliminary risk assessment that will determine whether insurance activities pose a material risk to the bank and what, if any, additional supervisory efforts are warranted in making this risk determination. If additional supervisory efforts are necessary, the OCC examiner will then select the appropriate steps from the additional risk assessment process. The risk assessment process anticipates that the OCC's examinations of a Functionally Related Affiliate or unaffiliated third-party insurance provider will be infrequent; nevertheless, the process does establish protocol in the event the risk assessment indicates that such an examination may be needed.

RISK ASSESSMENT PROCESS

The process is detailed in the next three sections under "Preliminary Risk Assessment," "Additional Risk Assessment, "and "Risk Assessment Conclusions."

The risk assessment process is consistent with GLBA functional regulation requirements limiting the OCC's authority to obtain reports directly from and examine a Functionally Regulated Affiliate (FRA), unless certain conditions exist. If the risk assessment identifies potential significant risk to the bank from the FRA's insurance activities, the Comptroller's Office seeks additional information or reports from the appropriate functional regulator. If such information or report is not made available, the Comptroller's Office may seek to obtain it from the FRA, if the information or report is necessary to assess:

- A material risk to the affiliated national bank;
- Compliance with a federal law the Comptroller's Office has specific jurisdiction to enforce with respect to the insurance entity;
- The system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank.

Direct Examination of FRA's

These limitations do not restrict the Comptroller's Office from seeking information on insurance activities conducted directly by the national bank, nor from obtaining information on an FRA from the bank or from sources other than the FRA to the extent needed to evaluate risks an FRA poses to the bank. GLBA also limits the OCC's ability to directly examine insurance activities conducted by FRAs. The Comptroller's Office may directly examine the FRA only when:

- There is reasonable cause to believe that the company is engaged in activities that pose a material risk to the affiliated national bank;
- After reviewing relevant reports, a reasonable determination is made that an examination of the company is necessary to adequately inform the Comptroller's Office of the system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank; or
- Based on reports and other information available, there is reasonable cause to believe that the company is not in compliance with federal law that the Comptroller's Office has specific jurisdiction to enforce against the company, including provisions relating to transactions with affiliates, and the Comptroller's Office cannot make such determination through examination of the national bank.

The OCC examiner seeks approval from his or her chain of authority before contacting the functional regulator for additional information on an FRA's or unaffiliated third party's insurance activities. These examination limitations do not apply to insurance activities conducted directly by the bank. In these arrangements, the state insurance regulators and the Comptroller's Office have joint jurisdiction. The state insurance regulator is responsible for functional regulation of the bank's insurance activities. The Comptroller's Office is responsible for supervising the safety and soundness of these activities and for evaluating compliance with banking law requirements. These examination limitations also do not apply to unaffiliated bank service companies subject to the Bank Service Company Act (BSCA) that provide insurance or insurance-related services to a bank. The OCC's supervisory focus in these examinations is on the bank service company's effect on the bank's safety and soundness.

Insurance Activities and FRA's

The preliminary risk assessment of the FRA or unaffiliated third-party conforms to the OCC's supervision by risk approach and is integrated into the normal supervisory process. The preliminary risk assessment is used to determine whether the national bank's insurance activities conducted in the bank, an FRA, or an unaffiliated third party pose a material risk to the bank.

Preliminary Risk Assessment

The preliminary risk assessment is meant to determine what, if any, additional supervisory efforts are warranted in making the risk determination on the part of OCC examiners.

Step 1: Level and Types of Risk

A preliminary assessment is developed as to the level and types of risks posed to a national bank by insurance activities conducted by the bank, an FRA, or an unaffiliated third party. This risk assessment should determine whether the activities pose material risk to the bank. This assessment will be used in deciding whether additional

supervisory efforts are necessary and, if appropriate, to establish the scope of the additional risk assessment. This is the list of procedures the OOC examiner follows:

1. Review the related findings in the OCC's electronic information systems that were prepared during the last supervisory cycle.
2. Contact the OCC's Customer Assistance Group to obtain any insurance related complaints (1-800-613-6743 or customer.assistance @occ.treas.gov).
3. Examiners can obtain from the bank the following information and reports applicable to insurance activities:
   - Board of director minutes and information reports.
   - Oversight committee minutes and information reports.
   - Risk management information reports.
   - Compliance and audit program reports.
   - Fiscal and interim financial reports.
   - Litigation reports.
   - Client complaint information.
4. Examiners discuss the following with the bank's risk managers;
   - Significant risk issues and management strategies relating to insurance activities.
   - Significant changes in strategies, services, and distribution channels.
   - Significant changes in organization, policies, controls, and information systems.
   - External factors affecting insurance activities and strategies to address these issues.
5. Develop a preliminary risk assessment and for perspective and strategy coordination. These items are taken into consideration:
   - The nature of the bank's insurance activities. In general, agent activities present less risk to the bank than underwriting.
   - The bank's strategic plan for its insurance activities.
   - The significance of current and planned earnings from insurance activities relative to the bank's earnings.
   - The sensitivity of insurance revenues relative to changing market or other external conditions.
   - The amount of capital necessary to support insurance activities.
   - The impact on the bank's liquidity from insurance activities either through direct funding requirements or from reputation risk.
   - Information obtained from the OCC's electronic information systems.
   - Any risk management deficiencies identified previously by the OCC, functional regulators, or the bank's risk control functions.

Also considered by OCC examiners are the following examples of insurance activities that involve potentially higher risks:

- Aggressive strategic plans and actions for expansion through acquisitions, mergers, and alliances.
- Significant program expansions by increasing product lines, licensing more agents, using more aggressive and varied distribution networks, and broadening the geographic target market.
- Sales programs involving riskier lines of business or significant concentrations of business.
- Underwriting activities.
- Manufacturing and marketing proprietary products.
- Deficiencies in the bank's oversight supervision and risk management systems.
- Negative findings from insurance regulators, auditors, compliance or risk managers.

- Adverse publicity or significant litigation.

Step 2: Sufficiency of Assessment
It must be determined whether the preliminary risk assessment is sufficient in assessing:

- Materiality of the risks posed to the bank from insurance activities.
- Effectiveness of the bank's risk management systems.
- Compliance with legal requirements under the OCC's jurisdiction.

Evaluation of Steps 1 & 2—If, Then…
If the examiners find that the preliminary risk assessment is sufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities, and the aggregate risk is not material, the examiner will STOP and proceed to the steps under the "Risk Assessment Conclusions" section.
If the preliminary risk assessment is insufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities, or the preliminary risk assessment indicates aggregate risk is potentially material, the examiner will continue with Step 3 for guidance on performing an additional risk assessment of the bank.

Step 3: Objectives, Scope and Work Plans
The objectives, scope, and work plans for the additional risk assessment of the bank to be completed are established.
1. Based on the preliminary risk assessment, examiners prepare a final planning memorandum that includes:

- A preliminary business and risk assessment profile of insurance activities.
- The objectives for the additional risk assessment.
- The timing and projected workdays for the additional risk assessment.
- The scope of the additional risk assessment to be completed. The selected steps should be consistent with the indications of risk identified during the preliminary risk assessment and focus on the identification of material risk to the bank from insurance activities. The steps to be used in this assessment should be selected from among those provided in the "Additional Risk Assessment" section.
- Required examiner resources to complete the additional risk assessment.
- The types of communication planned, such as meetings and final written products.

2. The following tasks are completed by OCC examiners after the planning memorandum has been approved by the appropriate OCC staff;

- The examination staff is selected and assigned consistent with the objectives, scope, and time frames of the planned additional risk assessment.
- Discuss the risk assessment plan with appropriate bank personnel and make suitable arrangements for on-site national bank accommodations and additional information requests.
- Examiner staff schedules and assignment responsibilities are detailed.
- Close consultation is held, and any needed authorization obtained from the OCC chain of authority before completing the additional risk assessment.

Additional Risk Assessment

This additional risk assessment is used when:

1. The preliminary risk assessment is insufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities conducted in the bank, an FRA, or an unaffiliated third party, or
2. The preliminary risk assessment indicates aggregate risk is potentially material.

The selected steps are consistent with the indications of risk identified during the preliminary risk assessment and focus on the identification of material risk to the bank from insurance activities. Examiners consult and obtain authorization from the OCC chain of authority before completing the additional risk assessments.

Quantity of Risk Assessment: Transaction Risk

Step 1: Quantity of Transaction Risk
Examiners identify and estimate the quantity of transaction risk posed to the bank from insurance activities.
1. Bank information reports relating to transaction processing and reporting in insurance activities are analyzed. The following structural assessment factors are considered:
The volume, type, and complexity of transactions, products, and services offered through the insurance program. It is determined whether the bank insurance unit internally processes premiums and claims.

- The condition, security, capacity, and recoverability of systems.
- The complexity and volume of conversions, integrations, and system changes.
- The development of new markets, products, services, technology, and delivery systems to maintain a competitive position or gain strategic advantage.
- The volume and severity of operational, administrative, and accounting control exceptions and losses from fraud and operating errors.

2. An analysis and discussion is made with appropriate bank risk managers how the following strategic assessment factors affect the quantity of transaction risk in insurance activities:

- The impact of strategic factors, including marketing plans and the development of new markets, products, services, technology, and delivery systems.
- The impact of acquisition and divestiture strategies.
- The maintenance of an appropriate balance between technology innovation and secure operations.

3. An analysis and discussion is made with appropriate bank risk managers how the following external assessment factors affect the quantity of transaction risk in insurance activities:

- The effect of external factors including economic, industry, competitive, and market conditions; legislative and regulatory changes; and technological advancement.
- The effect of infrastructure threats on the bank's ability to deliver timely support and service.
- The ability of service providers to provide and maintain service level performance that meets the requirements of the insurance activities.

4. The results of the bank information systems examination activities are obtained. The examination staff makes an analysis and discussion of the conclusions and recommendations.

Step 2: Conclusion is Reached
A conclusion is reached on the quantity of transaction risks posed to the bank from insurance activities.

Compliance Risk

Step 1: Quantity Identified and Estimated
The quantity of compliance risk posed to the bank from insurance activities are identified and estimated.
1. The type and level of policy exceptions, internal control deficiencies, and law violations that have been identified and reported internally by the bank are obtained and analyzed. Information from the following sources are reviewed:

- Board and committee minutes and reports.
- Risk management division reports.
- Compliance reports.
- Control self-assessment reports.
- Internal and external audit reports.
- Regulatory reports.
- Other Comptroller's Office examination programs.

2. The type and volume of litigation and consumer complaints related to insurance activities are obtained and analyzed.

3. Significant litigation and complaints with the appropriate bank risk managers to determine the risk to capital and the appropriateness of corrective action and follow-up processes are discussed.

Step 2: Insurance Customer Protections
Reference can be made to "Insurance Customer Protections," for the examination procedures necessary to review compliance with 12 CFR 14. These procedures can be used when they are viewed as necessary to determine the level of compliance or the quality of the bank's compliance program, or when the Comptroller's Office has identified or suspects violations.

Step 3: Legal Requirements Compliance
Determination is made whether the bank is in compliance with the legal requirements on transactions with affiliates under sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1.

Step 4: Conclusion Reached
A conclusion is reached on the quantity of compliance risk posed to the bank from insurance activities. The following assessment factors are considered by examiners, if applicable:

- The nature and extent of business activities, including new products and services.
- The volume and significance of noncompliance with policies and procedures, laws, regulations, prescribed practices, and ethical standards.
- The amount and significance of litigation and customer complaints.

Strategic Risk

Step 1: Strategic Risk Identified and Estimated

Strategic risk posed to the bank from insurance activities are identified and estimated.
1. An analysis of the bank's strategic plan for insurance activities is made by considering the following assessment factors;

- The magnitude of change in established corporate mission, goals, culture, values, or risk tolerance.
- The financial objectives as they relate to the short- and long-term goals of the bank.
- The market situation, including product, customer demographics, and geographic position.
- Diversification by product, geography, and customer demographics.
- Past performance in offering new products and services.
- Risks and performance in implementing innovative or unproven products, services, or technologies.
- Merger, acquisition and alliance plans, opportunities, and past experience.
- Potential or planned entrance into new businesses, product lines, or delivery channels, or implementation of new systems.

2. The strategic plan is discussed with appropriate bank risk managers and the impact of external factors on strategic risk is assessed. The following are considered: Economic, industry, and market conditions (impact on projected revenue).

- Legislative and regulatory change.
- Technological advances.
- Competition.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of strategic risk posed to the bank from insurance activities.

Reputation Risk

Step 1: Identify and Estimate Reputation Risk
An identity and estimate is made as to reputation risk posed to the bank from insurance activities.
1. The affect of the following assessment factors on reputation risk is discussed with the appropriate bank risk managers:

- • The volume and types of insurance activities.
- • Merger and acquisition plans and opportunities.
- • Potential or planned entrance into new businesses, product lines, or technologies (including new delivery channels), particularly those that may test legal boundaries.

2. The affect of the following external factors on reputation risk from insurance activities is discussed with the appropriate risk managers from the bank:

- The market's or public's perception of the corporate mission, culture, and risk tolerance of the bank and the insurance activities.
- The market's or public's perception of the bank's and the insurance entity's financial stability.
- The market's or public's perception of the quality of products and services offered by the bank and the insurance entity.
- The impact of economic, industry, and market conditions; legislative and regulatory change; technological advances; and competition.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of reputation risk posed to the bank from insurance activities.

Credit Risk

Step 1: Credit Risk Posed
Credit risk posed to the bank from insurance activities is identified and estimated.
1. Obtain and analyze bank information relating to credit exposures in insurance activities. The focus is on the bank's credit-related insurance, underwriting, and reinsurance activities. Consider the following risk assessment factors:

- Volume and trends in the book of business.
- Significant concentrations in the book of business, including individual, industry, geographic, and product concentrations.
- Financial strength and claims payment ability of counterparties.
- Loss experience and anticipated losses.
- Adequacy of the bank's allowance for loan and lease losses.
- Duration of insurance contracts.
- Expertise and experience of personnel responsible for overseeing and managing credit risk.
- Economic and other external factors.
- Findings from the latest examination conducted by the state insurance regulators.

2. An analysis is made of the effectiveness of the bank's due diligence process for selecting and ongoing monitoring of insurance carriers involved in the bank's credit-related, underwriting, and reinsurance activities. This effort is coordinated with the applicable steps under the "Quality of Risk Management Process" section.
3. The analysis of the above is coordinated with that of OCC examiners responsible for credit underwriting risk.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of credit risk posed to the bank from insurance activities. If the bank is involved in reinsurance activities, then the decision is made by examiners to continue to **Step 3** for additional guidance.

Step 3: Additional Analysis- Reinsurance
Additional analysis on the credit risk associated with the bank's reinsurance activities is performed. This is accomplished by understanding more about the nature of the bank's reinsurance business.
The section titled, "Insurance Product Types," has more information on reinsurance.
1. The method(s) used for ceding risks in the bank's reinsurance business and the proportion of the methods relative to the reinsurance activities are determined. The following are considered:

- Treaty reinsurance contracts require the reinsurer to underwrite part or all of a ceding company's book of business for one or more specific classes of business. Generally the reinsurer is bound automatically to reinsure any business the ceding company writes within these specific classes resulting in potentially greater risk than the method described next.

- Facultative reinsurance contracts only require the reinsurer to underwrite individual policies of the ceding company rather than all risks within a particular class of business.

2. The loss basis structure of treaty and facultative reinsurance contracts are determined. Taken into account is whether the reinsurance activities operate under proportional or non-proportional agreements. For proportional based reinsurance, consideration is given whether the agreement involves quota share or surplus share arrangements. Under quota share agreements, determination is made as to the percentage basis assumed in the bank's reinsurance business. Under the surplus share agreements, determination is made as to the share proportion of the individual risk reinsured. For non-proportional (or excess of loss) agreements, determination is made of the reinsurer's obligation to the primary insurer that is a predetermined amount of risk above the primary insurer's risk retention amount.
3. Whether the bank's reinsurance business uses retrocessions in transferring risk is determined. If retrocessions are used, the level of coverage obtained and the effectiveness of reducing the reinsurance loss exposures is determined.

Step 4: Conclusion Reached
A conclusion is reached on the quantity of credit risk posed to the bank from reinsurance activities.

Quality of Risk Management Assessment Policy

Step 1: Bank Policies Applicable
The adequacy and effectiveness of policies applicable to insurance activities is determined.
1. The bank board's program management plan for insurance activities is obtained. Portions of this plan may be contained within the bank's strategic plan for insurance activities or in other board directives.
2. The program management plan is reviewed to determine whether it is appropriate in guiding the bank's insurance activities. A determination is made whether the plan:

- Was formally adopted by the board and receives annual board review and approval.
- Establishes program objectives, strategic direction and risk tolerance standards.
- Addresses organizational structure and authority.
- Requires establishing appropriate policies and procedures.
- Outlines a comprehensive risk management system appropriate for the bank's insurance activities.
- Sets forth management information systems necessary for the board to oversee the activities properly.

3. Policy documents are reviewed to determine whether they:
Are approved formally by the board, or a designated committee(s).
Outline the program's goals and objectives, responsibilities, ethical culture, risk tolerance standards, and risk management framework consistent with the program management plan.
Address applicable law.
Address all significant products and services, including:
Product offering criteria.
A list and description of insurance products and services.
Compensation schedules.

Descriptions of marketing and distribution channels.
How new products and services are developed and approved.
Address the organizational structure and supervisory framework by establishing:
Organizational and functional charts.
Defined lines of authority and responsibility.
Delegation authority and approval processes.
Processes to select, employ, and evaluate legal counsel.
Standards for dealings with affiliated organizations.

Personnel practices.

Establish appropriate information reporting and risk monitoring processes that include:

- Initial and ongoing due diligence reviews of third-party vendor, products, and services.
- Written contracts with vendors.
- Proper oversight of bank direct programs.
- Customer complaint resolution procedures.
- Risk management systems.
- Policy exception tracking and reporting processes.
- • Address information systems and technology applications, such as:
- Accounting and other transaction recordkeeping systems.
- Management information system requirements.
- Systems security and disaster contingency plans.
- • Establish a compliance program. Determine whether the policy includes:
- A description of the program's purpose, responsibility, and accountability.
- Operating and testing procedures.
- Reporting and follow-up requirements and processes.
- Educational material and resource references.

4. Evaluate the policy review process and determine whether changes in risk tolerance, strategic direction, products and services, or the external environment are reviewed adequately and effectively.
5. Through discussion with management and other examiners, parts of the policy requiring development or revision are identified. Considering:
Recently developed and distributed products and services.
Discontinued products, services, organizational structures, and information systems.
Recent updates or revisions to existing policies and procedures.

Step 2: Conclusion Reached
Draw a conclusion about the adequacy and effectiveness of the bank's risk management policies relating to insurance activities.

Processes

Step 1: Oversight of Insurance Activities
Determine the adequacy and effectiveness of supervision by the bank's board and senior management.
1. Determine how supervisory oversight of insurance activities is organized and whether clear lines of authority, responsibility, and accountability are established through all levels of the organization. Obtain and evaluate:

- Bank bylaws and resolutions.
- Strategic plan and business strategies, including those related to functionally regulated entities.
- Board and management committees, charters, minutes, and reports.
- Management structures, authorities, and responsibilities.
- Other organizational structures.

2. If the board has delegated insurance supervisory oversight to one or more committees, review each committee's composition, charter, meeting frequency, attendance, information reports, and board reporting processes for consistency with board guidance and regulatory requirements.
3. Evaluate the bank's strategic planning process for insurance activities focusing on whether this planning process:

- Is part of the bank's overall strategic and financial planning processes.
- Considers all significant elements of risk that affect the insurance program, such as internal risk tolerance standards, the corporate ethical culture, available financial resources, management expertise, technology capabilities, operating systems, competition, economic and market conditions, and legal and regulatory issues.
- Evaluates and determines the amount of capital necessary to support the business.
- Includes monitoring how well the insurance program implements the strategic plan and reports performance to the bank's board or the designated oversight body.

4. Evaluate the appropriateness of board and senior management reports for overseeing the bank's insurance activities.
5. Evaluate the effectiveness of the bank's initial due diligence process when identifying and selecting an affiliated or unaffiliated third-party provider. Refer to the "Identification and Selection of Third Parties" under the "Risk Control" section of this book for factors that influence the selection process.
6. Evaluate the adequacy of the process used when establishing arrangements with affiliated and unaffiliated third-party providers. Refer to the "Guidelines for Written Contracts" under the "Risk Control" section of this course for factors that influence entering into a formal arrangement.
7. Evaluate management's effectiveness in overseeing and monitoring relationships with affiliated and unaffiliated third parties. Refer to the "Ongoing Oversight of Third Party Relationships" under the "Risk Monitoring" section of this book for factors that affect the decision-making process.
8. Evaluate the effectiveness of management's supervision of bank direct insurance programs ensuring that risks are controlled appropriately.

Step 2: Conclusion Reached
A conclusion is reached concerning the effectiveness of the bank's processes for managing risk posed to the bank from insurance activities.

Personnel: Insurance

Step 1: Policies, Practices, and Programs
A determination is made as to the adequacy and effectiveness of the bank's personnel policies, practices, and programs relating to insurance activities.
1. It is determined whether lines of authority and individual duties and responsibilities are defined and communicated clearly.
2. An evaluation is made as to the bank's recruitment and employee retention program by reviewing:

- Recent success in hiring and retaining high-quality personnel.
- Level and trends of staff turnover, particularly in key positions.
- The quality and reasonableness of management succession plans.

3. The insurance activities compensation and performance evaluation program is analyzed by considering whether:

- The compensation and performance evaluation program is appropriate for the types of products and services offered. Assess whether the compensation program provides incentive for improper sales practices.
- The program is formalized and reviewed periodically by the board and senior management.
- The program is consistent with the bank's risk tolerance and ethical standards.
- Responsibilities and accountability standards are clearly established for the performance evaluation program.
- The bank employee compensation program for insurance referrals conforms to legal requirements.

4. For bank direct insurance activities an evaluation is made of the effectiveness of management's efforts in ensuring that sales personnel are qualified, properly trained, and receiving appropriate supervision for their sales practices and other activities. For third-party relationships (bank subsidiary, affiliated and unaffiliated), assessment is made of the bank's oversight of the vendor's processes to meet qualification and training requirements.

5. The risk management training program is reviewed by considering:

- The types and frequency of training and whether the program is adequate and effective.
- The adequacy of financial resources allocated to risk management training.
- Whether employee training needs and accomplishments are a component of the performance evaluation program.

Step 2: Conclusion Reached

Examiners must reach a conclusion on the effectiveness of the bank's personnel policies, practices, and programs relating to insurance activities.

Control Systems: Insurance Activities

Step 1: Adequacy and Effectiveness of Control Systems

A determination is made as to the adequacy and effectiveness of the bank's control and monitoring systems relating to insurance activities.

1. The types of control and monitoring systems used by the bank's board and senior management are determined and evaluated. Taken into consideration are:

Board and senior management risk monitoring processes.

- Risk management groups.
- Committee structures and responsibilities.
- Management information systems.
- Quantitative risk measurement systems.
- Compliance programs.
- Control self-assessment processes.
- Complaint resolution process.
- Audit program.

2. The extent to which the bank's board and senior management are involved in supervising insurance activities are established. The following are considered:

- Types and frequency of board and senior management reviews used to determine adherence to policies, operating procedures, and strategic initiatives, including those related to functionally regulated entities.
- Adequacy, timeliness, and distribution of management information reports.
- Responsiveness to risk control deficiencies and effectiveness of corrective action and follow-up activities.

3. When the bank has a separate risk management function responsible for insurance activities, a review is made of its purpose, structure, reporting process, and effectiveness:

- Size, complexity, strategic plans, and trends in insurance activities.
- Independence and objectivity.
- Quality and quantity of personnel.
- Quality of risk assessment, transaction testing, monitoring systems, and reporting processes.

4. The bank's compliance program for insurance activities is considered, including:

- Extent of board and senior management commitment and support.
- Line management responsibility and accountability.
- Formalization, transaction testing, reporting structures, and follow-up processes.
- Qualifications and performance of compliance officer and supporting personnel.
- Communication systems.
- Training programs.

5. If the bank has implemented a control self-assessment program, information on the control self-assessments performed on insurance activities are obtained and evaluated.

6. The latest internal and external audit reports and follow-up reports pertaining to insurance activities are examined.

❋ The adequacy and effectiveness of the internal and external audit work on insurance activities is evaluated by considering:

- The independence, qualifications and competency of audit staff.
- The timing, scope, and results of audit activity.
- The quality of audit reports, work papers (if reviewed), and follow-up processes.

❋ If the review of audit reports and work papers raises questions about audit effectiveness, the issues are discussed with appropriate examiners and determine is made whether the scope of the audit review should be expanded. Issues that might require an expanded scope include:

- Unexplained or unexpected changes in auditors or significant changes in the audit program.
- Inadequate scope of the insurance activities audit program.
- Deficient audit work papers or work papers that do not support audit conclusions.
- Inadequate coverage of high risk insurance activities.
- Inappropriate actions by insiders to influence the findings or scope of audits.

Step 2: Conclusion Reached

Conclusions are drawn about the adequacy and effectiveness of the bank's control systems for managing risk posed to the bank from insurance activities. The findings and recommendations, if applicable, are forwarded to the examiner responsible for evaluating the bank's risk management, compliance, and audit programs.

Risk Assessment of Insurance Activities; Conclusions

These risk assessment conclusions are used when completing both preliminary and additional risk assessments on the bank's insurance activities conducted in the bank, an FRA, or an unaffiliated third party.

Step 1: Insurance and Banks Consolidated Risk Profile
A conclusion is reached as to the risks posed by insurance activities on the bank's consolidated risk profile.

1. The following concepts/ideas are used in making this conclusion:
- Materiality of the risks posed to the bank from insurance activities.
- The effectiveness of the bank's risk management systems for controlling risks posed to the bank from insurance activities. The bank's compliance with federal laws that the Comptroller's Office has specific jurisdiction to enforce, including provisions relating to transactions between affiliates and the national bank.

2. The large bank or community bank Risk Assessment System is completed (RAS).

Step 2: Summary of Risk
A summary document is prepared that includes the conclusions under **Step 1** and, if applicable, any other findings and recommendations for bank management.

Step 3: Findings Discussed with OCC
The review's findings are discussed with the OCC authority chain and findings are adjusted. Recommendations are made as needed. Based on those results, the appropriate next steps are;
1. Proceed to Step 4 if the preliminary or additional risk assessments conclude that the bank is not exposed to material risk from insurance activities and further supervisory efforts are not warranted.
2. The assessment is stopped and the circumstances discussed with the appropriate OCC supervisory personnel if the preliminary or additional risk assessments conclude that the bank is exposed to material risk from insurance activities and additional information is needed from the FRA or unaffiliated third party; or an examination of the FRA or unaffiliated party is necessary; or assessment findings should be referred to the functional regulators. The following information is reviewed:
- Summary document prepared in Step 2.
- The identity of the functional regulator and the name, address, and telephone number of the primary contact at the functional regulator (if applicable).
- A detailed description of the information to be requested or the reason(s) for requesting the information or for conducting the examination activity consistent with GLBA requirements, plus a copy of the proposed request to be delivered to the functional regulator.

Step 4: Bank Oversight Committees
A meeting is arranged with appropriate bank oversight committees or the appropriate risk managers to communicate the review's conclusions and recommendations. Bank management reviews draft conclusions and report comments.

Step 5: Conclusion Memorandum

A conclusion memorandum is prepared. Supplement the conclusion memorandum, when appropriate, include:

- The objectives and scope of completed supervisory activities.
- Reasons for changes in the supervisory strategy, if applicable.
- Overall conclusions, recommendations for corrective action, and management commitments and time frames.
- Comments on any recommended administrative actions, enforcement actions, and civil money penalty referrals, if appropriate.

Step 6: Final Comments
Final comments for the bank report of examination are prepared;

- Meeting Comptroller's Office report of examination guidelines.
- Supporting review conclusions and recommendations.
- Containing accurate violation citations.

Step 7: Update System
The OCC electronic information system is updated, including:

- Matters requiring attention (MRA).
- RAS.
- Violations of law or regulation.
- Core knowledge database.

Step 8: Recommended Strategy
A recommended supervisory strategy for the subsequent OCC supervisory cycle is preparedly.

Step 9: Memo or Update
A memorandum or update of work programs is prepared with any information that will facilitate future risk assessments or examinations.

CHAPTER 5 Insurance Product Types

The following are the most common types of insurance sold in most states by licensed agents. However, many varieties of these products, as well as other products, are available through insurance companies. Therefore, examiners need to understand that, because products vary significantly in purpose and complexity, the selling agents need different knowledge, qualifications, and expertise. This discussion also includes reinsurance activities.

Credit Life and Other Credit-Related Insurance

Credit Life Insurance

Credit life insurance is the mainstay product in the bank insurance industry and has been sold by national banks for decades. Credit life insurance includes credit life, health and accident insurance, sometimes referred to as credit life and disability insurance, and mortgage life and disability insurance. These policies are issued on the life of the

debtor and pay off consumer debt if the borrower dies or becomes disabled or unemployed before repayment. Mortgage life, disability, and unemployment policies make payments for a specified period of time or provide for a lump-sum payment, depending on the terms of the contract. The OCC's regulation governing credit life insurance and the disposition of credit life insurance income is 12 CFR 2. This regulation sets forth the principles and standards that apply to a national bank's sales of credit life insurance and the limitations that apply to the receipt of income from those sales by certain individuals and entities associated with the bank. Additionally, banks must comply with certain disclosure requirements in connection with the sales of credit life insurance.

Crop Insurance

Crop insurance, which includes both multiple peril crop insurance and hail/fire insurance, gives farmers a financial risk management tool to protect against excessive losses from crop failures or low yields. Historically, the federal government provided subsidies and price supports to the agriculture industry as a "safety net" to reduce the inherent production and price risk for the producer. Some minimal catastrophic coverage was required to participate in these programs. However, these programs, including federal crop insurance, were phased out under the Federal Agricultural Improvement and Reform Act of 1996. The void is being filled by crop insurance policies that are underwritten by private insurance companies.

Flood Insurance

The Comptroller's Office issued 12 CFR 22 to implement the requirements of the National Flood Insurance Act of 1968 and the Flood Disaster Protection Act of 1973. The regulation addresses requirements to purchase flood insurance where available, exemptions, escrow requirement, required use of standard flood hazard determination form, force placement of insurance coverage, determination fees, notice of special flood hazards and availability of federal disaster relief assistance, and notice of servicer's identity. A national bank is permitted to force place flood insurance if insurance is required by law and loan collateral is not covered by flood insurance or is covered in an amount less than that required by OCC's regulation. If a borrower fails to obtain flood insurance within 45 days after notification, the bank must purchase insurance on the borrower's behalf. The bank may charge the borrower for the cost of premiums and fees incurred in purchasing the insurance. Force placed flood insurance is not subject to the requirements of 12 CFR 14.

Life Insurance

The function of life insurance is to create a principal sum or estate, either through the death of the insured or through the accumulation of funds set aside for investment purposes. It is most commonly used to protect a person and his or her dependents against the undesirable financial consequences of premature death. Life insurance can be categorized into two broad types, temporary (term) and permanent insurance. There are numerous variations of Insurance Activities these products. However, life insurance products generally fall within one or a combination of the following categories.

Term Life Insurance

Term life insurance is a basic type of insurance that offers death benefits only and generally has no cash value or savings element. Because term insurance provides only mortality protection, it provides the most coverage per premium dollar. However, premiums generally increase with the age of the policyholder. Most term life insurance policies are renewable for certain periods or until the policyholder attains a specified age. Additionally, many are convertible to permanent life insurance without the insured having to show evidence of insurability. Term life insurance is commonly used in conjunction with a home mortgage, in which case the beneficiary is usually a family member, not the lienholder.

Permanent Life Insurance

Whole Life

The cash value (essentially a savings account) of a whole life insurance policy, accrues according to a guaranteed, predetermined rate of return by the insurance company. These policies are also referred to as “general account” products because the general assets of the life insurance company support the cash value. Most types provide lifetime protection to age 100. If the insured is still living at that age, the policy “endows,” and the guaranteed cash value equals the face amount of the policy. Also, cash value can be borrowed under the policy’s loan provisions. Premiums and death benefits are guaranteed for the duration of the policy. Because premiums are constant, the cost is much higher in the early years than equal coverage under a term life insurance policy. However, the cost relationship reverses in later years as the cost of term life insurance rises with the age of the insured.

Combination Policies

Combination policies usually combine term insurance with a base whole life policy by using an attachment or rider. This combination provides for additional death benefits without a significant increase in premium cost.

Universal Life

Another form of permanent life insurance, universal life is an interest-sensitive form of life insurance, designed to provide flexibility in premium payments and death benefit protection. Policyholders can adjust the premiums, cash values, and level of protection, subject to certain limitations, over the life of the contract. Additionally, unlike whole life, the interest credited to the cash value of universal life policies is based upon current interest rates, subject to an interest rate floor. Universal life has a pure insurance component (mortality protection) and a professionally managed investment component. The policyholder can pay maximum premiums and maintain a high cash value. Alternatively, the policyholder can make minimal premium payments in an amount large enough to cover mortality and other expense charges, thus not accumulating as much cash value.

Variable Life

Variable life is a form of whole life insurance with the critical difference being that the policy's cash value is invested in a segregated account comprised of equity and other securities. Premiums may be placed in the insured's choice of stock, bond, or money market funds offered through the insurance company. The death benefit and cash value of the policy depend upon the performance of the underlying investment portfolio, thus shifting the investment risk to the policyholder. There is generally, however, a minimum guaranteed death benefit. The policy allows for tax-deferred appreciation of the accumulated assets. Because variable life policies are classified as securities, life insurance agents selling these policies must also be registered representatives of a broker-dealer licensed by the National Association of Securities Dealers Regulation (NASDR) and registered with the Securities and Exchange Commission (SEC).

Variable Universal Life

Variable universal life combines the flexible premium features of universal life with the investment component of variable life. These products also are classified as securities and subject to SEC and NASD requirements.

Accident and Health Insurance

Accident and health insurance, generally referred to merely as "health insurance," is defined as insurance against loss by sickness or accidental bodily injury. The loss may be lost wages caused by the sickness or accident, or it may be expenses for doctor bills, hospital bills, medicine, and so forth. Included within this definition is insurance that provides lump sum or periodic payments, such as disability income insurance and accidental death and dismemberment in the event of loss occasioned by sickness or accident. Although these types of insurance can be written for individual coverage, most coverage is underwritten on a group basis to make premiums cost effective.

Group Life and Health Insurance

Many people are covered under group policies usually sponsored through their employers. Group plans provide low-cost insurance, and coverage is offered to everyone in the group regardless of their age or health status. Group plans have some disadvantages. There is no guarantee that the plan will be continued, and if an employee is terminated or resigns, the coverage will end. It is possible to convert group coverage to individual coverage; however, converting can be expensive for the insured.

Disability and Employment

Disability insurance is designed to replace a portion of a borrower's income, when the borrower is disabled by a covered condition. Similarly, unemployment insurance provides a portion of income, for a limited period of time, to a policyholder that subsequently becomes unemployed.

Property and Liability Insurance

Property insurance insures the policyholder against physical damage to or loss of personal or commercial property, such as homes, automobiles, and business property. Most property insurance policies require the insured to share in the loss in the form of a deductible or coinsurance. Liability insurance protects the insured against loss resulting from being found legally liable for an injury to another person or damage to property of

others. Most liability policies provide for payment of sums that the insured becomes legally obligated to pay (for the medical expenses of those injured and any damage to property of others), subject to limits. It is also typical of insuring agreements to promise defense of the insured and to reserve the right to make an out-of-court settlement. Professional liability insurance protects the insured from loss brought about by a failure to use due care and the degree of skill expected of a person in a particular situation. Malpractice insurance and errors and omissions insurance are examples of professional liability insurance.

Reinsurance

Reinsurance is a device whereby an original insurer reduces its underwriting risk by transferring all or part of the risk under an insurance policy or a group of policies to another company or insurer. Reinsurance can provide the original insurer protection against catastrophic unexpected losses. In addition, reinsurance can enable an insurance company to expand its underwriting capacity, stabilize its underwriting results, and finance its expanding volume. The original insurer is called the direct writer, ceding company or cedant, and the recipient of the transferred risk is known as the reinsurer. The original insurer typically retains only a portion of the risk and reinsures the balance with a second underwriter. The reinsurer assumes a portion of the risk and in return receives a portion of the premium from the ceding company. State insurance regulators generally conduct examinations every three to five years, but may examine a company when deemed necessary. The examinations focus primarily on solvency of reinsurers and their cedants and the collectibility of the reinsurance asset. A reputable reinsurer will be licensed (not all states require licensing), well capitalized, and prompt-paying. Most insurers are licensed in one or more states to write insurance or reinsurance business. A licensed reinsurer typically must satisfy at least the same financial, reporting and examination requirements applied to primary insurers by the state insurance regulators. Some states have more stringent financial standards for reinsurers than for original insurers.

The *credit for reinsurance* laws, regulations, and standards typically provide that a ceding insurer cannot treat reinsurance recoverables as an asset on its financial statements unless the reinsurer meets certain tests. In general, a ceding insurer can take credit if the reinsurer is licensed or accredited in the ceding insurer's state of domicile. A large number of states and the NAIC model law on credit for reinsurance recognize well-capitalized reinsurers domiciled in another state with substantially similar laws, as well as reinsurers that maintain large trust asset accounts in the U.S. If the reinsurer does not meet those standards, the ceding insurer must treat the recoverable as a liability that can be reduced only by acceptable security—usually a letter of credit, trust fund, or amounts withheld by the ceding insurer. The requirements vary, but both the NAIC model law and the versions of the model law enacted in many states reflect a movement toward higher and more uniform standards.

Reinsurance Contracts

There are two basic methods of reinsuring or "ceding" risks to a reinsurer. The more common method is *treaty reinsurance*, which accounts for about 80 percent of the placements in the U.S., and the less common is *facultative reinsurance.* Under a treaty reinsurance contract, the reinsurer underwrites part or all of a ceding company's book of business for one or more specific classes of business. The reinsurer is generally automatically bound to reinsure any business the company writes within these specified

classes. Under a facultative reinsurance contract, the ceding company cedes risk under individual policies to a reinsurer, rather than all risks within a particular class. This method reduces the ceding company's exposure to a loss on an individual risk basis, because each facultative certificate is separately negotiated. Whether treaty or facultative, reinsurance contracts can be structured on a proportional or non-proportional (excess of loss) basis. Proportional reinsurance allows for a sharing of risk, or it may result in an increase to the primary insurer's surplus, thus allowing the primary insurer to write more business. In **quota share agreements,** the ceding company and the reinsurer share in the premiums and losses of each policy the company cedes on a fixed percentage basis. A facultative certificate written on a quota share basis would work similarly, but on an individual risk, rather than a whole book basis. **Surplus share agreements** allow the company greater flexibility in ceding risks to the reinsurer. The ceding company selects the proportion of liability it wishes to retain on any one risk or policy and may then cede multiples, known as lines, of its retention to the reinsurer. Losses and premiums are divided between the ceding company and the reinsurer in the proportion each shares in the individual risk. These agreements are generally issued only on a treaty basis.

Non-proportional or excess of loss agreements require that the primary insurer pay, and be solely responsible for, claims arising from a given book of business up to a predetermined amount, known as retention. The reinsurer is obligated to reimburse the primary insurer's claims up to another predetermined amount above retention. Thereafter, the primary insurer is solely responsible for claims in excess of the reinsurer's tier of losses on a given book. When assessing risks, examiners should consider whether the reinsurer is operating under a proportional or non-proportional agreement. Retrocessions are reinsurance agreements that protect reinsurers for business they have assumed. These agreements, in effect, are reinsurance for reinsurers. Generally reinsurers will use retrocessional agreements to cover a larger number of reinsurance agreements to obtain the coverage needed. For example, if a reinsurer has reinsurance contracts with 12 insurance companies, only four retrocession agreements may provide needed coverage. These agreements are usually worded broadly to ensure intended coverage of all losses, and to avoid conflicts with terminology used in the various underlying reinsurance contracts.

Insurance Customer Protections

Part 14 of 12 CFR implements section 305 of GLBA. Banks must comply with the insurance consumer protection rule published under 12 CFR 14. This regulation applies to retail sales practices, solicitations, advertising, or offers of any insurance product or annuity by a depository institution or any person that is engaged in such activities at an office of the institution or on its behalf. The Comptroller's Office does not consider debt cancellation contracts or debt suspension agreements as insurance; consequently, they are not governed by 12 CFR 14. Part 14 applies to "covered persons." A covered person includes a bank; a person that sells, solicits, advertises, or offers an insurance product or annuity to a consumer at an office of the bank; or a person that sells, solicits, advertises, or offers an insurance product or annuity to a consumer on behalf of the bank. To determine compliance with this rule, a *consumer* is an individual who purchases, applies to purchase, or is solicited to purchase from a covered person insurance products or annuities primarily for personal, family, or household purposes. Small businesses are not consumers under this regulation. A person is acting *on behalf of* the bank when the person represents that the sale is *on behalf of* the bank; when the bank refers a customer to a seller of insurance, and the bank has a contractual relationship to receive commissions or fees derived from the sale of an insurance

product or annuity resulting from that referral; or when documents evidencing the sale, solicitation, advertising, or offer of the insurance product or annuity identify or refer to the bank. An *office* is the premises of a bank where retail deposits are accepted from the public.

The rule prohibits misrepresentation- Banks often disseminate information to bank customers and the general public describing insurance products that are available from the bank, its subsidiaries or affiliates, or unaffiliated third parties. Banks also communicate with their customers about how to obtain more information on insurance products. To comply with 12 CFR 14, those communications must not suggest or convey any inaccurate information and should be designed with care to avoid misunderstanding, confusion, or misrepresentation to the bank's customers. Covered persons, including banks, may not engage in any practice or use any advertisement at any office of, or on behalf of, the bank or a subsidiary of the bank that could mislead any person or otherwise cause a reasonable person to reach an erroneous belief for:

- The uninsured nature of any insurance product or annuity offered for sale.
- An insurance product or annuity that involves investment risk, (the fact that there is an investment risk, including the potential that principal may be lost and that the product may decline in value).

The fact that the approval of an extension of credit (when insurance products or annuities are sold or offered for sale) may not be conditioned on the purchase of an insurance product or annuity from the bank or its affiliates and that the consumer is free to purchase the product from another source.

The rule also requires the following affirmative disclosures, except when the disclosures would not be accurate:

- In connection with the initial purchase of an insurance product or annuity, the following disclosures must be provided orally and in writing before completion of the initial sale to the consumer.
- The insurance product or annuity is not a deposit or other obligation of, or guaranteed by the bank or an affiliate of the bank.
- The insurance product or annuity is not insured by the FDIC or any other agency of the United States, the bank, or an affiliate of the bank.
- If there is an insurance product or annuity that involves an investment risk, there is investment risk associated with the product, including the possible loss of value.
- In connection with an application for credit in which an insurance product or annuity is solicited, offered, or sold, banks must disclose that the bank may not condition an extension of credit on either:
- The consumer's purchase of an insurance product or annuity from the bank or any of its affiliates; or
- The consumer's agreement not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity.

In most cases, these disclosures must be made orally and in writing at the time the consumer applies for an extension of credit that is associated with an insurance product or annuity that is solicited, offered, or sold. There are various exceptions to this requirement for mail, telephone, and electronic transactions;

- Mail — Oral disclosures are not required if the sale of the insurance product or the application for credit is taken by mail.

- Telephone — If the sale is conducted by telephone, a covered person may provide the written insurance disclosures by mail within three business days beginning on the first business day after the sale. A covered person may also provide the written credit disclosure by mail if the covered person mails it to the consumer within three days beginning the first business day after the credit application is taken.
- Electronic disclosures — A covered person may provide the written insurance and credit disclosures through electronic media if the customer affirmatively consents to receiving the disclosures electronically, and the consumer can download the disclosures in a form that can be retained later, such as by printing or storing electronically.

All disclosures must be readily understandable and meaningful. Disclosures must be conspicuous, simple, direct, readily understandable, and designed to call attention to the nature and significance of the information provided. Examples of meaningful disclosures include plain language headings, easy-to-read typeface and type-size, wide margins, boldface or italics for key words, and distinctive type styles. Disclosures are not meaningfully provided in the electronic context if the consumer can bypass the visual text of the disclosures before purchasing the product.

Certain short form disclosures may be used in visual media and, as appropriate, in other circumstances. For example, a covered person may use the following disclosures in visual media:
• NOT A DEPOSIT
• NOT FDIC-INSURED
• NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY
• NOT GUARANTEED BY THE BANK
• MAY GO DOWN IN VALUE

Banks must also obtain written acknowledgement from the consumer that he/she received the required disclosures. The acknowledgement must be received at the time the consumer receives the disclosures or before the initial sale. Banks must, to the extent practicable, keep the area where it conducts its insurance and annuities transactions physically segregated from areas where retail deposits are routinely accepted from the general public. In addition to physical segregation, the rule also requires the bank to identify the areas where the sales activity occurs and to distinguish those areas from the areas where the bank’s retail deposit-taking activities occur. (The area where retail deposits are routinely accepted generally means traditional teller windows and teller lines.) Any person accepting deposits from the public, in an area where such transactions are routinely conducted in the bank, may refer a consumer who seeks to purchase an insurance product or annuity to a qualified person who sells that product. If the bank has a referral fee program, the referral fee paid to this person may not be more than a one-time, nominal fee of a fixed dollar amount that does not depend on whether the referral results in a transaction.

Examination Procedures 12 CFR 14

These examination procedures are used when Comptroller’s Office personnel are performing the additional risk assessment. These procedures are used, when they are necessary to determine the level of compliance with 12 CFR 14, to determine the quality

of the bank's compliance program, or because the Comptroller's Office has identified or suspects violations.

The objective is to determine the bank's level of compliance with 12 CFR 14, Consumer Protection in Sales of Insurance.

1. Samples are selected of initial sales of insurance and annuities and credit applications when insurance or an annuity is solicited by the applicant, or offered or sold to the applicant by the bank or covered person (include sales made and loan applications received by telephone, mail, and electronic media). Sample are also selected of advertisements and promotional materials for the sale of insurance and annuities.

2. The samples are reviewed, along with consumer complaint information, and audit findings to determine whether:

a.) Before completion of the initial sale, consumers received and acknowledged receipt of information disclosing the fact that the insurance or annuity [12 CFR 14.40(c)(1) and (c)(7)]:

Is not a deposit or other obligation of, or guaranteed by, the bank or an affiliate of the bank [12 CFR 14.40(a)(1)].

Is not insured by the Federal Deposit Insurance Corporation or any other agency of the United States, the bank or a bank affiliate [12 CFR 14.40(a)(2)].

May involve investment risk, including the possible loss of value, if applicable [12 CFR 14.40(a)(3)].

b.) At the time the consumer applied for credit, the consumer received and acknowledged (at that time or at the time of the sale) receipt of information disclosing the fact that the bank may not condition a credit extension on [12 CFR 14.40(c)(1) and (c)(7)]:

Purchase of an insurance product or annuity from the bank or any of its affiliates [12 CFR 14.40(b)(1)].

Agreement not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity [12 CFR 14.40(b)(2)].

c.) Advertisements and promotional materials include the disclosures described in 2a, [12 CFR 14.40(d)].

d.) The bank led the consumer to believe that in obtaining a loan from the bank, the consumer must purchase insurance or an annuity from the bank or its affiliates, or the consumer must agree not to purchase insurance or an annuity from a nonaffiliated [12 CFR 14.30(a)].

e.) The bank led the consumer to believe that the insurance product was backed by the federal government or bank, was insured by the FDIC, or when an investment risk existed, that the product did not involve an investment risk [12 CFR 14.30(b)].

f.) The bank considered the status of the consumer as victim of domestic violence, or provider of services to victims of domestic violence, as a criterion in any decision for insurance underwriting, pricing, renewal, scope of coverage, or payment of claims [12 CFR 14.30(c)].

3. The disclosures in 2a and 2b are reviewed by OCC staff, and a determination is made whether they were conspicuous, simple, direct, readily understandable, designed to call attention to the nature and significance of the information provided, and provided in a meaningful form [12 CFR 14.40(c)(5) and (c)(6)].

4. Through discussions with insurance sales personnel and a review of the bank's training program, it is determined whether sales personnel provide, and are trained to provide, disclosures orally and in writing prior to completion of the initial sale and at the

time a consumer applies for credit (in connection with insurance solicitations, offerings, or sales) [12 CFR 14.40(c)(1)].
5. Through discussions with management and on-site inspection, a conclusion is reached whether the bank physically segregates and identifies such areas within the bank where it conducts insurance product and annuity transactions and where it conducts retail deposit-taking activities [12 CFR 14.50(a)].
6. A review is made of the bank's compensation program for insurance referrals and a sample of employee compensation records (employees who accept deposits from the public in an area where such transactions are routinely conducted in the bank and make referrals to others for the sale of insurance products or annuities) is selected. Verification is made that such employees receive no more than a one-time, nominal fee of a fixed dollar amount for each referral, and that payment of this fee does not depend on whether the referral results in a transaction [12 CFR 14.50(b)].
7. A sample of people who sell or offer for sale any insurance product or annuity in any part of the bank or on its behalf is selected. Then it is determined whether each person has always been qualified and licensed appropriately under applicable state insurance licensing standards for the specific products they sell or recommend [12 CFR 14.60].

Conclusions

After OCC personnel audit a bank's insurance sales activities, a written summary is drawn up with conclusion and findings. If necessary, needed corrective actions are recognized as to which policies or internal controls appear to be deficient or when violations of law or regulation are identified.
1. Findings and violations from the preceding procedural steps are identified to assess the bank's level of compliance with 12 CFR 14, Consumer Protection in Sales of Insurance.
2. For those violations found to be significant or a pattern or practice, determination is made as to their root cause by identifying weaknesses in:
Internal controls.

- Audit/independent compliance review.
- Training.
- Management oversight.

3. Action needed to correct violations and weaknesses in the institution's compliance system is identified.
5. A determination is made as to whether any items identified during this examination could evolve into supervisory concerns before the next on-site examination, with consideration given as to whether the bank has plans to increase monitoring in the affected area, or anticipates changes in personnel, policy, outside auditors or consultants, or business strategy.
6. The effect on aggregate risk and direction of risk for any concerns identified during the review is ascertained using the following criteria;

- Risk categories: compliance, transaction, reputation.
- Risk conclusions: high, moderate, or low.
- Risk direction: increasing, stable, or declining.

7. A conclusion must be reached about the reliability of the compliance management system for Consumer Protection in Sales of Insurance and conclusions provided to the OCC authority chain.
8. Conclusions and sanctions (if any) are recommended concerning:

- • A summary of violations and recommended CMPs or enforcement actions, if any.

- • Recommended corrective action.
- • The quantity of risk and quality of risk management.
- • Recommended MRAs.
- MRAs should cover practices that:
    - □ Deviate from sound fundamental principles and are likely to result in financial deterioration, if not addressed.
    - □ Result in substantive noncompliance with laws.
    - □ MRAs should discuss:
    - □ Causative factors contributing to the problem.
    - □ Consequences of inaction.
    - □ Management's commitment for corrective action.
    - □ The time frame and person(s) responsible for corrective action.

9. Findings are discussed with management. A commitment(s) for corrective action as needed is obtained. Included in the discussion is:

- • The quantity of risk and quality or risk management.
- • Violations of 12 CFR 14.
- • MRAs.

Privacy Rule — 12 CFR 40 and the Fair Credit Reporting Act

Banks must provide their customers an annual privacy notice in addition to the initial privacy notices discussed previously in this text. All privacy notices must be clear and conspicuous, and must be provided so that each intended recipient can reasonably be expected to receive actual notice. The notices must be in writing (unless the consumer agrees to electronic delivery) and must describe the types of nonpublic personal information collected and disclosed, the types of affiliated and nonaffiliated third parties with whom the information may be shared, and, if applicable, the consumer's right to opt out and thereby limit certain information sharing by the bank.

Banks generally may not, directly or through an affiliate, disclose a consumer's nonpublic personal information to any nonaffiliated third party unless the consumer is given a reasonable opportunity to direct that such information not be disclosed, i.e., to opt out. Before a bank may disclose nonpublic personal information about a consumer to a nonaffiliated third party, the bank must provide the consumer with an initial privacy notice and an opt-out notice. GLBA contains a number of specific exceptions to these opt-out requirements, however, to ensure that banks can continue to disclose information to nonaffiliated third parties to conduct routine business. These exceptions include, for instance, the disclosure of information by banks to third parties who are providing services to the bank or to their customers as the bank's agent.

The interagency rule also provides that a bank generally may not disclose a credit card, deposit, or transaction account number of a consumer to any nonaffiliated third party for use in telemarketing, direct mail, or other marketing through electronic mail to the consumer. The rule also limits the redisclosure or reuse of information obtained from other nonaffiliated financial institutions. Functionally regulated subsidiaries that sell insurance must comply with state laws and regulations that govern the handling of consumer information, such as health information, in connection with insurance activities. Under GLBA, state insurance authorities are expected to promulgate privacy regulations that apply to insurance companies. States could, for example, adopt the NAIC's model privacy regulation that requires all licensees of a state insurance Comptroller's department to obtain specific consumer authorization (opt in) before

disclosing health information. The disclosure of certain consumer information may also trigger requirements under the Fair Credit Reporting Act (FCRA). Although the FCRA imposes no limits on a bank's disclosure to third parties of information about the bank's transactions and experiences with its customers, the FCRA governs the sharing of credit reports and other information that meets the statutory definition of "consumer report." The FCRA provides that banks and other entities may share such information among their affiliates without being considered consumer reporting agencies if they provide their consumers with notice about the sharing and an opportunity to opt out. Banks engaged in insurance sales activities should consider the applicability of the FCRA and any regulations that may be promulgated before disclosing "consumer report" information.

Federal Prohibitions on Tying

Under 12 USC 1972, federal law prohibits certain tying arrangements. The statute's implementing regulation (12 CFR 225.7) provides some exceptions to the statutory tying restrictions for banks, including national banks. The exceptions permit certain tying arrangements for national banks and are applicable to national bank operating subsidiaries. For purposes of the federal tying prohibitions, a national bank financial subsidiary is considered a subsidiary of the bank holding company and not the bank, as provided in 12 USC 1971 (also see 12 CFR 5.39(h)(6)). Thus, the general tying restrictions applicable to national banks and their operating subsidiaries are not applicable to financial subsidiaries. A financial subsidiary is subject to the limited tying prohibition in 12 CFR 225.7(d) involving tying electronic benefit transfer services to other point-of-sale services. Tying arrangements may violate other laws, including the federal antitrust laws, in addition to anti-tying provisions.

OCC Bulletin 95-20, "Tying Restrictions," describes measures banks can take that help to ensure compliance with the tying prohibitions. The measures include:

- Monitoring to eliminate impermissible coercion when offering customers multiple products or services.
- Training bank employees about the tying prohibitions, including providing examples of prohibited practices and sensitizing employees to the concerns raised by tying.
- Involving management in reviewing training, audit, and compliance programs, and updating any policies and procedures to reflect changes in products, services, or applicable law.
- Reviewing customer files to determine whether any extension of credit is conditioned impermissibly on obtaining an insurance product from the bank or affiliates.
- Monitoring incentives, such as commissions and fee splitting arrangements, that may encourage tying.
- Responding to any customer allegations of prohibited tying arrangements.

In situations involving sales of insurance in connection with extending a loan, banks must also comply with the requirements of 12 CFR 14. In summary, Part 14 prohibits engagement in any practice that would lead a consumer to believe that an extension of credit is conditional upon:

- The purchase of an insurance product or annuity from the bank or any of its affiliates.
- An agreement by the consumer not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity.

Tying prohibitions do not prevent bank sales personnel from *informing* a customer that insurance is required to obtain a loan or that loan approval is contingent on the customer obtaining acceptable insurance. In such circumstances, sales personnel may indicate that insurance is available from the bank and may provide instructions on how the customer can obtain additional information. However, the bank should clarify to the customer that the bank's decisions on a loan application are independent of the customer's decision on where to obtain insurance. Tying concerns are equally pertinent and potentially more acute if a type of insurance that is unrelated to, or not required in connection with, a pending loan application is offered to a loan applicant as part of the loan application process. In that situation, banks should use great care to dispel any impression that the unrelated products are being mentioned because of a potential connection to the bank's credit decision. The bank should ensure that, if such offers are permitted, they are monitored adequately by the bank's compliance system.

CHAPTER 6 Comparison- Bank & Insurance Regulatory Frameworks

The National Association of Insurance Commissioners (NAIC) and the Federal Reserve System (FRS) joint Troubled Company Subgroup (Subgroup) was formed in 2000. The Subgroup's initiative was conducted by staff from several state insurance departments, the NAIC, the Board of Governors of the Federal Reserve System (Federal Reserve Board) and the Federal Reserve Bank of Boston under the auspices of the NAIC's Financial Condition (E) Committee. The Subgroup, which was originally established under the NAIC Coordinating with Federal Regulators Working Group now reports up through the NAIC Financial Analysis Working Group (FAWG) of the NAIC Financial Condition (E) Committee. The Subgroup's objective was to compare insurance and banking regulatory frameworks for identifying and supervising companies in weakened financial condition, and was one of four joint subgroups established by the NAIC and the FRS to address implementation of the Gramm-Leach-Bliley Act (GLB Act) enacted in November 1999. Unless otherwise noted, the banking supervisory framework presented in this paper is the approach used by the FRS as it pertains to state member banks and bank holding companies (BHCs). The FRS also has supervisory responsibility for certain U.S. bank branches and certain other U.S. banking offices of foreign banking organizations (FBOs); however, the scope of this summary does not include FBO supervision. Additionally, the scope of this summary was generally limited to financial soundness monitoring and the supervision of financially weakened institutions. Comparisons of frameworks for identifying and correcting issues pertaining to compliance with consumer protection regulations were also beyond the scope of this summary.

GLB and Sector Integration

The GLB Act facilitated the already growing integration of the insurance, banking and securities sectors by permitting wider latitude for insurance companies, banks and securities firms to operate within a single financial holding company (FHC), and mandated the coordinated supervision of entities within an FHC by the financial sector regulators. The joint efforts of the insurance and banking supervisors over the past several years have provided a foundation for effective communication and coordination

between the state insurance departments and the FRS consistent with the GLB Act. Topics include-
1) Regulatory financial reporting frameworks;
2) Off-site surveillance and monitoring including "early warning systems" for identifying supervised companies having weak or deteriorating financial conditions;
3) On-site examinations;
4) Corrective action plans;
5) Enforcement powers;
6) Risk-based capital (RBC) frameworks;
7) Resolution processes for failing and failed insurance companies and banks; and
8) The FRS's role as umbrella supervisor for FHCs.

Summary of Resolution Procedures

Separately, in connection with this initiative, staff of the Federal Deposit Insurance Corporation (FDIC) presents a summary of that agency's resolution procedures to the NAIC task force members. In comparing the two frameworks of law, regulation, policy and procedures, the Subgroup members and other discussants stressed that the specific supervisory approaches taken for any given financially weakened insurance or banking company are dependent upon the specific facts and circumstances as well as upon the respective supervisory frameworks.

The Subgroup found that the frameworks for identifying and supervising financially weakened companies used by state insurance regulators and the FRS have many similarities. For example, both the state insurance departments and the FRS:

- generally require supervised institutions to file detailed quarterly financial condition and income reports, related supplementary information, and information identifying affiliated entities of an insurer or a bank;
- conduct routine off-site monitoring of supervised companies other than small, noncomplex BHCs, in part based upon information contained in regulatory reports, and also using market information, to assist in early identification of financially weakened companies and in allocating on-site examination resources;
- have minimum capital standards, including an RBC framework that requires regulatory intervention when capital of a supervised insurance company or insured bank falls below a designated level. State insurance departments and certain bank regulators are responsible for handling insurance company and bank insolvencies, respectively; insolvencies of insurance holding companies and BHCs are handled under federal bankruptcy laws.
- impose limitations on and reporting requirements related to certain transactions within holding company systems, including certain acquisitions of or by a supervised entity;
- may require a financially weakened, supervised company to develop written corrective action plans and submit progress reports on compliance with plans; and
- may take various other supervisory actions against a financially weakened company, including imposing restrictions on activities.

Phases of Supervisory Activities

The Subgroup also identified three broad phases of supervisory activities as follows:

Conducting both off-site monitoring of financial condition using financial statement and market information analysis, and on-site examinations;
Implementing corrective action plans for financially weakened companies; and undertaking insolvency proceedings (generally the responsibility of the FDIC for bank insolvencies).

The **Tables A and B** at the end of this Section contain summary information regarding the insurance and banking regulatory processes for identifying and supervising financially weakened insurance and banking organizations.

BACKGROUND ON THE GLB ACT

The GLB Act amendments to the Bank Holding Company Act of 1956 (BHC Act) authorized a qualifying bank holding company (BHC) to operate as an FHC and to engage in a diversified range of financial activities, including insurance sales, insurance underwriting, securities underwriting and dealing, acting as a futures commission merchant, and engaging in merchant banking. To qualify as an FHC, each of the BHC's depository institution subsidiaries must be well capitalized and well managed and each of the BHC's insured depository subsidiaries must have received at least a "Satisfactory" Community Reinvestment Act (CRA) rating in its most recent CRA examination. A CRA rating is an indicator of how well the depository institution has met its legal requirement to serve its community, in accordance with applicable laws and regulations. CRA examinations are conducted by a depository institution's primary federal banking regulator.

Allowed Insurance Activities

Those insurance activities that are permitted to be conducted by an FHC include-
Insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death;

- Providing and issuing annuities; and
- Acting as principal, agent, or broker for the foregoing activities.

Permissible activities also include those that the Federal Reserve Board and the Secretary of Treasury jointly determine to be financial in nature or incidental to financial activities, or that the Federal Reserve Board determines are complementary to a financial activity and do not pose a substantial risk to the safety and soundness of depository institutions or the financially system generally. Under the GLB Act, state regulation of insurance is preserved. A state law applicable to insurance may be preempted, however, if it prevents or restricts a depository institution or a depository institution affiliate from engaging in any activity authorized under the GLB Act. For instance, state laws relating to insurance sales, solicitation and cross-marketing activities may not prevent or significantly interfere with the ability of a bank or bank affiliate to engage in insurance sales activities.

With limited exceptions that existed prior to the passage of the GLB Act, insurance underwriting activities of an FHC may only be conducted by the FHC parent company or by a nonbank subsidiary of the FHC. A bank and its subsidiaries are generally precluded from insurance underwriting, other than the underwriting of credit life and credit health products. As set forth in the GLB Act, general insurance sales may be conducted by an FHC parent company or a nonbank subsidiary of the FHC, or by a

financial subsidiary of a bank. The GLB Act did not change the authority for national or state-chartered banks to sell or underwrite insurance directly. Federal banking laws, however, generally continue to limit insurance underwriting activities of banks to credit-related underwriting activities. Most state banking laws now permit state-chartered banks to sell general insurance.

The Federal Reserve Board is the umbrella supervisor of BHCs, including FHCs. In accordance with the GLB Act, the Federal Reserve Board is to rely to the fullest extent possible on reports of examination made by the applicable functional securities and insurance regulators, including for any licensed insurance company and any other subsidiary that the Federal Reserve Board finds to be comprehensively supervised by a federal or state authority. If information that is needed to assess the risk of a functionally regulated subsidiary of a banking organization is not available from the functional regulator, the Federal Reserve Board may examine a functionally regulated subsidiary of a BHC only if: the Federal Reserve Board has reasonable cause to believe that such subsidiary is engaged in activities that pose a material risk to an affiliated depository institution; the Federal Reserve Board reasonably determines, after reviewing relevant reports, that examination of the subsidiary is necessary to adequately inform the Board of the systems for monitoring and controlling operational risks that may pose a threat to the safety and soundness of a depository institution subsidiary of the BHC; or, based on reports and other available information, the Federal Reserve Board has reasonable cause to believe that the subsidiary is not in compliance with the GLB Act or any other federal law that the Federal Reserve Board has jurisdiction to enforce against such subsidiary, and the Federal Reserve Board cannot make such a determination through examination of the affiliated depository institution or the bank holding company.

FRAMEWORKS FOR SUPERVISING BANKS AND INSURANCE

The primary objective of insurance regulation is to correct market failures that would otherwise cause insurers to incur an excessive risk of insolvency or engage in market abuses that hurt consumers. Significant state insurance department regulatory resources are employed to monitor market behaviors, compliance, and solvency. Each state, the District of Columbia, and the U.S. territories are responsible for regulating the insurance business within their own jurisdictions (the fifty states, the District of Columbia, and the U.S. territories are collectively referred to as “states” in this document). Each state maintains its own insurance department, which operates under the supervision of a commissioner, director, or superintendent who is either appointed or elected. Some states have combined the regulation of insurance, banking, and securities, activities under one department or office.

NAIC Insurance Supervision

The NAIC, formed in 1871, is a private, non-profit, voluntary association of the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S territories (American Samoa, Guam, Puerto Rico, and the Virgin Islands). The NAIC provides its members with a forum for discussing common interests and for working cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. The NAIC is not a regulatory body or a trade association, but is instead an organization whose members consist solely of insurance regulators for the purpose of facilitating communication and interaction among insurance regulators to enhance insurance regulation and establish national standards, where appropriate.

State Solvency Efforts

The NAIC coordinates and assists state solvency efforts in a number of ways, including:

- Maintaining extensive insurance databases and a computer network that are assessable to all state insurance departments;
- Analyzing and informing regulators as to the financial condition of insurance companies;
- Coordinating examinations and regulatory actions with respect to financially weakened companies;
- Establishing and certifying states' compliance with minimum financial regulation standards through the NAIC's Financial Regulations Standards and Accreditation Program (Accreditation Program);
- Providing financial, reinsurance, actuarial, legal, computer and economic expertise to state insurance departments;
- Valuing securities held by insurers;
- Analyzing and listing nonadmitted alien insurers;
- Developing uniform statutory financial statements and accounting rules for insurers;
- Conducting education and training programs for insurance department staff;
- Developing model laws and coordinating regulatory policy on significant insurance issues;
- Conducting research and providing information on insurance and its regulation to regulators, state legislators, Congress, U.S. government agencies, insurance regulators in other countries, and the general public.

A nonadmitted insurer (as mentioned in #7 above) is a company not licensed by a state to sell insurance policies within the state. Alien insurers are those formed according to the legal requirements of a foreign country. In order for an alien insurer to conduct operations and sell its products in a particular state, the insurer must conform to the state's rules and regulations governing insurance companies. A nonadmitted alien insurer may be allowed to write on a surplus lines basis if it complies with the state's eligibility requirements. To assist states in their review of nonadmitted alien insurers, the NAIC produces a Quarterly *Listing of Nonadmitted Alien Insurers* (the Listing). If an insurer appears in the Listing, it has filed specified documents with the NAIC International Insurers Department (IID) and, based upon these documents and other information, appears to fulfill the criteria for eligibility set forth by the NAIC. Several states utilize the Listing to some capacity within their respective state statutes or regulations in relation to their eligibility requirements.

NAIC Objective

The objective of the NAIC is to serve the public interest by assisting state insurance supervisory officials, individually and collectively, in achieving the following fundamental insurance regulatory objectives:
1) protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
2) promote the reliability, solvency and financial solidity of insurance institutions; and
3) support and improve state regulation of insurance.

The primary means for NAIC members to be actively involved in the association is through the NAIC committee system. Each commissioner serves, or delegates to state insurance department staff, the responsibility to serve on various NAIC committees, task forces and working groups. The NAIC is committed to conducting its business

openly, subject to the discretion of the chairpersons of committees, subcommittees, tasks forces, working groups and subgroups, who may determine those situations in which public discussions would not be appropriate.

Financial Regulation Standards

In June 1989, the NAIC adopted the Financial Regulation Standards (the Standards), that established baseline sound practices for an effective regulatory system in each insurance department. The Standards are applied through a formal, voluntary certification program administrated by the NAIC. The objective of the Accreditation Program is to provide a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored by the states. The Standards are grouped into three areas: 1) laws and regulations; 2) regulatory practices and procedures; and 3) organizational and personnel practices. Under this Accreditation Program, an independent team of experienced consultants reviews each insurance department's compliance with the Standards at least every five years. All states have enacted legislation designed to achieve compliance with the Standards, and as a result, insurance department budgets and staffing have increased significantly. As of March 1, 2005, 49 states and the District of Columbia were accredited under the Accreditation Program.

Insurance companies are chartered by individual jurisdictions and receive a certificate of authority (that is, a license) to conduct business from each jurisdiction in which the company desires to underwrite insurance. This has been the case since 1792, when chartered insurance companies were first required by the states to limit company activities and investments, and to file financial statements. The power of a state to regulate insurance was established in 1869 in *Paul v. Virginia*, where insurance was declared a local matter rather than commerce between the states. By 1870, many of the states had appointed a state official to oversee insurance. In 1944, the U.S. Supreme Court in *United States v. South-Eastern Underwriters Association* ruled that insurance was "commerce" and subject in its interstate activity to regulation by the Congress and the statutory restriction of the Sherman Act prohibition against restraint of trade. In 1945, however, Congress enacted the McCarran-Ferguson Act, which included a limited exception from certain antitrust laws for certain insurance-related activities. The McCarran-Ferguson Act generally made insurance subject to state control and withheld the application of federal statutes to the extent that state law regulated such business, except in instances where the federal law specifically relates to insurance.

The states issue a number of different insurance company license types, including life and health, and property and casualty licenses. The states also issue insurance producer license types, including broker, independent agents, managing general agents, and general agent licenses. An independent agent is a contractor who represents more than one insurance company when placing a client's business. A general agent is a person appointed by one insurer who is responsible for insurance agency operations in a particular geographical area, including the sale of life and health insurance, recruiting and training agents, and providing administrative support.

Reinsurer Regulation

Reinsurers may either be authorized or licensed to write reinsurance business depending on the states laws and regulations. Under state insurance law, provided the owner meets certain criteria through the regulatory approval process, there are very few outright restrictions on a licensed insurer's ownership by, or affiliation with, other

financial or non-financial companies. An exception is the general prohibition on foreign government ownership of an insurer. State insurance law does not provide for consolidated supervision of the insurance holding company or the parent holding company. However, an insurance company is subject to state restrictions and disclosures regarding inter-affiliate relationships, and change in ownership is subject to state insurance department approval. Under state law, a licensed insurance company is generally authorized to own subsidiaries that conduct insurance or insurance-related business activities, including real estate management and real estate development. Investments in higher risk activities are limited by state statutes and indirectly through statutory RBC minimum standards.

State insurance regulators have recognized a growing need to more fully coordinate their regulatory efforts with other state insurance regulators, including efforts for sharing confidential supervisory information. Historically, there has been significant coordination with respect to supervising financially weakened companies; similar efforts are also underway to focus on holding company systems or insurance groups that are financially strong. In 2000, the NAIC formed the Insurance Holding Company (E) Working Group (IHCWG) in an effort to document a framework for information sharing and coordination of regulatory processes for analyzing insurance holding companies and their insurance subsidiaries. The NAIC *Framework for Insurance Holding Company*

Regulation (Framework) is the result of the IHCWG's work. The Framework provides guidance for state insurance regulators to understand the holding company structure of insurers operating in their state, as well as to coordinate their supervisory approaches for reviewing holding company transactions that may impact insurance subsidiaries domiciled in multiple jurisdictions. Currently, this Framework is in the implementation stage.

Banking Regulation Framework

The FRS is the primary federal banking regulator for state member banks. It also has supervisory authority for all U.S. bank holding companies. In the U.S., commercial banks are either federally chartered by the Comptroller of the Currency (OCC) as national banks, or are chartered by a state. National banks are supervised by the OCC and are members of the FRS. State-chartered banks that are members of the FRS are referred to as state member banks, and are supervised by both the applicable state banking department(s) and the FRS. A state bank that does not choose to become a member of the FRS is referred to as a state nonmember bank and is supervised by both the applicable state banking department(s) and the FDIC. The OCC, FRS and FDIC are the primary federal bank supervisors for national banks, state member banks and state nonmember banks, respectively. A "dual banking system" exists in the U.S. whereby state-chartered banks have both a federal bank and a state bank regulator(s). A state-chartered bank may be subject to supervision in all states in which it operates. Therefore, the FRS actively coordinates its supervision of state member banks with the applicable state banking department(s).

Prior Federal Reserve Board approval is required for a company to initially become a BHC or for an existing BHC to acquire control of, or more than five percent of a class of voting securities of, additional BHCs or banks. Relevant federal statutes state that control of a BHC or bank exists when a company has (i) ownership, control, or power to vote 25 percent or more of the outstanding shares of any class of voting securities of the BHC or bank, directly or indirectly or acting through one or more other persons; (ii)

control in any manner over the election of a majority of the directors, trustees, or general partners (or individuals exercising similar functions) of the BHC or bank; or (iii) the power to exercise, directly or indirectly, a controlling influence over the management or policies of the BHC or bank. A company includes corporations, partnerships, associations, certain trusts, and similar organizations. Also, non-financial firms generally are prohibited from controlling banks and thus are prohibited from owning 25 percent or more of the voting stock of a bank.

FRS Authority

The Federal Reserve System (FRS) has supervisory authority over BHCs, including those that are FHCs, and supervises these entities on a consolidated basis. The FRS supervisory approach reflects the “source of strength” doctrine, which asserts that a BHC should serve as a source of financial and managerial strength to its subsidiary banks, within certain constraints. This doctrine was reconfirmed in the GLB Act, except that the Act indicates that the FRS cannot require a BHC that is an insurance company, or an insurance company that is an affiliate of a depository institution, to provide funds or other assets to the affiliated depository institution if the state insurance authority makes a determination, in writing, that such action would have a material adverse effect on the financial condition of the insurance company.

The FRS is comprised of 12 regional Federal Reserve Banks under the general oversight of the Federal Reserve Board, which is located in Washington, D.C. The Federal Reserve Board and its staff develop FRS regulations and policies. The Federal Reserve Board is an independent government agency overseen by 7 board members, including the Federal Reserve Board Chairman and Vice Chairman, all of whom are appointed by the president and confirmed by the Senate. Each Federal Reserve Board member is appointed to serve a 14-year term, or if replacing a board member whose term has not yet expired, to serve the remainder of the previous board member’s 14-year term. The Federal Reserve Board Chairman has a 4-year term, and may be reappointed.

In carrying out responsibilities for the comprehensive supervision of BHCs, including FHCs, the FRS coordinates and cooperates, as appropriate, with the other bank and thrift regulators, including the OCC, the FDIC, the Office of Thrift Supervision (OTS), and state banking departments. The Federal Financial Institutions Examination Council (FFIEC), whose members consist of the FRS, OCC, OTS, FDIC and National Credit Union Administration (NCUA), is an organization that fosters uniform depository institution regulatory reporting and consistent supervisory policy among those federal agencies. Moreover, federal and state bank and thrift supervisors share certain databases and other supervision tools and resources in order to develop coordinated and consistent regulation of supervised entities. Additionally, in carrying out its role as the consolidated supervisor for BHCs, including FHCs, the FRS also relies on and coordinates its supervisory activities with, as appropriate, the Securities and Exchange Commission (SEC) and the Commodity Futures Trading Commission, and state insurance and securities regulators.

CHAPTER 7 Tools for Identifying Financially Weakened Institutions

The NAIC reporting requirements have evolved considerably since its annual statement introduction in 1879. All states require an insurer to use the NAIC annual and quarterly statement reporting forms to satisfy their statutory financial statement filing requirements, except that states may exempt an insurer from this requirement, as appropriate. The complete annual statement filing currently includes a balance sheet, income statement, statement of cash flow, notes to financial statements, general interrogatories, and a significant number of supporting details in various exhibits, schedules and supplemental filings. General interrogatories are limited-scope questions regarding an insurer and its financial position and operations.

Insurance and Financial Reporting

Some of the more important exhibits and schedules provide information about: investment income and realized gains and losses; nonadmitted assets; Asset Valuation Reserve and Interest Maintenance Reserve; premiums and losses; expenses; long-term investments in bonds, preferred stock, common stock, real estate, mortgage loans, and other investments; derivatives; short-term investments; cash and cash equivalents; reinsurance; and transactions with affiliates. Supplemental filings are also required of most insurers, such as the actuarial opinion, the management's discussion and analysis, the annual audited financial report, and the RBC report. Other supplemental filings include specialty information such as the Medicare supplement report, the credit insurance report, and the long-term care report. Since December 31, 2003, insurers are also required to report affiliations with a BHC, bank, thrift or securities firm; to provide the names of each such affiliate; and to identify the relevant federal regulators of each insurer's financial institution affiliate. In addition to the annual statements, most insurers also are required to file the NAIC quarterly statement reporting form that contains key information on assets and liabilities; income and surplus; changes in investments; reinsurance; premiums written; losses and reserves.

Insurance company statutory financial reports are based on statutory accounting principles (SAP), which are designed to address the concerns of regulators. SAP stresses measurement of the ability to pay claims of insurers in the future, while generally accepted accounting principles (GAAP) stresses measurement of earnings of a business from period to period, and the matching of revenues and expenses for the measurement period (source: Preamble of the NAIC Accounting Practices and Procedures Manual). Conservatism serves as a major principle in SAP. For example, some assets are not allowed to be included in an insurer's surplus; these are referred to as nonadmitted assets. Another example of conservatism is the prohibition against discounting reserves, and the fact that specific tables approved by regulators are required to establish reserves for various life insurance products. Under GAAP, the experience expected by each insurance company, with provision for the risk of adverse deviation, is used to determine the reserves it will establish for its policies.

Solvency Screening and Financial Analysis Systems

The fundamental objective of insurance company solvency monitoring is to ensure that companies meet regulatory standards and to alert regulators if actions need to be taken

to protect policyholders. To accomplish this task, the state insurance regulators conduct financial analysis using regulatory financial reports, financial tools and other sources of information to detect problems that may jeopardize a company's long-term viability. These sources include SEC filings, corporate reports, external, independent certified public accountant (CPA) attestation reports, financial examination and market conduct reports, rate and policy form filings, consumer complaints, independent rating agency reports, correspondence from agents and insurers, and business media.

State insurance departments generally prioritize the review of their domiciliary companies based on a system of financial ratios and other screening tools, including those maintained by the NAIC. The NAIC has created a network of financial information systems and tools, such as the Financial Analysis Solvency Tools (FAST) System that includes the Insurance Regulatory Information System (IRIS), the Scoring System, and the Insurer Profiles System that are discussed below. The NAIC makes the information systems and tools available to state insurance regulators over the NAIC's Internet-State Interface Technology Enhancement (I-SITE). I-SITE provides a common user interface for more than 50 applications that are used to produce a wide variety of standard and custom reports. To be accredited, a state is required to conduct quarterly financial analysis on their domiciliary multi-state insurers. Most states conduct quarterly financial analysis on their single-state insurers as well. Typically, insurers with anomalous results, or those that have been previously identified for attention are subject to additional analysis.

The domiciliary state is relied upon as the primary solvency regulator. When there are concerns about the financial condition of an insurer, communications between the domiciliary state and the other states in which the company is licensed are increased. However, any state in which a company is licensed to conduct insurance business may perform its own monitoring, financial examinations, and may take regulatory action, as appropriate.

FAST System

The FAST System is a collection of analytical tools designed to provide state insurance regulators with an integrated approach to screening and analyzing the financial condition of insurance companies. The following are three key tools within the FAST System:

1) Insurance Regulatory Information System (IRIS)

IRIS has served as a baseline solvency screening system for the NAIC and state regulators since the mid-1970s. IRIS is designed to help regulators prioritize insurers for detailed financial analysis. The "statistical phase" of IRIS involves calculating a series of financial ratios for each insurer based on its annual statement data. The IRIS ratio results are available to the public. Because the ratios by themselves are not indicative of adverse financial condition, an experienced team of state insurance examiners and analysts (Analyst Team) reviews the IRIS ratio results and various other financial information in the "analytical phase" of IRIS, called the Analyst Team System (ATS). For the ATS, the Analyst Team meets annually at the NAIC Executive Headquarters to identify insurers that appear to require immediate regulatory attention in order to assist state insurance regulators in prioritizing their annual financial analysis reviews of insurers. The Analyst Team reviews a computer-selected priority listing of insurers that

may be experiencing weak or declining financial results. It then validates the listing based on further analysis of those companies, and provides a brief synopsis of its findings in a document that can be accessed only by state insurance regulators and authorized NAIC staff.

2) Scoring System

The Scoring System is based on several financial ratios and is similar in concept to IRIS ratios. The Scoring System, however, includes a broader range of financial ratios and assigns a score to each ratio based on the level of solvency concern each result generates. The ratio results and scores are available only to state insurance regulators and authorized NAIC staff. The Scoring System is evaluated and updated, as appropriate, by the Financial Analysis Research and Development Working Group on an annual basis.

3) Insurer Profiles System

The Insurer Profiles System produces quarterly and annual profiles reports on property and casualty, life and health insurers. These profiles provide either a quarterly or annual five-year summary of a company's financial position. The Insurer Profile reports provide not only a snapshot of the company's financial statement, but also include analytical tools such as financial ratios and industry aggregate information that can be used in an analyst's review of the company. Insurer Profile reports can assist state insurance department analysts in identifying unusual fluctuations, trends or changes in the mix of an insurer's assets, liabilities, capital and surplus and operations.

Peer Review Process

As a check and balance on the solvency screening efforts conducted by the states, a peer review process was created. The objective of the NAIC's peer review process conducted by the FAWG is to monitor whether domiciliary regulators are taking appropriate and effective supervisory action with respect to nationally significant insurers that are in financial difficulty. The FAWG is made up of commissioner appointed members from sixteen states.

On a quarterly basis, the NAIC's Financial Regulatory Services Division staff identifies nationally significant insurers for review using analytical criteria. Division financial analysts perform preliminary reviews of identified insurers and then select insurers that warrant more in-depth reviews. For those insurers, the FAWG will review the analysts' reports and then query the domiciliary state on various aspects of each insurer's financial condition and any regulatory actions being taken. If the FAWG determines that the domiciliary regulator is taking appropriate actions, then the FAWG may close the file or continue to monitor the company. If the FAWG determines that further measures are desirable, it will recommend the appropriate corrective action to the domiciliary state. If the domiciliary regulators fail to follow the FAWG's recommendation, the FAWG will alert other affected states accordingly and coordinate their supervisory response.

State Insurance Department Financial Examination Process

The purpose of a financial condition examination is to: 1) detect insurers with potential weaknesses; 2) determine compliance with state statutes and regulations; and 3)

compile information needed for timely, appropriate regulatory action. On-site financial condition examinations of insurers are either full-scope or limited-scope examinations. The full-scope examination is considered a comprehensive examination with an overall objective to report on the company's financial position and affairs. A limited-scope examination, often referred to as a target examination, is conducted to review specific financial accounts and or specific areas of the company's operations.

State laws and regulations, as guided by the Accreditation Program, require the states to conduct a full-scope examination for each multi-state domestic company at least once every five years. Individual state statutes may require financial condition examinations more often, and several states impose a three-year requirement. Limited-scope examinations do not satisfy the NAIC Accreditation Standards to conduct financial condition examinations at least once every five years. However, failing to conduct limited-scope examinations for financial weakened companies may impact the results of the accreditation review. Frequently, full-scope examinations will be conducted as so called "zone examinations." A zone examination is a process to reduce the number of financial condition examinations of multi-state licensed insurers. The concept of zone examinations developed in response to the fact that states are entitled to conduct financial condition examinations on insurers that are licensed in their state regardless if they are domiciled elsewhere. As this ability could result in multiple examinations of the same company, the process of inviting representatives from other zones to participate evolved in order to reduce regulatory burden and increase efficiency.

Financial Condition Examinations

On-site financial condition examinations investigate a company's accounting methods and procedures, financial statement presentation, and validate what is presented in the annual financial statement assets, liabilities, capital and surplus line items, to ascertain whether the company is in good financial standing. The main thrust of the examination is to verify the company's solvency and determine whether the company has complied with state laws and regulations. In general, financial condition examinations shall at least encompass a review of all of the following matters:

1) company history;
2) management and control;
3) corporate records;
4) fidelity bonds and other insurance;
5) officers', employees', and agents' welfare and pension plans;
6) territory and plan of operation;
7) growth of company;
8) business in force by states;
9) mortality and loss experience;
10) reinsurance;
11) accounts and records; and
12) financial statements.

Examinations are conducted using a risk-based approach, whereby those areas identified as more likely to be prone to material financial reporting error are accorded greater attention during both the examination planning phase and the on-site examination. The state financial condition examination process also places emphasis on the quality of the company's internal control structure. This requires the state examiners to assess the internal control environment based on interviews with company

management and personnel and other control testing procedures. On occasion, state insurance departments will engage outside experts to evaluate and test the effectiveness of internal controls (e.g., information system controls). The financial condition examination process also considers the work performed by external, independent CPAs as well as the work of internal auditors.

Regulatory Capital Framework for Insurance Companies

An insurer's capital and surplus provides a cushion against unexpected increases in liabilities and decreases in the value of assets, and are intended to absorb the costs of a rehabilitation or liquidation with minimal losses to policyholders and claimants. States require insurers to have a certain amount of capital and surplus to establish and continue operations. A state insurance department is authorized to take over, or "seize" an insurance company if the state can show to the applicable state court that the insurer will be unable to meet its obligations to policyholders.

Fixed minimum capital and surplus standards for licensing and operating an insurance company typically range in the area of $2 million to $5 million for a multi-line life and health or property and casualty insurer. Because of the limitations of fixed minimum capital standards, the NAIC adopted the Risk-based Capital (RBC) for Insurers Model Act. To be accredited, a state is required to adopt a substantially similar version of the Model Act, which contains separate formulas for life and health insurers and property and casualty insurers, and prescribes regulatory action to be taken if an insurer's Total Adjusted Capital declines below certain thresholds. The stated objectives of the NAIC RBC requirements are to provide a standard of capital adequacy that: 1) is related to risk; 2) raises the safety net for insurers; 3) is uniform among states; and 4) provides authority for regulatory action when actual capital falls below the standard. The model act specifies four levels of company and regulatory action, with more severe action required at lower levels.

The NAIC's life and health RBC formula encompasses six major categories of risk:
1) asset risk — affiliates;
2) asset risk – common stock;
3) asset risk — other;
4) insurance or pricing risk;
5) interest-rate risk and health credit risk and
6) business risk.

The risks addressed by the NAIC's property and casualty formula include:
1) asset risk — subsidiary insurance companies;
2) asset risk — fixed income;
3) asset risk — equity;
4) asset risk — credit;
5) underwriting risk — reserves; and
6) underwriting risk — net written premium.

Databases and Information Systems

The NAIC maintains a number of databases that state insurance regulators and NAIC staff use for financial analysis and other regulatory functions, including:
1) the Financial Data Repository (FDR);
2) the State Producer Licensing Database (SPLD);

3) Valuation of Securities (VOS);
4) Regulatory Information Retrieval System (RIRS); and
5) Special Activities Database (SAD).

The NAIC financial databases serve as the core resource of the solvency surveillance and other analysis activities of state insurance regulators and the NAIC. The FDR database contains the most recent 10 years of annual and quarterly financial statement information for the approximately 5,200 U.S. insurance companies. This database provides source data for reports on individual companies and for analytical tools, such as the FAST System. The VOS database contains credit quality designations and fair values for insurers' securities that are not rated and monitored by a Nationally Recognized Statistical Rating Organization (NRSRO). This database, combined with NRSRO ratings data, allows regulators to assess the relative credit risk of the securities owned and reported by insurers.

The SPLD database contains information on insurance companies, such as consumer complaints, and on nearly 3.5 million individual producers, including producer licensing and appointment information. RIRS database contains formally adjudicated regulatory actions taken by participating state insurance departments against insurance producers, companies and other entities engaged in the business of insurance. The SAD is a confidential database that contains information related to suspicious market activities and legal actions involving entities engaged in the business of insurance. The RIRS and SAD databases enhance state insurance regulators' ability to share information among state insurance departments on individuals or companies suspected of illegal or questionable activities and are tools to assist in the prevention of movement of these activities into new areas. State insurance regulators and NAIC staff also use an electronic mail system on the NAIC's computer network to communicate and coordinate supervisory developments with respect to examinations, regulatory actions, financially weakened companies, and a variety of other matters.

Banking (State Member Banks and BHCs)

All banks, including state member banks, are required to file quarterly regulatory reports known as FFIEC Call Reports consisting of consolidated balance sheets, income statements, RBC data and selected supplementary financial information. All BHCs are also required to file periodic regulatory reports.

Financial Reporting

Those BHCs with consolidated assets over $150 million, and BHCs below that threshold that are categorized by the FRS as "complex," are required to file consolidated balance sheets, income statements and RBC data, as well as parent company financial statements, on a quarterly basis. BHCs under $150 million that are non-complex BHCs are required to file parent company only financial statements semi-annually, but are not required to file fully consolidated financial reports. Additionally, all BHC are required to file periodic regulatory reports detailing certain intercompany transactions and balances between a bank and its nonbank affiliates; balance sheet and income statement data for certain of its domestic, non-functionally regulated nonbank subsidiaries and certain foreign domiciled bank and non-bank subsidiaries; and reports of new activities commenced. There are a number of other regulatory reports that must be filed by state member banks and BHCS. A complete listing of bank and BHC report forms and

instructions may be found on the Federal Reserve Board and the FFIEC websites (http://www.federalreserve.gov/ and http://www.ffiec.gov/, respectively).

Surveillance and Monitoring

The FRS off-site surveillance program is designed to monitor the financial condition and performance of individual state member banks and BHCs on a quarterly basis to facilitate identifying deterioration in the condition of companies between on-site examinations and inspections. Monitoring is accomplished, in part, through the use of automated screening systems and econometric models. These tools rely significantly on data reported on standardized regulatory reports and from the findings of on-site examinations. The surveillance program takes into consideration a number of aspects of banking performance, including capital adequacy, asset growth, loan quality and loan concentrations, liquidity, and capital markets activities. These surveillance results, produced by Federal Reserve Board staff, are distributed to the Federal Reserve Banks for further review, analysis, and follow-up. FRS Surveillance screens incorporate the results of two econometric models, together known as the System for Estimating Examination Ratings (SEER). The SEER system developed by a FRS Surveillance Task Force was formerly known as the Financial Institutions Monitoring System (FIMS). The SEER models have been updated since they were first implemented, but a detailed description of the econometric frameworks used is contained in an article by Rebel Cole, Barbara Cornyn and Jeff Gunther in the Federal Reserve Bulletin, volume 81, number 1, January, 1995, pps. 1-15. The SEER risk rank model estimates the probability that a bank will become critically undercapitalized within the next two years. The SEER rating model estimates a bank's composite CAMELS rating based upon Call Report data and examination rating information. The surveillance screening results are strictly confidential.

To support off-site monitoring of bank performance and condition and on-site examinations, the FFIEC produces a quarterly Uniform Bank Performance Report (UBPR) for each commercial bank and FDIC-insured savings bank. These reports display current and historic balance sheet and income statement items, along with key performance ratios and peer group statistics. The FRS produces a similar report, the Bank Holding Company Performance Report (BHCPR), for BHCs over $150 million in consolidated assets. These UBPR and BHCPR reports are publicly available.

Bank Examinations and BHC Inspections

The FRS's safety and soundness examinations of state member banks and inspections of BHCs are focused on determining the financial condition and performance of an institution, and on evaluating management, internal controls and the risk management structure. The Federal Reserve is required to conduct a full-scope, on-site examination of every insured state member bank at least once during each 12-month period, with the exception that certain small institutions may be examined once during each 18-month period. The frequency of BHC inspections is determined by the size, condition, and complexity of the BHC.

Examiners assign a composite rating to a banking institution reflecting an assessment of the overall condition of the institution, including an assessment of relevant processes and risk management techniques. The rating system used for banks is known as CAMELS, an acronym for the components it evaluates: capital, asset quality,

management, earnings, liquidity and sensitivity to market risk. Until January 1, 2005, BHCs were assigned a supervisory rating using a rating system known as BOPEC, which included evaluations of: bank subsidiaries ("B"); "other" (nonbank subsidiaries) ("O"); the parent company ("P"); consolidated BHC earnings ("E"); and consolidated BHC capital adequacy ("C"). A new BHC rating system has been adopted effective January 1, 2005 (SR letter 04-18, *Bank Holding Company Rating System,* may be accessed on the Federal Reserve Board's public website). Under this system, a BHC is assigned an RFI/C(D) rating rather than a BOPEC rating. RFI/C(D) is an acronym for the components of: risk management ("R"); financial condition ("F"); potential adverse impact ("I") of nonbank affiliates on the affiliated depository institution(s); a composite BHC rating ("C") based on an evaluation and rating of the BHC's managerial and financial condition and an assessment of future potential risk to its subsidiary depository institution(s); and a rating for the depository institution(s) ("D") that will generally mirror the primary regulator's assessment of the subsidiary depository institution(s). Bank and BHC supervisory ratings and the reports of bank examinations and BHC inspections are strictly confidential.

FHCs are generally supervised similarly to any other BHC with a focus on understanding and assessing the quality of centralized risk management and control processes for key business lines, as well as understanding the intra-group exposures and risk concentrations across all business lines. To supervise a diversified BHC, the FRS relies to the extent possible on, and coordinates with, the appropriate functional regulators. Financial safety and soundness examinations and inspections generally include a review of compliance with a wide range of laws and regulations. In addition, the FRS also conducts consumer compliance examinations of state member banks to determine adherence with applicable consumer protection laws and regulations and assigns a compliance examination rating. Depository institutions, including state member banks supervised by the FRS, are also evaluated for their compliance with the CRA and assigned a separate CRA rating. An institution's CRA rating is publicly available.

Regulatory Capital Frameworks

Basel Capital Accord

The Basel Capital Accord (Basel I), the current international framework for bank capital adequacy, was adopted in 1988 by the G-10 group of central banks and other national supervisory authorities, working through the Basel Committee on Banking Supervision. The Basel Committee on Banking Supervision was established in 1974 comprising members from the central banks or other supervisory authorities of Belgium, Canada, France, Germany, Italy, Japan, Luxembourg, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom, and the U.S. The FRS and the other federal banking agencies implemented an RBC approach for U.S. banking organizations in 1989. The fundamental objectives of Basel I are to promote the soundness and stability of the international banking system and to provide an equitable basis for international competition among banks. More specifically, Basel I sets forth RBC standards intended to assist in the assessment of capital adequacy of depository institutions. Other key objectives of the standards were to:

1) make regulatory capital requirements more sensitive to differences in risk profiles among banks;

2) factor off-balance sheet exposures into the assessment of capital adequacy;

3) minimize disincentives to holding liquid, low-risk assets; and
4) achieve greater consistency in the evaluation of the capital of the major banks throughout the world.[15]

Additional detail and background on the FRS's and the NAIC's RBC approaches can be found in the *Report of the NAIC and the Federal Reserve System Joint Subgroup on Risk-Based Capital and Regulatory Arbitrage,* dated May 24, 2002.

Under the Basel I framework, capital adequacy is assessed primarily in relation to credit risk with the other risks addressed implicitly. In 1996, Basel I was amended to take explicit account of market risk in trading accounts (i.e., the risk of loss due to a change in market prices, such as equity prices or interest or exchange rates).
Under the Basel I framework, a bank (and, in the U.S., generally a BHC with consolidated assets greater than $150 million) is required to have regulatory capital, as measured by combinations of equity, allowance for loan and lease losses (ALLL), qualified subordinated debt, and certain other instruments, at least equal to 8 percent of the amount of its risk-weighted assets. For the calculation, assets are weighted according to the level of perceived risk, and each off-balance sheet exposure is converted to an on-balance sheet equivalent, and then risk-weighted. Assets and off-balance sheet equivalents are generally risk-weighted at 100, 50, 20, or 0 percent. This measure is referred to as the total RBC ratio.

Another measure of capital adequacy used in the banking organization RBC framework is the Tier 1 RBC ratio. The Tier 1 RBC ratio is a more conservative measure that generally excludes debt instruments and the ALLL from the capital numerator. To be adequately capitalized, a U.S. banking organization must have a minimum Tier 1 RBC ratio of 4 percent. In addition, banking organizations are subject to a leverage ratio measure to evaluate capital adequacy. The leverage ratio, which is calculated as equity capital as a percentage of average balance sheet assets, is also used to evaluate capital adequacy. Currently, a revised RBC framework referred to as the Basel II Capital Accord is in the process of being implemented by U.S. and many foreign bank regulators. The objectives for reform include improving risk measurement and management; linking, more precisely, the amount of minimum regulatory capital to the amount of risk taken; further focusing the dialogue between supervisors and a banking organization on the measurement and management of risk and the connection between risk and capital; and increasing market discipline through enhanced transparency. Additional information pertaining to the Basel II Capital Accord may be found on the FRS public website (http://www.federalreserve.gov/) and the Bank for International Settlements public website (http://www.bis.org/index.htm).

Prompt Corrective Action (PCA)

As a result of the bank failures in the late 1980s and the rapid depletion of the federal deposit insurance fund, Congress mandated a PCA framework in the Federal Deposit Insurance Corporation Improvement Act of 1991 (FDICIA). This act requires federal bank regulators to administer timely corrective action to a bank when its capital position is deemed to have declined below certain threshold levels. The PCA framework specifies mandatory actions that regulators must take if capital ratios fall below certain thresholds, as well as discretionary actions that may be taken. The PCA regulations applicable to state member banks are found at the Federal Reserve Board's Regulation H, Subpart D (12 C.F.R. 208.40 et seq.).

Under the PCA statute and accompanying regulations, a bank is assigned to one of five capital categories based primarily on the capital ratios reported in the quarterly FFIEC Call Reports. Four of the five PCA capital categories – "well capitalized," "adequately capitalized," "undercapitalized," and "significantly undercapitalized," are based on three capital adequacy ratios: the total RBC ratio, the Tier 1 RBC ratio, and the leverage ratio. The most severe capital category, "critically undercapitalized," is determined by a bank's tangible equity ratio, which measures the equity capital to assets ratios excluding intangible assets from the numerator and the denominator.

If a bank is deemed to be "undercapitalized," "significantly undercapitalized," or "critically undercapitalized" as defined in FDICIA based on its capital ratios, the bank must submit a capital restoration plan that is acceptable to its primary federal regulator, may not make any capital distribution, and may not pay a management fee to anyone that controls the bank. In addition, the bank may not increase its asset size, except under limited conditions, and may not make acquisitions or establish new branches or new lines of business, unless it meets certain conditions. Significantly undercapitalized and critically undercapitalized banks are subject to additional mandatory restrictions. The bank's primary federal regulator may also impose one or more of the discretionary restrictions enumerated in the statute and regulations through the issuance of a Prompt Corrective Action Directive to any undercapitalized, significantly undercapitalized, or critically undercapitalized bank. A bank may contest the issuance of such a directive through an agency appeal process. Under the PCA statute, a critically undercapitalized bank generally must be placed in conservatorship or receivership within 90 days of becoming critically undercapitalized.

In accordance with FDICIA, a BHC must guarantee its subsidiary bank's capital restoration plan and provide appropriate assurances of performance. Additionally, the cross-guarantee provision of FDICIA requires that, generally, any insured depository institution is liable for losses to the FDIC arising from the default of a commonly controlled insured depository institution. This provision was implemented, in part, to avoid the potential adverse effect of a bank shifting bad assets into a failing affiliate bank and thereby increasing the cost to the FDIC insurance fund.

Databases and Information Systems

The Federal Reserve Board maintains the National Information Center (NIC), a repository for both bank structure, financial, and confidential supervisory data for all commercial banks and BHCs. Additionally, the Central Document Text Repository (CDTR) is the repository for the electronic versions of commercial bank examination and BHC inspection reports, as well as other confidential supervisory documents. Front-end systems are available to authorized FRS staff for accessing these databases containing both publicly available and confidential supervisory information.

APPROACHES FOR SUPERVISING A FINANCIALLY WEAKENED COMPANY

The state insurance regulators and the FRS each have enforcement powers to support their ability to carry out their supervisory responsibilities, and both are subject to laws that require the regulator to take specified corrective action based on RBC thresholds for supervised insurers and supervised state member banks, respectively.

State Insurance Departments

Regulatory actions of an insurance department include activities that go beyond the monitoring and surveillance activities described above include:

Hearings/Conferences – These are sessions in which witnesses are requested to discuss, testify, or otherwise provide information to a state's insurance department with respect to a specific insurance company or group of companies. Hearings or conferences may be conducted either informally, involving only the department and insurance company personnel, or formally, involving the presence of an appointed hearing officer to conduct the session.

Implementation of a Corrective Plan – This involves the execution of a plan of action, reviewed and monitored by a state insurance department, for an insurer to correct a troubled or potentially troubled situation. This may include corrective plans required under RBC requirements.

Restrictions on Activities – Such activities may include prohibitions, conditions, or limitations placed by a state insurance department on certain activities or transactions of an insurance company. Examples include requiring pre-approval by the department of specific activities or transactions. The ability to place restrictions on an insurance company depends, in part, on the laws or regulations of the particular jurisdiction.

Notice of Impairment – This is a formal regulatory communication from a state insurance department to an insurance company informing the insurance company that the company does not meet stated minimum statutory capital and/or surplus requirements and requiring the company to correct the deficiency by a certain date.

Cease and Desist/Suspension Order – This is a formal regulatory communication from a state insurance department ordering an insurance company to stop certain activities, such as the issuance of new insurance policies.

Supervision – This is an action taken by a state insurance department under its administrative or legal provisions, under which a supervisor is appointed by an insurance department or by a court to "supervise" the operations of an insurance company. The supervision may be "confidential" (i.e., unannounced or "drawer"), "announced" by the insurance department, or "voluntary" (i.e., assistance was requested or acknowledged by the insurance company).

The Federal Reserve System

The FRS employs a range of tools to identify and address a supervised bank or BHC exhibiting emerging problems or weakened financial condition in order to maintain a sound banking system, minimize potential losses to the FDIC insurance fund, and facilitate the institution's return to financial health, if possible. Routinely, a summary of examiner findings and expected actions is conveyed to the banking organization following each targeted review of a particular business line or business activity, as well as in an examination report that summarizes the key findings of the reviews conducted during the 12- to 18- month examination cycle. For those institutions whose problems warrant additional supervisory action, a range of informal and formal supervisory actions is available, in addition to the PCA measures for banks described above.

Informal corrective actions include resolutions adopted by an institution's board of directors and Memoranda of Understanding between the appropriate Federal Reserve Bank and an institution, whereby the institution's board agrees to implement the actions that the institution will take to correct deficiencies. Informal actions are not made

publicly available by the FRS. The SEC requires publicly traded companies to make public disclosure of certain material information that may affect the securities markets. A publicly traded financial institution, therefore, may be required to disclose the existence of certain informal actions taken by the FRS if the actions are deemed to be material.

Formal corrective actions, including Written Agreements and Cease and Desist Orders, are authorized by the Federal Deposit Insurance Act (FDI Act) to correct violations of law and unsafe or unsound practices. These agreements and orders may require a depository institution, a BHC, certain other entities, and any institution-affiliated party, including any director, officer, employee or controlling shareholder to take affirmative action to correct deficiencies or to cease engaging in the violations or other unsafe or unsound practices. Written Agreements and Cease and Desist Orders are made publicly available. They may include measures designed to improve a bank's capital and asset quality by placing restrictions on dividends, requiring the employment of more qualified management and improved oversight by the bank's board of directors. Written Agreements and Cease and Desist Orders against BHCs may also include requirements for capital infusions to an undercapitalized FDIC-insured subsidiary bank; restrictions on additional debt, dividends, and inter-corporate transactions; and the termination of certain nonbank activities that constitute violations of law or unsafe or unsound banking practices.

In cases where specific violations or practices are likely to cause insolvency, cause dissipation of assets or earnings, weaken the condition of the institution, or prejudice the depositors' interests, the FRS may issue a Temporary Cease and Desist Order to address these violations or practices. A Temporary Cease and Desist Order requires the banking organization to take or cease specific actions and remains in effect pending the outcome of an administrative hearing on the issues. Temporary Cease and Desist Orders are generally not made public by the FRS. In the event that an institution does not consent to supervisory action, the FRS may issue a Notice of Charges to initiate litigation. The FRS is authorized by the FDI Act to suspend or remove institution-affiliated parties who have engaged in a violation of law, an unsafe or unsound practice, or a breach of fiduciary duty, which has caused a bank to suffer a financial loss or other damages or has resulted in a gain to the individual, and that involves personal dishonesty or demonstrates continuing or willful disregard for the safety and soundness of the institution.

Notwithstanding these enforcement powers, the GLB Act prohibits the Federal Reserve Board from requiring an insurance company that is a BHC or an insurance company that is a subsidiary of a BHC to provide capital to a depository institution subsidiary of the BHC if the state insurance authority determines, in writing, that such a funds transfer would have a material adverse effect on the financial condition of the insurance company. Additionally, the GLB Act generally prohibits the Federal Reserve Board from taking enforcement action against an insurance company, unless the action is necessary to prevent or redress a practice that poses a material risk to an affiliated depository institution or to the domestic or international payments system, and it is not reasonably possible to protect against the material risk through action directed at the depository institution. These provisions are codified at 12 U.S.C. 1844(g) and 12 U.S.C. 1848a, respectively.

RECEIVERSHIP AND LIQUIDATION

Both state insurance regulators and banking regulators have statutory requirements for receiverships and liquidations of supervised entities. State receivership and liquidation laws vary to some degree. For a state insurance department to be accredited by the NAIC, a state must have laws that substantially conform to the NAIC Model Receivership Act.

State Insurance Supervisors

Delinquency proceedings are instituted against an insurance company by a state insurance department for the purpose of conserving, rehabilitating, reorganizing, or liquidating the insurance company. Among the various types of delinquency that may be permissible under state law are the following:

Conservation — This term has different meanings in different jurisdictions. The scope of conservation efforts can vary from a seizure of certain assets to rehabilitation.

Seizure of Assets — A state's legal or administrative provisions provide for an insurance department to take control of an insurer's assets, books, records, and business premises if the insurer is domiciled in the state, in order to conserve the company's assets for the benefit of its policyholders and creditors.

Rehabilitation — An insurance company may be placed in a rehabilitation status by an insurance department through a jurisdiction's legal or administrative proceeding. The rehabilitation process generally involves, sometimes under a court order, the transfer of operational authority from insurance company management to a rehabilitator with the objective of returning the company to a sound financial and operational condition. The court order could, among other matters, direct the rehabilitator to take possession of the assets and administer the assets and the operations of the insurance company under the supervision of the court or under a formal plan approved by the court with notice to the company's affected creditors.

Liquidation — In the event that rehabilitation of an insurer is unsuccessful, the insurance department may, through legal proceedings, place the insurer in liquidation. The liquidation process ordinarily would include the seizure and marshalling of the company's assets, a determination of the company's liabilities, and the distribution of the assets of the insurance company under the supervision of the court to address or redeem those liabilities.

Dissolution — An insurance department may petition a court for an order to dissolve or terminate the corporate existence of a domestic insurance company following its complete liquidation.

The nature, timing, and extent of regulatory action in any given troubled company situation depends, in part, on the applicable jurisdiction's laws and regulations to which the insurance company is subject, as well as the circumstances of the particular situation. State insurance law may use different terms to refer to essentially similar actions, and the actions that are available to an insurance department differ among the states. When an insurer is found to be insolvent and is ordered liquidated, the guaranty funds are the source of last resort to provide protection for the insurer's policyholders and claimants. Not all policy obligations, however, are covered. For those that are covered, statutory limits apply. Additionally, not all policyholders and claimants are covered.

Bank Supervisors

In the event that a commercial bank is formally declared insolvent by its chartering agency (a state banking department or the OCC), the chartering agency and the applicable federal regulator — the FRS, OCC, or the FDIC, in its supervision capacity — generally no longer have any responsibility for supervising the bank. Federal statutes name the FDIC as receiver and outline the process of a bank receivership and liquidation as well as the prioritization of claims. The amount of FDIC insurance coverage of $100,000 per depositor is uniform nationwide in the event of a bank insolvency. Deposits of larger amounts have priority over all other non-depositor creditors.

In the event that all of a BHC's insured depository institutions are placed into receivership, the company is no longer a BHC, and, therefore, is no longer supervised by the FRS. The FRS generally has no role in the liquidation of a BHC or a company that was formerly a BHC. Such liquidations are administered in accordance with federal bankruptcy laws.

Summary

This section points out advances in the insurance and banking regulators' understanding of each other's approaches for identifying and supervising financially weakened institutions and enhances coordination between the state insurance departments and the FRS, consistent with the GLB Act mandates for supervision of FHCs. In addition, many other efforts between the FRS and the state insurance supervisors, including the implementation of Memoranda of Understanding now in place between most state insurance departments and the Federal Reserve Board for sharing appropriate confidential, supervisory information and consumer complaints, as envisioned in the GLB Act, [have] fostered effective coordination of supervisory activities. These accomplishments represent significant milestones in the achievement of effective cooperation between banking and insurance regulators.

Table A Summary of State Regulation for Identifying and Supervising Financially Weakened Insurers

Regulatory Response Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Periodic (annual and quarterly) financial analysis of statutory financial statements	Annual Statements are filed by March 1 of each year. Quarterly Statements are filed within 45 days following each quarter-end. The annual statement review process tends to be the more comprehensive of the two periodic reviews, because of the amount and depth of information provided by the statement. The analytical tools described in the cells below are utilized throughout the reviews. In addition, the state insurance department analyst also consider other factors/conditions such as a prolonged devaluation in the stock or real estate markets; reinsurance recoveries; deterioration of parent company's public debt rating; and class action lawsuits.	Used in annual reviews, quarterly reviews and financial condition examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	NA	The NAIC Accreditation Program provides timelines by which analysis of domestic insurers should be completed by state insurance departments.

[1]The term, “phase” in this table is used to refer to possible levels of progression relating to supervisory action as outlined in the NAIC Troubled Company Handbook.
[2]Powers confirmed by discretionary authority of a commissioner or department of insurance.
[3]Powers permissible by state statute or regulation.

Regulatory Response 1					
Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Scoring System	The NAIC Scoring System ratios and scores provide an integrated approach to screening and analyzing the financial condition of insurers.	Used in annual reviews, quarterly reviews and examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		Ratios and scores are confidential. Ratios address critical areas of an insurer's operations, such as leverage of capital, growth, underwriting and investment profitability, investment holdings and liquidity. Companies receiving highest scores receive immediate attention, which often leads to a more in-depth analysis.
1	Analyst TeamSystem (ATS) Review	The NAIC ATS is a multi-tiered process through which insurers are assigned levels of priority by a team of state analysts/examiners. The system is based on a series of tests applied to an insurer's financial results, which then assigns a "level" ranking. If an insurer receives a ranking in the top two levels, the company is reviewed by a team member who then validates or changes the assigned level.	Used in annual reviews and examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		Like the Scoring System, the review process and results of the ATS are confidential. They are used by some states to gauge the financial soundness of non-domestic (foreign) insurers operating within the state.

Regulatory Response					
Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Financial Condition Examination	An on-site examination may detect existing or potential financial problems or may be used to investigate problems arising from routine financial analysis.		Required by state law; state insurance commissioner has absolute power to conduct examinations as appropriate; insurer must respond to examination report comments and recommendations.	Examinations are conducted on either a full or limited-scope basis. Full-scope examinations are conducted every 3 - 5 years. Limited-scope examinations may be conducted more frequently, depending on circumstances.
1	Model Regulation Regarding Hazardous Financial Condition	This model is a Standard in the NAIC Accreditation Program. The purpose of this regulation is to set forth standards, which the state insurance department may use for identifying insurers found to be in an unsound financial condition and for authority to initiate action.	Standards considered and measured during analysis process; analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	These standards provide the basis for a court petition to rehabilitate or liquidate.	All accredited states have passed laws substantially similar to the NAIC model. A state's rehabilitation and liquidation act may incorporate by reference its hazardous financial condition law.
1	Reinsurance Company Failure	An insurer's reinsurance program is closely monitored by a state insurance department's staff and measured by various financial ratios. A significant rating downgrade or failure of any reinsurer triggers a reaction from department staff to identify affected insurers and to assess potential impact on the insurer's solvency.	Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	May result in limited-scope examination.	Credit for reinsurance is heavily regulated through statutes, regulations, statutory accounting and reporting rules. These rules are part of the NAIC Accreditation Program.

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
1	Holding Company Filing	All insurers are required to register certain information with their domiciliary regulator, if part of a holding company system. Information must be disclosed regarding transactions, relationships and agreements with parent, subsidiary and affiliate (PSA) entities, among other information.	Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meetings with management.	May result in limited-scope examination.	Filings are required pursuant to NAIC Insurance Holding Company System Model Act. All accredited states have passed laws substantially similar to the NAIC model.
1	Market Conduct Finding	All insurers periodically undergo some form of "market conduct" examination. As with financial condition examinations, these may be used to detect or investigate problems that impact existing as well as prospective policyholders. These examinations may also affect the insurer's financial stability.		State insurance commissioner has absolute power to conduct examinations as appropriate; insurer must respond to examination report comments and recommendations.	The NAIC continues to work toward developing standards of practice for conducting market conduct examinations.
1	Actuarial Opinion	All insurers are required to appoint "qualified actuary," as defined by the NAIC *Annual Statement Instructions Property and Casualty (P&C)*, to provide an opinion on the adequacy of loss and loss adjustment expense reserves, if a P&C insurer; or policy reserves and other actuarially-determined reserves, if a life or health insurer.	Opinion statements or a change in actuary may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		To the extent possible and appropriate, examiners may utilize the work of the appointed actuary, to validate reserve adequacy.

Regulatory Response

Phase1	Trigger Points	Explanation	nformal2	Formal3	Comments
1	Independent Audit Report (Report on Significant Deficiencies in Internal Controls)	All insurers are required to obtain an opinion from an independent auditor on their annual financial statements. In addition, each insurer must submit a report prepared by the auditor describing significant deficiencies in the insurer's internal control structure identify during the annual audit. An insurer is also required to report a change in auditor to the insurance department of the state of domicile within five business days of the event.	Report findings or a change in auditor may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	Associated with this filing are reporting requirements the independent, external auditor must fulfill if the insurer has materially misstated its financial condition. If internal control deficiencies are reported, the insurer must submit a remediation plan.	To the extent possible and appropriate, examiners may utilize the work of the independent auditor, following some re-testing.
2	Business or Corrective Plan	Closer monitoring requires obtaining the insurer's business plan or corrective plan (including financial projections), depending on the severity of the situation. Two to three year plans are often requested. Financial analyst/examiners utilize these plans to monitor management's execution of the plan and to stimulate dialogue.	A business plan or corrective action plan may be required under general supervisory authority.	In some instances, state law explicitly requires the insurer to file a business or corrective action plan. For example, if an insurer triggers a certain RBC action level, a Corrective Action Plan is required.	Some state insurance departments are moving to routinely request business plans and financial projections from domestic insurers, particularly life insurers

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
	Risk-Based Capital (RBC)	There are five action levels, which are determined by comparing a company's Total Adjusted Capital (TAC) to its Authorized Control Level (ACL) RBC as computed by the RBC formula. TAC is compared to ACL RBC because the ACL RBC is the level at which a state insurance commissioner may first take control of an insurer – that is, control of the insurer may be seized.		RBC standards and actions are statutory requirements.	The NAIC Risk-Based Capital for Insurers Model Act, or an act substantially similar, is required to attain state insurance department accreditation under the NAIC's Accreditation Program.
2	RBC Company Action Level	TAC of 150% to 200% of minimum RBC constitutes a company action level under which an insurer must prepare a report to the state regulator outlining the corrective actions the company intends to take. At this level, an insurer must submit a comprehensive financial plan to the regulator that identifies the conditions contributing to the company's financial condition. This plan must contain proposals to correct the company's financial problems and provide projections of the company's financial condition, both with and without the proposed		RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
		corrections. The plan also must list the key assumptions underlying the projections and identify the quality of, and the problems associated with, the insurer's business. If a company fails to file this comprehensive financial plan, this failure to respond triggers the next action level.			
2	RBC RegulatoryAction Level	TAC of 100% to 150% of minimum RBC triggers a Regulatory Action Level initiative. At this level, an insurer is also required to file an action plan, and the state insurance commissioner is required to perform any examinations or analyses of the insurer's business and operations deemed necessary. The state insurance commissioner also issues appropriate corrective orders to address the company's financial problems	.	RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
3	RBC AuthorizedControl Level	TAC of 70 to 100% of the minimum RBC triggers an Authorized Control Level. This is the first point that the law authorizes the regulator to take control of an insurer. This authorization is in addition to the remedies available at the company and regulatory action levels. It is important to note that the law grants the state insurance commissioner this power. This action level occurs at a point where the insurer may still be technically solvent according to traditional standards – that is, the company's assets may still be greater than its liabilities.		RBC standards and actions are statutory requirements.	
3	RBC MandatoryControl Level	TAC of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place an insurer under control. This situation can occur while the insurer still has a positive level of capital and surplus, although a number of the companies that trigger this action level are technically insolvent (liabilities exceed assets).		RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
3	Administrative Supervision	State insurance commissioner exercises varying levels of control over operations of an insurer, dependent upon the circumstances of the specific case. Ownership of company is not disturbed and directors remain in place. This phase usually involves submission of a corrective plan by the insurer. The state insurance commissioner may appoint an on-site supervisor to monitor performance.		Statutory requirements relating to administrative supervision vary by state.	
4	Receivership	State insurance commissioner obtains a court order authorizing 1) seizure of a company; 2) appointment of the state insurance commissioner as receiver; and 3) vesting legal title to all assets of the company in the state insurance commissioner’s name. Management and directors are removed. As receiver, the state insurance commissioner's actions		Statutory requirements relating to receivership vary by state.	Initial seizure order may be obtained ex parte in some situations. State insurance commissioner has broad discretion in administering the receivership.

		are subject to supervision by the state court that issued the receivership order. State insurance commissioner typically appoints a special deputy receiver to manage the receivership. Receiver may attempt to rehabilitate the insurer or, if rehabilitation is not practical, the receiver will liquidate the company.			

Table B Summary of Federal Reserve System Framework for Identifying and Supervising Financially Weakened State Member Banks and Bank Holding Companies

This table highlights key elements of the FRS's supervisory framework pertaining to bank holding companies (BHCs) and state member banks. It does not purport to include all events that may trigger a supervisory response or the full range of applicable supervisory actions.

Event That May Trigger Supervisory Response	**Applicable Regulation/ Policy or Guidance**[1]	Supervisory Action and Time Frames for Action if Applicable
1) Quarterly surveillance results for state member banks	SR letter 00-7: System Bank Watch List Program	Reserve Bank staff investigates potential financial weaknesses and prepares or updates analyses for watch list banks identified through the FRS's quarterly surveillance process. The analyses address the sources of potential weakness and their potential effect on safety and soundness; assess the appropriateness of current supervisory ratings and on-site examination schedules; and detail future supervisory plans.
2) Quarterly surveillance results for BHCs	SR letter 95-43: Revised Bank Holding Company Surveillance Procedures SR letter 02-01: *Revisions to BHC Supervision Procedures for Organizations with Total Consolidated Assets of $5 Billion or Less* (Contains separate guidance for both BHCs $1 - $5 billion, and BHCs less than $1 billion in assets.)	Reserve Bank staff prepares or updates analyses for BHCs with assets of $1 billion or more identified by quarterly exception screens. The Reserve Bank analyses detail the sources of potential weakness, their effect on safety and soundness, and supervisory actions in response to surveillance screen results. For BHCs under $1 billion, (except small, non-complex BHCs), quarterly surveillance screens are also used to identify potentially

		significant changes in the conditions of these companies between on-site supervisory reviews.

[1] SR letters, the *Commercial Bank Examination Manual,* and the *Bank Holding Company Inspection Manual* provide guidance to Federal Reserve Banks for implementing their Federal Reserve Board-delegated responsibility for the supervision of banking organizations. SR letters are issued by Federal Reserve Board staff to the officers in charge of supervision at each Reserve Bank. These documents are accessible on the Federal Reserve Board's website at www.federalreserve.gov.

Event That May Trigger Supervisory Response	**Applicable Regulation/ Policy or Guidance**1	Supervisory Action and Time Frames for Action if Applicable
3) Risk assessments of BHCs, including FHCs, and banks are prepared by Federal Reserve Bank staff. Risk assessments include an analysis of the level of risk, the direction of risk, and management controls. The following risks are assessed for the consolidated organization, as well as for the major business lines: operational risk, credit risk, market risk, liquidity risk, legal risk, reputational risk, and overall risk. For FHCs, particular focus is on understanding intra-group exposures and risk concentrations across all business lines.	SR letter 97-24: *Risk-Focused Framework for the Supervision of Large Complex Institutions* SR letter 97-25: *Risk-Focused Framework for the Supervision of Community Banks* SR letter 99-15: *Risk-Focused Supervision of Large Complex Banking Organizations* SR letter 02-01: *Revisions to BHC Supervision Procedures for Organizations with Total Consolidated Assets of $5 Billion or Less* SR letter 00-15: *Risk-Focused Supervision Policy for Small Shell BHCs* SR letter 00-13: *Framework for Financial Holding Company Supervision*	Based on the risk assessment, supervisory staff determines the scope, objectives and dates for targeted on-site reviews of selected risk areas. Supervisory staff coordinates with functional and primary regulators when appropriate.
4) Significant market, economic or other external event affecting banking industry condition	FRS's role to maintain stability of the banking system as well as role of prudential regulator for banking institutions.	Conduct monitoring and targeted reviews of banking organizations, as appropriate, and develop action plans.
5) Bank examinations and BHC inspections	Federal Deposit Insurance Corporation Improvement Act of 1991 (FDICIA) requires full-scope on-site examinations of state member banks are required at least once during each 12-month period with the exception that certain small institutions can be examined once during each 18-month period. The frequency of BHC inspections is dependent on the size, condition, and complexity of the institution.	Institutions are required to respond to issues identified. A range of informal and formal supervisory actions that may be appropriate to address weaknesses identified include but are not limited to: • Written Agreement, • Cease and Desist Order, • Temporary Cease and Desist Order, and • Prompt Corrective Action (PCA) (see below portion of this chart regarding PCA).

Event That May Trigger Supervisory Response	Applicable Regulation/ Policy or Guidance1	Supervisory Action and Time Frames for Action if Applicable
6) FHCs whose depository institution subsidiaries become less than well capitalized or are not well managed	Formal corrective action is required under section 4(m) of the BHC Act	• Requires an agreement between the FHC and the FRS within 45 days of notification of deficiency. • Institution must submit a plan for corrective action. • Institution must correct deficiency within 180 days; FRS may extend the deadline based on reasonable cause.
7) Capital deterioration - Bank capital deterioration:	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	
Well capitalized		No action required
Adequately capitalized		No action required
Undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Increase monitoring. The following conditions apply: • Capital restoration plan is required; • Parent BHC must guaranty bank's capital plan; • Cessation of dividends; and • Limitation on management fees paid to controlling persons.

Significantly undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Conditions (see above) for “Undercapitalized” banks apply. Mandatory and discretionary restrictions include: • Sale of shares to increase capital; • Sale or merger of bank; • Restrictions on transactions with affiliates; • Restrictions on interest rates; and • Restrictions on senior officer compensation.

Event That May Trigger Supervisory Response	Applicable Regulation/ Policy or Guidance1	Supervisory Action and Time Frames for Action if Applicable
Critically undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Conditions (see above) for “Undercapitalized” and “Significantly Undercapitalized” banks apply. The Federal Deposit Insurance Corporation (FDIC) may be appointed receiver within 90 days.
BHC capital deterioration	BHC Act	BHC capital deterioration may trigger informal or formal action such a Memorandum of Understanding, Written Agreement, or Cease and Desist Order.
8) Bank & BHC insolvency		
• Bank insolvency or other factors identified by the chartering agency (state banking department or OCC) that are likely to result in losses to the federal deposit insurance fund • BHC insolvencies	Federal Deposit Insurance Act N/A: BHC insolvencies fall under federal bankruptcy laws.	FDIC is generally appointed receiver. N/A

Section II The FDIC

CHAPTER 8 FDIC- How it Functions

The FDIC (Federal Deposit Insurance Corporation) is an independent agency of the United States government that protects citizens against the loss of their deposits if an FDIC-insured bank or savings association fails. FDIC insurance is backed by the full faith and credit of the United States government. Since the FDIC's creation in 1933, no depositor has ever lost even one penny of FDIC-insured funds. The FDIC insures deposits in most, but not all, banks and savings associations. Deposits in separate branches of an insured bank are not separately insured. Deposits in one insured bank are insured separately from deposits in another insured bank. All insured institutions must display an official FDIC sign at each teller window or teller station.

What It Covers

FDIC insurance covers all deposit accounts at insured banks and savings associations, including checking, NOW, and savings accounts, money market deposit accounts and certificates of deposit (CDs) up to the insurance limit. The FDIC does not insure the money invested in stocks, bonds, mutual funds, life insurance policies, annuities or municipal securities, even if the product was purchased from an insured bank or savings association. Deposits are insured up to $250,000. A depositor can have more than $250,000 at one insured bank or savings association and still be fully insured provided the accounts meet certain requirements. In addition, federal law provides for insurance coverage of up to $250,000 for certain retirement accounts. The basic FDIC coverage limits are as follows-
Single Accounts (owned by one person): $250,000 per owner
Joint Accounts (two or more persons): $250,000 per co-owner
IRAs and certain other retirement accounts: $250,000 per owner
Revocable trust accounts: Each owner is insured up to $250,000 for the interests of each beneficiary, subject to specific limitations and requirements

These deposit insurance coverage limits refer to the total of all deposits that account holders have at each FDIC-insured bank. The listing above shows only the most common ownership categories that apply to individual and family deposits, and assumes that all FDIC requirements are met.

A depositor may qualify for more than $250,000 in coverage at one insured bank or savings association if he or she owns deposit accounts in different ownership categories. The most common account ownership categories for individual and family deposits are single accounts, joint accounts, revocable trust accounts and certain retirement accounts.

Single Account

A ‘single account’ is a deposit account owned by one person and titled in that person's name only, with no beneficiaries. All an individual’s single accounts at the same insured bank are added together and the total is insured up to $250,000. For example, if someone has a checking account and a CD at the same insured bank, and both accounts are in that individual’s name only, the two accounts are added together and the total is insured up to $250,000. Note that retirement accounts and eligible trust accounts are not included in this ownership category.

Example of Insurance Coverage for Single Accounts		
Depositor	Type of Deposit	Amount Deposited
Jane Smith	Savings account	$25,000
Jane Smith	Certificate of Deposit	$250,000
Jane Smith	NOW account	$50,000
Jane Smith's sole proprietorship	Checking account	$50,000
Total Deposited		$375,000
Insurance Available		$250,000
Uninsured Amount		$125,000

Joint Account

This is a deposit account owned by two or more people and titled jointly in the co-owners' names only, with no beneficiaries. If all co-owners have equal rights to withdraw money from a joint account, a co-owner's shares of all joint accounts at the same insured bank are added together and the total is insured up to $250,000. Note that jointly owned revocable trust accounts are not included in this ownership category. If a couple has a joint checking account and a joint savings account at the same insured bank, each co-owner's shares of the two accounts are added together and insured up to $250,000 per owner, providing up to $500,000 in coverage for the couple's joint accounts.

Requirements for Joint Accounts

Joint accounts are insured separately from other ownership categories if all of the following conditions are met:

All co-owners must be natural persons. This means that legal entities such as corporations or partnerships are not eligible for joint account deposit insurance coverage.

Each of the co-owners must have personally signed a deposit account signature card. The execution of an account signature card is not required for certificates of deposit, deposit obligations evidenced by a negotiable instrument or accounts maintained by an agent, nominee, guardian, custodian, or conservator, but the deposit must in fact be jointly owned.

Each of the co-owners must have a right of withdrawal on the same basis as the other co-owners.

For example, if one co-owner can withdraw funds on his or her signature alone, but the other co-owner can withdraw funds only on the signature of both co-owners, then this requirement has not been satisfied; the co-owners do not have equal withdrawal rights. Likewise, if a co-owner's right to withdraw funds is limited to a specified dollar amount, the funds in the account will be allocated between the co-owners according to their withdrawal rights and insured as single account funds. For example, if $250,000 is deposited in the names of A and B, but A has the right to withdraw only up to $50,000 from the account, $50,000 is allocated to A and the remainder ($200,000) is allocated to B. The funds, as allocated, are then added to any other single account funds of A or B, respectively.

Example: John and Mary have three joint accounts totaling $600,000 at an insured bank. Under FDIC rules, each co-owner's share of each joint account is considered equal unless otherwise stated in the bank's records. John and Mary each own $300,000 in the joint account category, putting a total of $100,000 ($50,000 for each) over the insurance limit.

Joint Account Example		
Account Title	Type of Deposit	Account Balance
Mary and John Smith	Checking	$50,000
John or Mary Smith	Savings	$150,000
Mary Smith or John Smith	CD	$400,000
Total Deposits		$600,000

Insurance coverage for each owner is calculated as follows:			
Account Holders	Ownership Share	Amount Insured	Amount Uninsured
John	$300,000	$250,000	$50,000
Mary	$300,000	$250,000	$50,000
Total	$600,000	$500,000	$100,000

Mary's ownership share in all joint accounts equals $300,000 [1/2 of the checking account ($25,000), 1/2 of the savings account ($75,000), and 1/2 of the CD ($200,000), for a total of $300,000]. Since her coverage in the joint ownership category is limited to $250,000, $50,000 is uninsured.
John's ownership share in all joint accounts is the same as Mary's, so $50,000 is uninsured.

How joint accounts are insured

An individual's (co-owner's) interests in all qualifying joint accounts are added together and the total is insured up to the $250,000 maximum. Each co-owner's interest (or share) in a joint account is deemed equal. The balance of a joint account can exceed $250,000, as long as no owner's share of joint accounts at the same bank exceeds $250,000. The use of different Social Security numbers does not determine insurance coverage, nor does rearranging the owners' names, changing the style of the names, or using "or" rather than "and" to join the owners' names in a joint account title.

Example of Insurance Coverage for Joint Accounts		
Account Title	Owners	Balance
#1	A and B	$250,000
#2	B and A	$120,000
#3	A and B and C	$180,000
#4	A and D	$80,000
Total		$630,000

Each owner's ownership interests in these four joint accounts follow:

A's Ownership Interest	
1/2 of the balance in account #1	$125,000
1/2 of the balance in account #2	$60,000
1/3 of the balance in account #3	$60,000
1/2 of the balance in account #4	$40,000
Total of A's Ownership Interest	$285,000

A's ownership interest in the joint account category is $285,000. This amount is more than the $250,000 maximum, so $250,000 is insured and $35,000 is uninsured.

B's Ownership Interest	
1/2 of the balance in account #1	$125,000
1/2 of the balance in account #2	$60,000
1/3 of the balance in account #3	$60,000
Total of B's Ownership Interest	$245,000

B's ownership interest in the joint account category is $245,000. That amount is less than the $250,000 maximum, so B is fully insured.

C's Ownership Interest	
1/3 of the balance in account #3	$60,000
Total of C's Ownership Interest	$60,000

C's ownership interest in the joint account category is $60,000. That amount is less than the $250,000 maximum, so C is fully insured.

D's Ownership Interest	
1/2 of the balance in account #4	$40,000
Total of D's Ownership Interest	$40,000

D's ownership interest in the joint account category is $40,000. That amount is less than the $250,000 maximum, so D is fully insured.

Summary of Insurance Coverage for Joint Accounts			
Owner	Account Balance	Insured	Uninsured
A	$285,000	$250,000	$35,000
B	$245,000	$245,000	$0
C	$60,000	$60,000	$0
D	$40,000	$40,000	$0
Total	$630,000	$595,000	$35,000

Retirement Accounts

These are deposit accounts owned by one person and titled in the name of that person's retirement plan. Only the following types of retirement plans are insured in this ownership category:

Individual Retirement Accounts (IRAs) including traditional IRAs, Roth IRAs, Simplified Employee Pension (SEP) IRAs, and Savings Incentive Match Plans for Employees (SIMPLE) IRAs

Section 457 deferred compensation plan accounts (whether self-directed or not)

Self-directed defined contribution plan accounts

Self-directed Keogh plan (or H.R. 10 plan) accounts

All deposits that an individual has in any of the types of retirement plans listed above at the same insured bank are added together and the total is insured up to $250,000. For example, if an individual has an IRA and a self-directed Keogh account at the same bank, the deposits in both accounts would be added together and insured up to $250,000.

Note: Naming beneficiaries on a retirement account does not increase deposit insurance coverage.

Revocable Trust Account

This is a deposit account held as a payable on death (POD) or in trust for (ITF) account or that is established in the name of a formal revocable trust (also known as a living or family trust account).

POD and ITF accounts These are also known as testamentary or Totten Trust accounts — are the most common form of revocable trust deposits. These informal revocable trusts are created when the account owner signs an agreement — usually part of the bank's signature card — stating that the deposits will be payable to one or more beneficiaries upon the owner's death.

Living trusts — or family trusts — are formal revocable trusts created for estate planning purposes. The owner of a living trust controls the deposits in the trust during his or her lifetime. The trust document sets forth who shall receive trust assets after the death of the owner.

Deposit insurance coverage for revocable trust accounts is provided to the owner of the trust. However, the amount of coverage is based on the number of beneficiaries named in the trust and, in some cases, the interests allocated to those beneficiaries, up to the insurance limit. A trust beneficiary can be an individual (regardless of the relationship to the owner), a charity or another non-profit organization (as defined by the IRS).

Revocable trust coverage is based on all revocable trust deposits held by the same owner at the same bank, whether formal or informal. If a revocable trust account has more than one owner, each owner's coverage is calculated separately, using the following rules:

Revocable Trust Deposits with Five or Fewer Beneficiaries — Each owner's share of revocable trust deposits is insured up to $250,000 for each beneficiary (i.e., $250,000 times the number of different beneficiaries), regardless of actual interest provided to beneficiaries.

Revocable Trust Deposits with Six or More Beneficiaries — Each owner's share of revocable trust deposits is insured for the greater of either (1) coverage based on each beneficiary's actual interest in the revocable trust deposits, with no beneficiary's interest to be insured for more than $250,000, or (2) $1,250,000.

Note: Determining coverage for living trust accounts that have six or more beneficiaries and provide different interests for the trust beneficiaries can be complicated.

How revocable trust accounts are insured

Deposit insurance coverage for revocable trust accounts is provided to the owner of the trust. However, the amount of coverage is based on the number of beneficiaries named in the trust and, in some cases, the interests allocated to those beneficiaries, up to the insurance limit. A trust beneficiary can be an individual (regardless of the relationship to the owner), a charity or another non-profit organization (as defined by the IRS). Revocable trust coverage is based on all revocable trust deposits held by the same owner at the same insured bank, whether formal or informal. If a revocable trust account has more than one owner, each owner's coverage is calculated separately, using the following rules:

Revocable Trust Deposits with Five or Fewer Beneficiaries — Each owner's share of revocable trust deposits is insured up to $250,000 for each beneficiary (i.e., $250,000 times the number of different beneficiaries), regardless of the actual interests of the beneficiaries.
Revocable Trust Deposits with Six or More Beneficiaries — Each owner's share of revocable trust deposits is insured for the greater of either (1) the coverage based on each beneficiary's actual interest in the revocable trust deposits, with no beneficiary's interest to be insured for more than $250,000, or (2) $1,250,000.

Example — POD Accounts with One Owner			
Account Title	Account Balance	Amount Insured	Amount Uninsured
John Smith POD to son	$250,000	$250,000	$0

Explanation: This revocable trust account is insured up to $250,000 since there is one beneficiary who will receive the deposit when the owner dies.

Revocable trust account needing more than $250,000 in insurance coverage
If a revocable trust account has more than one owner (e.g., husband and wife) or is held for more than one beneficiary, the insured balance of the account can exceed $250,000 and still be fully insured. If there is more than one owner, the FDIC will assume that the owners' shares are equal unless the deposit account records state otherwise.

Example — POD Accounts with Multiple Owners and Beneficiaries			
Account Title	Account Balance	Amount Insured	Amount Uninsured
Husband and Wife POD 3 children	$1,500,000	$1,500,000	$0
Husband POD wife	$250,000	$250,000	$0
Wife POD husband	$250,000	$250,000	$0
Husband POD niece and nephew	$500,000	$500,000	$0
Husband and wife POD grandchild	$600,000	$500,000	$100,000
Total	$3,100,000	$3,000,000	$100,000

Explanation: All but one account is fully insured. The account naming the one grandchild is insured to $500,000 because each owner is entitled to $250,000 insurance coverage for the sole beneficiary.

Living Trust Example: A husband and wife have a living trust leaving all trust assets equally to their three children upon the death of the last owner. All deposits held in the name of this trust at one FDIC-insured bank would be covered up to $1,500,000. Each owner is entitled to $750,000 of insurance coverage because they each have three beneficiaries who will receive the trust deposits when both owners have died.

What is the deposit insurance coverage of a revocable trust deposit when the beneficiaries do not have equal interests?
If a revocable trust has five or fewer beneficiaries, then each owner's share of all trust deposits at one insured bank is covered up to $250,000 times the number of beneficiaries, regardless of the actual proportional interests set forth in the trust document. For example:
An individual has $750,000 in revocable trust deposits at one FDIC-insured bank. The trust document specifies that 60% goes to one child, 30% goes to a second child, and 10% to a third child. The full balance of the trust is insured, because the owner receives coverage of $250,000 per beneficiary, regardless of the actual interests set forth in the trust document.

If a revocable trust has six or more beneficiaries, then each owner's share of revocable trust deposits is insured for the greater of either (1) the coverage based on each beneficiary's actual interest in the revocable trust deposits, with no beneficiary's interest to be insured for more than $250,000, or (2) $1,250,000. For example:
An individual has $1,400,000 in revocable trust deposits at one FDIC-insured bank. The trust document specifies that 50% of the funds will belong to the owner's son and 10% will belong to each of his five grandchildren. Coverage for this depositor's revocable trust funds is determined using the rule for a revocable trust account with six or more beneficiaries. Maximum coverage for this depositor's funds is the greater of (1) the coverage based on each beneficiary's actual interest in the revocable trust deposits, with no beneficiary's interest exceeding $250,000, or (2) $1,250,000. Applying this rule, the maximum coverage based on actual interests is $500,000 ($250,000 divided by 50% (the son’s share) = $500,000). Since this is less than $1,250,000, the trust owner's deposits would be insured up to $1,250,000, and $150,000 would be uninsured.
An individual has $2.5 million in revocable trust deposits at one FDIC-insured bank. The trust document specifies that 10% of the funds will belong to each of her five children and 5% will belong to each of her 10 grandchildren. Maximum coverage for this depositor's funds is the greater of (1) the coverage based on each beneficiary's actual interest in the revocable trust deposits, with no beneficiary's interest to be insured for more than $250,000, or (2) $1,250,000. Applying this rule, the maximum coverage based on actual interests is $2.5 million ($250,000 divided by 10% (each child’s share) = $2,500,000). Since this amount is greater than $1,250,000, the trust owner would be fully insured.

How a beneficiary's life estate interest is insured for a formal living (or family) trust
Living trusts often give a beneficiary the right to receive income from the trust or to use trust assets during the beneficiary’s lifetime (known as a life estate interest). When the beneficiary with the life estate interests dies, the remaining assets pass to other beneficiaries. A life estate interest is insured up to $250,000, separate from the interests of the other remaining beneficiaries. For example:
A husband creates a living trust giving his wife a life estate interest in the trust assets, with the remaining assets to belong equally to the couple's two children upon both parent's death.

Deposits held in the name of this trust would be insured up to $750,000 ($250,000 for each beneficiary — the wife and two children).

Living trust accounts and POD accounts- separately insured

The $250,000 per beneficiary insurance limit applies to all revocable trust accounts — POD and living trust accounts — that an owner has at the same insured bank. For example:
A father has a POD account with a balance of $400,000 naming his son and daughter as beneficiaries. He also has a living trust account with a balance of $200,000 naming the same beneficiaries. The funds in both accounts would be added together and $300,000 would be attributable as the beneficial interest of each child. Therefore, the two accounts together would be insured for $500,000 ($250,000 per beneficiary) and uninsured for $100,000.

Irrevocable Trust Accounts

Irrevocable trust accounts are deposit accounts held by a trust established by statute or a written trust agreement, in which the creator of the trust (grantor/settlor/trustor) contributes funds or property and gives up all power to cancel or change the trust.

There are two types of irrevocable trusts —
Those created following of the death of an owner of a revocable trust. The insurance coverage of these irrevocable trusts is the same as for revocable trusts, which is described above.
Those that are created as an irrevocable (usually by a court order or established under a will) and are *not* derived from a revocable trust. The insurance coverage of these irrevocable trusts is described below.
How funds deposited pursuant to an irrevocable trust document are insured
The interests of a beneficiary in all deposit accounts established by the same settlor and held at the same insured bank under an irrevocable trust are added together and insured up to $250,000, provided all of the following requirements are met:
The insured bank's deposit account records must disclose the existence of the trust relationship
The beneficiaries and their interests in the trust must be identifiable from the deposit account records of the bank or from the records of the trustee
The amount of each beneficiary's interest must not be "contingent" as that term is defined by FDIC regulations
The trust must be valid under state law
Since the amount of insurance for an irrevocable trust depends upon specific terms and conditions of the trust, owners or trustees of an irrevocable trust may wish to consult with their legal or financial advisor for assistance in determining the amount of insurance coverage available to trust deposits.
What is the insurance coverage if the grantor retains an interest in the trust?
If the grantor retains an interest in the trust, the amount of the retained interest would be added to any single accounts owned by the grantor at the same bank and the total insured up to $250,000.
What if the beneficiaries or their interests in an irrevocable trust cannot be ascertained?
When the ownership interests of the beneficiaries cannot be determined, insurance coverage for the entire trust is generally limited to a maximum of $250,000.

POD Account Example: *This example applies to POD accounts only. (Coverage may be different for some living trusts.)* Bill has a $250,000 POD account with his wife Sue as beneficiary. Sue has a $250,000 POD account with Bill as beneficiary. In addition, Bill and Sue jointly have a $1,500,000 POD account with their three children as equal beneficiaries.

Account Title	Account Balance	Amount Insured	Amount Uninsured
Bill POD to Sue	$250,000	$250,000	$0
Sue POD to Bill	$250,000	$250,000	$0
Bill and Sue POD to 3 children	$1,500,000	$1,500,000	$0
Total	$2,000,000	$2,000,000	$0

These three accounts totaling $2,000,000 are fully insured because each owner is entitled to $250,000 of coverage for each beneficiary. Bill has $1,000,000 of insurance coverage because he names four beneficiaries — his wife in the first account and his three children in the third account). Sue also has $1,000,000 of insurance coverage $250,000 for each of her beneficiaries — her husband in the second account and her three children in the third account.
When calculating coverage for revocable trust accounts, *keep in mind that:*
Coverage is based on the number of beneficiaries (and, if the account has six or more beneficiaries, the interests of the beneficiaries) named by each owner. Additional coverage is not provided for the trust owner(s). For example, if a father owns a $750,000 POD account naming his two sons as beneficiaries, the account is insured for $500,000 — $250,000 for the interest of each beneficiary. The remaining $250,000 is uninsured.
FDIC insurance limits apply to all revocable trust deposits — including all POD/ITF and living trust accounts — that a trust owner has at one insured bank. In applying the $250,000 per beneficiary insurance limit, the FDIC combines an owner's POD accounts with the living trust accounts that name the same beneficiaries at the same bank.

The Uniform Transfer to Minor Act

The Uniform Transfer to Minor Act is a state law that allows an adult to make a gift to a minor. Funds given to a minor by this method are held in the name of a custodian for the minor's benefit. Funds deposited for the minor's benefit under the Act are added to any other single accounts of the minor, and the total is insured up to a maximum of $250,000.

Sole Proprietorship accounts

These are deposits owned by an unincorporated business, in contrast to a business that is incorporated or a partnership. Deposit accounts owned by a sole proprietor are insured as the single funds of the person who owns the business. So, if an individual has an account in his name alone and another account in the name of his sole proprietorship, the balances in those accounts would be combined and insured to a up to a maximum of $250,000 in the single account category.

Decedent Estate accounts

These are funds deposited by an executor or administrator for the estate of a deceased person. These accounts are insured up to $250,000 as the single account funds of the deceased person. This coverage limit would include any other funds maintained in the name of the deceased individual. It is important to note that coverage is not provided on a per beneficiary

basis. So, even though there might be multiple beneficiaries of the decedent's estate, the account established for the estate would not be insured for more than $250,000. The funds are, however, insured separately from the personal funds of the executor or administrator.

Certain Retirement Accounts

These are deposit accounts owned by one person and titled in the name of that person's:
Individual Retirement Account including traditional IRA, Roth IRA, Simplified Employee Pension (SEP) IRA or Savings Incentive Match Plans for Employees (SIMPLE) IRA
Section 457 deferred compensation plan account (such as eligible deferred compensation plans provided by state and local governments regardless of whether the plan is self-directed)
Self-directed defined contribution plan account, such as a self-directed 401(k) plan, a self-directed SIMPLE plan held in the form of a 401(k) plan, a self-directed defined contribution money purchase plan, or a self-directed defined contribution profit-sharing plan
Self-directed Keogh plan account (or H.R. 10 plan account) designed for self-employed individuals

Definition of 'Self-Directed'- The FDIC defines the term "self-directed" to mean that plan participants have the right to direct how the money is invested, including the ability to direct that the deposits be placed at an FDIC-insured bank.

If a participant of a retirement plan has the right to choose a particular depository institution's deposit accounts as an investment, the FDIC would consider the account to be self-directed. Also, if a plan has as its default investment option deposit accounts at a particular FDIC-insured institution, the FDIC would deem the plan to be self-directed for deposit insurance purposes because, by inaction, the participant has directed the placement of such deposits.

However, if a plan's only investment vehicle is the deposit accounts of a particular bank, so that participants have no choice of investments, the plan would not be deemed self-directed for deposit insurance purposes. Finally, if a plan consists only of a single employer/employee, and the employer establishes the plan with a single-investment option of plan assets, the plan would be considered self-directed for deposit insurance purposes.

Roth IRAs

A Roth IRA is treated the same as a traditional IRA for deposit insurance purposes. So, if a depositor has both a Roth IRA and a traditional IRA at the same insured bank, the funds in both accounts are added together and insured up to $250,000.

Example of Insurance Coverage for Self-Directed Retirement Accounts	
Account Title	Account Balance
Bob Johnson's Roth IRA	$110,000
Bob Johnson's IRA	$75,000
Total	$185,000
Amount Insured	$185,000

Explanation: Since Bob's total in all self-directed retirement accounts at the same bank is less than the $250,000 limit, both IRAs are fully insured.

Coverdell IRAs or Health Savings Accounts

Coverdell Education Savings Accounts (formerly known as an Education IRAs), Health Savings Accounts and Medical Savings Accounts are **not** included in the certain retirement ownership category. Depending on the structure, these accounts may be included in the single account or trust account ownership category. Also, accounts established under section 403(b) of the Internal Revenue Code (annuity contracts for certain employees of public schools, tax-exempt organizations and ministers) are **not** included in the certain retirement ownership category.

Revocable Trust Accounts

A revocable trust account is a deposit account that indicates an intention that the funds will belong to one or more beneficiaries upon the death of the owner (grantor/settlor/trustor). There are both informal and formal revocable trusts:

Informal revocable trusts — often called payable on death (POD), Totten trust, or in trust for (ITF) accounts — are created when the account owner signs an agreement, usually part of the bank's signature card, stating that the funds are payable to one or more beneficiaries upon the owner's death.

Formal revocable trusts — known as living or family trusts — are written trusts created for estate planning purposes. The owner (also known as a grantor, settlor or trustor) controls the funds in the trust during his or her lifetime and reserves the right to revoke the trust.

Employee Benefit Plan Accounts

The general rule is that deposits belonging to pension plans and profit-sharing plans receive pass-through insurance, meaning that each participant's non-contingent and ascertainable interest in a deposit—as opposed to the deposit as a whole—is insured up to $250,000. In order for a pension or profit-sharing plan to receive pass-through insurance, the institution's deposit account records must specifically disclose the fact that the funds are owned by an employee benefit plan. In addition, the details of the participants' beneficial interests in the account must be ascertainable from the institution's deposit account records or from the records that the plan administrator (or some other person or entity that has agreed to maintain records for the plan) maintains in good faith and in the regular course of business.

Employee benefit plan coverage and the number of plan participants

Employee benefits are various non-wage compensations provided to employees in addition to their cash wages. Normally, employer provided benefits are tax-deductible to the employer and non-taxable to the employee. Coverage for an employee benefit plan's deposits is based on each participant's share of the plan. Because plan participants normally have different interests in the plan, insurance coverage cannot be determined by simply multiplying the number of participants by $250,000. To determine the maximum amount a plan can have on deposit in a single bank and remain fully insured, first determine which participant has the largest share of the plan assets, then divide $250,000 by that percentage. For example, if a plan has 20 participants, but one participant has an 80% share of the plan assets, the most the plan can have on deposit in a single bank and still remain fully insured is $312,500. ($250,000/.80 = $312,500)

Example — Employee Benefit Plan that Qualifies for Pass-Through Coverage				
Account Title				Balance
Happy Pet Clinic Benefit Plan				$700,000
Plan Participants	Plan Share	Share of Deposit	Amount Insured	Amount Uninsured
Dr. Todd	35%	$245,000	$245,000	$0
Dr. Jones	30%	$210,000	$210,000	$0
Tech Evans	20%	$140,000	$140,000	$0
Tech Barnes	15%	$105,000	$105,000	$0
Plan Total	100%	$700,000	$700,000	$0

Explanation: This employee benefit plan can deposit $700,000 in an FDIC-insured bank and have all of its participants fully insured. The $700,000 deposit results in Dr. Todd's interest (the largest participant) being insured for $245,000 (35% of $700,000). When Dr. Todd's interest is fully insured, the interests of the other participants are also fully insured, since they have smaller shares of the plan.

Corporation, Partnership, and Unincorporated Association Accounts
These are accounts established by businesses and organizations — including for-profit and not-for-profit organizations — engaged in an independent activity, meaning that the entity is operated primarily for some purpose other than to increase insurance coverage. Unincorporated associations typically include religious, community and civic organizations and social clubs that are not incorporated.

Deposit insurance coverage for funds deposited by a corporation, partnership, or unincorporated association
Funds deposited by a corporation, partnership, or unincorporated association are insured up to a maximum of $250,000. Funds deposited by a corporation, partnership, or unincorporated association are insured separately from the personal accounts of the stockholders, partners or members. To qualify for this coverage, the entity must be engaged in an independent activity, meaning that the entity is operated primarily for some purpose other than to increase deposit insurance.

Additional insurance coverage
There is no way that a corporation, partnership or unincorporated association can qualify for more than $250,000 in insurance coverage for its deposits at one bank. Separate accounts owned by the same entity, but designated for different purposes, are not separately insured. Instead, such accounts are added together and insured up to $250,000. If a corporation has divisions or units that are not separately incorporated, the deposit accounts of those divisions or units will be added to any other deposit accounts of the corporation for purposes of determining deposit insurance coverage.

Total of partners, members or account signatories
The number of partners, members or account signatories that a corporation, partnership, or unincorporated association has does not affect coverage. For example, deposits owned by a

homeowners association are insured up to $250,000 in total, not $250,000 for each member of the association.

Sole-proprietorships not insured
Deposits owned by a business that is a sole proprietorship are not insured under this category. Rather, they are insured as the single account deposits of the person who is the sole proprietor. So, funds deposited in the sole proprietorship's name are added to any other single accounts of the sole proprietor and the total is insured to a maximum of $250,000.

Government Accounts
Government accounts are also known as public unit accounts. This category includes deposit accounts of the United States, any state, county, municipality (or a political subdivision of any state, county, or municipality), the District of Columbia, Puerto Rico and other government possessions and territories, or an Indian tribe

How public unit accounts are insured
Insurance coverage of a public unit account differs from a corporation, partnership, or unincorporated association account in that the coverage extends to the official custodian of the funds belonging to the public unit rather than the public unit itself. The insurance coverage of public unit accounts depends upon (1) the type of deposit, and (2) the location of the insured depository institution. All time and savings deposits owned by a public unit and held by the same official custodian in an insured depository institution within the State in which the public unit is located are added together and insured up to $250,000. Separately, all demand deposits owned by a public unit and held by the same official custodian in an insured depository institution within the State in which the public unit is located are added together and insured up to $250,000. For the purpose of these rules, the term "savings deposits" includes NOW accounts, money market deposit accounts and other interest-bearing checking accounts.

Maintaining funds in an out of state bank
The insurance coverage of public unit accounts is different if the depository institution is located outside the State in which the public unit is located. In that case, all deposits owned by the public unit and held by the same official custodian are added together and insured up to $250,000. Time and savings deposits are not insured separately from demand deposits.

The definition of a political subdivision- The term "political subdivision" is defined to include drainage, irrigation, navigation, improvement, levee, sanitary, school or power districts, and bridge or port authorities and other special districts created by state statute or compacts between the states. The term "political subdivision" also includes any subdivision or principal department of a public unit (state, county, or municipality) if the subdivision or department meets the following tests:
The creation of the subdivision or department has been expressly authorized by the law of such public unit;
Some functions of government have been delegated to the subdivision or department by such law; and
The subdivision or department is empowered to exercise exclusive control over funds for its exclusive use.

Definition of an official custodian- An "official custodian" is an officer, employee or agent of a public unit having official custody of public funds and lawfully depositing the funds in an insured institution. In order to qualify as an official custodian, a person must have plenary authority — including control — over the funds. Control of public funds includes possession as well as the

authority to establish accounts in insured depository institutions and to make deposits, withdrawals and disbursements.

What Is Not Insured

Increasingly, institutions are also offering consumers a broad array of investment products that are not deposits, such as mutual funds, annuities, life insurance policies, stocks and bonds. Unlike the traditional checking or savings account, however, these non-deposit investment products are not insured by the FDIC.

Mutual Funds

Investors sometimes favor mutual funds over other investments, perhaps because they hold promise of a higher rate of return than say, CDs. And with a mutual fund, such as a stock fund, the risk of a company going bankrupt, resulting in the loss of investors' funds - is more spread out because the investor owns a piece of a lot of companies instead of a portion of a single enterprise. A mutual fund manager may invest the fund's money in either a variety of industries or several companies in the same industry. Or the funds may be invested in a money market mutual fund, which may invest in short-term CDs or securities such as Treasury bills and government or corporate bonds. Do not confuse a money market mutual fund with an FDIC-insured money market deposit account (described earlier), which earns interest in an amount determined by, and paid by, the financial institution where the funds are deposited. Potential investors can - and should - obtain definitive information about any mutual fund before investing in it by reading a prospectus, which is available at the bank or brokerage where he or she plans to do business. The key point to remember when contemplating purchasing mutual funds, stocks, bonds or other investment products, whether at a bank or elsewhere, is: Funds so invested are NOT deposits, and therefore are NOT insured by the FDIC - or any other agency of the federal government.

Securities owned by an investor, including mutual funds, that are held for his or her account by a broker, or a bank's brokerage subsidiary are not insured against loss in value. The value of investments can go up or down depending on the demand for them in the market. The Securities Investors Protection Corporation (SIPC), a non government entity, replaces missing stocks and other securities in customer accounts held by its members up to $500,000, including up to $100,000 in cash, if a member brokerage or bank brokerage subsidiary fails. For more information contact:

Treasury Securities

Treasury securities include Treasury bills (T-bills), notes and bonds. T-bills are commonly purchased through a financial institution. Customers who purchase T-bills at banks that later fail become concerned because they think their actual Treasury securities were kept at the failed bank. In fact, in most cases banks purchase T-bills via book entry, meaning that there is an accounting entry maintained electronically on the records of the Treasury Department; no engraved certificates are issued. Treasury securities belong to the customer; the bank is merely acting as custodian. Customers who hold Treasury securities purchased through a bank that later fails can request a document from the acquiring bank (or from the FDIC if there is no acquirer) showing proof of ownership and redeem the security at the nearest Federal Reserve Bank. Or, customers can wait for the security to reach its maturity date and receive a check from the acquiring institution, which may automatically become the new custodian of the failed bank's T-bill customer list (or from the FDIC acting as receiver for the failed bank when there is no

acquirer). Even though Treasury securities are not covered by federal deposit insurance, payments of interest and principal (including redemption proceeds) on those securities that are deposited to an investor's deposit account at an insured depository institution ARE covered by FDIC insurance up to the $250,000 limit. And even though there is no federal insurance on Treasury securities, they are backed by the full faith and credit of the United States Government - the strongest guarantee anyone can get.

Safe Deposit Boxes

The contents of a safe deposit box are not insured by the FDIC. (Depositors should make sure to read the contract with the bank when renting the safe deposit box in the event that some type of insurance is provided; some banks may make a very limited payment if the box or contents are damaged or destroyed, depending on the circumstances.) If a person is concerned about the safety, or replacement, of items placed in a safe deposit box, he or she may wish to consider purchasing fire and theft insurance. Separate insurance for these perils may be available through the boxholder’s insurance agent. Usually such insurance is part of a homeowner's or tenant's insurance policy for a residence and its contents.
In the event of a bank failure, in most cases an acquiring institution would take over the failed bank's offices, including locations with safe deposit boxes. If no acquirer can be found the FDIC would send boxholders instructions for removing the contents of their boxes.

Robberies and Other Thefts

Stolen funds may be covered by what's called a banker's blanket bond, which is a multi-purpose insurance policy a bank purchases to protect itself from fire, flood, earthquake, robbery, defalcation, embezzlement and other causes of disappearing funds. In any event, an occurrence such as a fire or bank robbery may result in a loss to the bank but should not result in a loss to the bank's customers.
If a third party somehow gains access to an account and transacts business that the account holder would not approve of, he or she must contact the bank and local law enforcement authorities, who have jurisdiction over this type of wrongdoing.

Coverage Summary	
FDIC-Insured Checking Accounts (including money market deposit accounts) Savings Accounts (including passbook accounts) Certificates of Deposit	Not FDIC-Insured Investments in mutual funds (stock, bond or money market mutual funds), whether purchased from a bank, brokerage or dealer Annuities (underwritten by insurance companies, but sold at some banks) Stocks, bonds, Treasury securities or other investment products, whether purchased through a bank or a broker/dealer

CHAPTER 9 The FDIC, How it Came to Be

The **Federal Deposit Insurance Corporation** (**FDIC**) was created by the Glass-Stegall Act of 1933. It is a government sponsored entity that provides deposit insurance guaranteeing the safety of checking and savings deposits in member banks. The coverage limit has changed over the years. In the fall of 2008, the limit was raised to $250,000 per depositor per bank. A brief period of unlimited deposit coverage was mandated by the Dodd-Frank legislation of 2010, but the standard coverage limit returned to $250,000 for all deposit categories on January 1, 2013. The vast number of bank failures in the Great Depression lead to the creation of an institution to guarantee deposits held by commercial banks.

The FDIC insures accounts at different banks separately. For example, a person with accounts at two separate banks (not merely branches of the same bank) can keep $250,000 in each account and be insured for the total of $500,000. Also, accounts in different ownerships (such as beneficial ownership, trusts, and joint accounts) are considered separately for the $250,000 insurance limit. Under the Federal Deposit Reform Act of 2005, Individual Retirement Accounts are insured to $250,000.

History of Deposit Insurance, Introduction

“After all, there is an element in the readjustment of our financial system more important than currency, more important than gold, and that is the confidence of the people.”

These words were spoken by President Franklin D. Roosevelt in his first “fireside chat” to the people of the United States on March 12, 1933. In announcing an end to the bank holiday he had proclaimed six days earlier, President Roosevelt was exhorting the people to remain calm and avoid the panicked withdrawals that had crippled the nation’s banking system in the first months of 1933. However, despite the federal government’s newly adopted plans to reorganize many closed but viable banks, some 4,000 banks that had closed earlier in 1933 or during the bank holiday never reopened.

The confidence of the people still was shaken, and public opinion remained squarely behind the adoption of a federal plan to protect bank depositors. Opposition to such a plan had been voiced earlier by President Roosevelt, the Secretary of the Treasury and the Chairman of the Senate Banking Committee. They believed a system of deposit insurance would be unduly expensive and would unfairly subsidize poorly managed banks. Nonetheless, public opinion held sway with the Congress, and the Federal Deposit Insurance Corporation was created three months later when the President signed into law the Banking Act of 1933. The final frenetic months of 1933 were spent organizing and staffing the FDIC and examining the nearly 8,000 state-chartered banks that were not members of the Federal Reserve System. Federal deposit insurance became effective on January 1, 1934, providing depositors with $2,500 in coverage, and by any measure it was an immediate success in restoring public confidence and stability to the banking system. Only nine banks failed in 1934, compared to more than 9,000 in the preceding four years.

Millennium

At the new Millennium, federal deposit insurance remains an integral part of the nation's financial system, although some have argued at different points in time that there have been too few bank failures because of deposit insurance, that it undermines market discipline, that the current coverage limit of $100,000 is too high, and that it amounts to a federal subsidy for banking companies. Each of these concerns may be valid to some extent, yet the public appears to remain convinced that a deposit insurance program is worth the cost, which ultimately is borne by them. The severity of the 1930s banking crisis has not been repeated, but bank deposit insurance was harshly tested in the late 1980s and early 1990s. The system emerged battered but sound and, with some legislative tweaking, better suited to the more volatile, higher-risk financial environment that has evolved in the last quarter of the 20th century.

This chapter focuses on the insurance function of the FDIC. The agency also serves as the primary federal supervisor for state-chartered nonmember banks and has backup supervisory authority over all other insured depository institutions; and the FDIC manages the receiverships of failed insured banks and thrifts. These supervisory and receivership-management functions are not fully addressed here. The document also does not directly address the savings-and-loan crisis of the 1980s. The FDIC only began insuring the deposits of savings associations in 1989, as a result of the legislation that resolved the S&L crisis.

Antecedents of Federal Deposit Insurance

During the years immediately following the organization of the federal government in 1789, banks were chartered by special acts of state legislatures or the Congress, usually for a limited number of years. Initially, bank failures were nonexistent. It was not until 1809, with the failure of the Farmers Bank of Gloucester, Rhode Island, that people realized that such an event was even possible (Carter H. Golembe, "Origins of Deposit Insurance in the Middle West, 1834-1866," *The Indiana Magazine of History*, Vol. LI, June, 1955, No. 2, p. 113). Any notion that this failure represented an isolated incident was dispelled after the first wave of bank failures occurred five years later.

Insurance of Bank Obligations, 1829 – 1866

The ensuing economic disruptions caused by these and subsequent bank failures fueled demands for banking reform. In 1829, New York became the first state to adopt a bank-obligation insurance program. The term "bank obligation" refers to both circulating notes and deposits.

New York's program was devised by Joshua Forman, a Syracuse businessman. The insurance concept embodied in his plan was suggested by the regulations of the Hong merchants in Canton (*Assembly Journal*, New York State, 1829, p. 179).

The regulations required merchants who held special charters to trade with foreigners to be liable for one another's debts. Writing in 1829, when bank-supplied circulating medium was largely in the form of bank notes rather than deposits, Forman noted:
The case of our banks is very similar; they enjoy in common the exclusive right of making a paper currency for the people of the state, and by the same rule should in common be answerable for that paper.

The plan conceived by Forman had three principal components:
the establishment of an insurance fund, to which all banks had to pay an assessment;

a board of commissioners, which was granted bank examination powers; and
a specified list of investments for bank capital.

The first two provisions were adopted virtually intact; the proposal pertaining to the investment of bank capital initially was rejected. Upon reconsideration during the 1830s, the bank capital proposal was modified and subsequently enacted. From 1831 to 1858, five additional states adopted insurance programs: Vermont, Indiana, Michigan, Ohio, and Iowa. The purposes of the various plans were similar:

- to protect communities from severe fluctuations of the circulating medium caused by bank failures
- to protect individual depositors and noteholders against losses

Available evidence indicates that the first of these, concern with the restoration of the circulating medium *per se*, predominated (Carter H. Golembe, "The Deposit Insurance Legislation of 1933: An Examination of Its Antecedents and Its Purposes," *Political Science Quarterly*, Vol. LXXV, No. 2, June, 1960, p.189).

Nature of plans

In striving to meet these insurance goals, the states employed one of three approaches. Following New York's lead, Vermont and Michigan established insurance funds. Indiana did not; instead, all participating banks were required mutually to guarantee the liabilities of a failed bank. The insurance programs adopted by Ohio and Iowa incorporated both approaches. Although participating banks were bound together by a mutual guaranty provision, an insurance fund was available to reimburse the banks in the event special assessments were necessary immediately to pay creditors of failed banks. The insurance fund was replenished from liquidation proceeds. Table 1 summarizes the principal provisions of the six programs which operated between 1829-1866.

Coverage

In the first four programs adopted, insurance coverage primarily extended to circulating notes and deposits. New York later restricted coverage to circulating notes. In the case of Ohio and Iowa, insurance coverage from the outset only extended to circulating notes. None of the six programs placed a dollar limit on the amount of insurance provided an individual bank creditor. The extension of insurance coverage to bank notes in all of the six programs reflected their importance as a circulating medium. Because it was common practice for banks to extend credit by using bank notes, nearly one-half of the circulating medium before 1860 was in this form. In those states that limited insurance coverage to bank notes, the belief was that banks affected the circulating medium only through their issuance. Additionally, it was believed that depositors could select their banks, whereas noteholders had considerably less discretion and thus were in greater need of protection (Federal Deposit Insurance Corporation, *Annual Report*, 1952 (1953), p. 61).

Methods used to protect creditors of banks in financial difficulty

Ad hoc measures frequently were taken in some of the six states to protect creditors of banks in financial difficulty. Faced with the possible insolvency of several banks in 1837, New York State's Comptroller began redeeming their notes from the insurance fund. This action prevented the banks from failing and they eventually were able to reimburse the insurance fund. In 1842, New York faced a more serious crisis after the failure of eleven participating banks within a three-year period threatened the solvency of the insurance fund.

Table 1 Principal Provisions of Bank-Obligation Insurance Programs in Operation 1829 – 1866

State	Period of Operation	Obligations Insured	Banks Participating	Assessments; Size of Fund	Payment of Bank Creditors
New York	1829 – 1866	1829-42, all debts[2] 1842-66, circulating notes [3]	All banks established or rechartered subsequent to passage of act[4]	Annually ½ of 1% of capital stock to maximum of 3%. If fund reduced, annual assessment not to exceed above rate until fund restored to maximum.	After completion of liquidation of failed bank.
Vermont	1831 – 1866	All debts[2]	All banks established or rechartered subsequent to passage of act[5]	Annually ¾ of 1% of capital stock to maximum of 4 ½%. If fund reduced, annual assessments not to exceed above rate until fund restored to maximum.	After completion of liquidation of failed bank.
Indiana	1834 – 1866	All debts[2]	Branch banks[6]	No specific amount; special assessments as necessary.	Within one year after failure, if liquidation proceeds and stockholder contributions are insufficient
Michigan	1836 – 1842	All debts[2]	All banks established or rechartered subsequent to passage of act	Annually ½ of 1% of capital stock to maximum of 3%. If fund reduced, annual assessment not to exceed above rate	After completion of liquidation of failed bank.

				until fund restored to maximum.	
Ohio	1845 – 1866	Circulating notes	Branch banks	Single assessment prior to opening of bank: 10% of amount of circulating notes. Thereafter, assessments at above rate applicable only to circulating notes, if any, issued by bank.	Immediately, through special assessments on solvent branch banks. Assessments to be repaid from insurance fund, and fund repaid from proceeds of liquidation of assets of failed bank.
Iowa	1858 – 1865	Circulating notes	Branch banks	Single assessment before opening of bank: 10% of amount of circulating notes. Thereafter, assessments at above rate applicable only to circulating notes, if any, issued by bank.	Immediately, through special assessments on solvent branch banks. Assessments to be repaid from insurance fund, and fund repaid from proceeds of liquidation of assets of failed bank.

Notes:
1 In a number of cases, the law was repealed subsequent to the terminal date shown above. In some of the states, closing dates may have preceded the date shown by one year.
2 Included circulating notes, deposits and miscellaneous liabilities; excluded capital accounts.
3 Act of April 12, 1842.
4 Free banks, which were authorized in 1838, did not participate in insurance.
5 Free banks, which were authorized in 1851, did not participate in insurance. In 1842, participating banks were authorized under specified conditions to withdraw from insurance.
6 Branch banks were essentially independent banks that had their own officers, distributed earnings to their own stockholders and collectively constituted the "State Bank" in these states.
Source: Federal Deposit Insurance Corporation*, Annual Report*, 1952 (1953), pp. 62-63.

The legislature authorized the State Comptroller to sell bonds sufficient to meet all claims against the insurance fund. The bonds later were redeemed from subsequent payments into the fund by participating banks. Other states similarly grappled with the question of whether to assist or close a distressed bank. On several occasions, authorities in Ohio kept a number of distressed banks from closing by levying special assessments upon healthy participating banks. Indiana and Iowa also granted financial assistance to distressed banks.

Method of paying creditors of failed banks

Only the programs of Ohio and Iowa provided for immediate payment of insured obligations. Necessary funds were made available in those two states through special assessments levied on the sound participating banks. Creditors in New York, Vermont and Michigan were not paid until the liquidation of a failed bank had been completed. Indiana's program provided that creditors were to be paid within one year after a bank failed if liquidation proceeds and stockholder contributions were insufficient to cover realized losses.

Role of bank supervision

Bank supervision was an essential element of the insurance programs that operated prior to 1866. The function of supervision was essentially twofold:
1.) To reduce the potential risk exposure of the various insurance programs.
2.) To provide some measure of assurance to well-managed banks that the unsound banking practices of badly managed banks would not go completely unchecked
(Carter H. Golembe and Clark Warburton, *Insurance of Bank Obligations in Six States* (Washington, D.C.: Federal Deposit Insurance Corporation, 1958), pp. I-9).

Table 2 summarizes the principal provisions relating to bank supervision in the six insurance states. Better supervision of banks was achieved by the programs with mutual guaranty than by the simple insurance fund programs (Federal Deposit Insurance Corporation, *Annual Report*, 1953 (1954), p. 59).

Under the mutual guaranty programs in Indiana, Ohio and Iowa, supervisory officials were largely selected by, and accountable to, the participating banks. The officials were given wide latitude to check unsound banking practices because the participating banks were keenly aware that the cost of lax supervision ultimately would be borne by them. During the Indiana program's 30 years of operation, not one state-chartered bank failed. Indiana's success principally was attributable to the quality of bank supervision. A strong supervisory board was the cornerstone of the program. The board, which included four members appointed by the Indiana General Assembly and one representative from each of the participating banks, could close any member bank.

Table 2 Principal Provisions Relating to Supervision of Banks Participating in Bank-Obligation Insurance Programs, Six States, 1829 – 1866

State	Supervisory Agency	Bank Examination	Condition Reports	Supervisory Enforcement Powers
New York	1829-37: Three Bank Commissioners; one appointed by Governor, two by banks. 1837-43: Three Bank Commissioners appointed by Governor. 1843-51: State Comptroller. 1851-55: Banking Department; Superintendent appointed by Governor.	1829-43: Each bank three times per year; additional examinations if requested by three participating banks. 1843-66: Examination only when bank was believed to be insolvent or to have submitted false condition report.	1829-43: Annually to Bank Commissioners. 1843-66: Quarterly to Comptroller or Superintendent of Banking Department. Content expanded.	If bank insolvent or had violated law, could apply to court of chancery for injunction against continued operation.
Vermont	1831-37: Three Bank Commissioners; one appointed by legislature, two by banks. 1837-58: One Bank Commissioner appointed by legislature.	Each bank once per year; additional examinations if requested by a stockholder or bank debtor.	Annually to Bank Commissioners.	If bank insolvent or had violated law, could apply to court of chancery for injunction against continued operation.
Indiana	1834-55: Board of Directors of the State Bank of Indiana; President and four directors appointed by legislature and one director by each Branch Bank. 1856-65: Board of Directors of the Bank of the State of Indiana; four directors appointed by legislature, one director by each Branch Bank and President by Board.	Each bank twice per year; additional examinations if requested by directors of a bank.	Monthly to Board	If bank insolvent, had violated law or was mismanaging its affairs, could close bank. Could regulate dividend payments.[1] Could establish ratio, between specified limits, of loans and discounts to capital for any or all banks. Loans of deposited funds exempted.
Michigan	1836-37: One Bank Commissioner appointed by Governor. 1837-40: Three Bank Commissioners appointed by	1836-40: Each bank three times per year; additional examinations if requested by three participating banks. 1840-42: At Governor's request.	Annually to Bank Commissioners or Attorney General.	If bank insolvent or had violated law, could apply to court of chancery for injunction against continued operation.

	Governor. 1840-42: Attorney General.			
Ohio	Board of Control of the State Bank of Ohio; one member appointed by each Branch Bank; President elected by Board from outside its membership.	Left to discretion of Board; policy was to examine each bank annually.	Quarterly to Board; policy to require monthly reports to Board.	If bank insolvent, had violated law or any order of Board, could close bank. Could order any bank to reduce its circulation or liabilities to whatever level was considered safe. Could determine proportion of reserve to be in vault cash.[1]
Iowa	Board of Directors of the State Bank of Iowa; three directors appointed by legislature; one director by each Branch Bank; President by Board.	Left to discretion of Board; policy was to examine each bank twice per year.	Monthly to Board	If bank insolvent, had violated law or any order of Board, could close bank. Could regulate dividend payments. Could order any bank to reduce its circulation or liabilities to whatever level was considered safe.
Notes: 1 Not stipulated in law but assumed by agency. *Source*: Carter H. Golembe and Clark Warburton, *Insurance of Bank Obligations in Six States* (Washington, DC: The Federal deposit Insurance Corporation, 1958), pp. 1-8, 1-9.				

The causes for closing a bank were:

- insolvency;
- mismanagement; and
- refusal to comply with any legal directive of the board.

The board's power was absolute since there was no provision for appeal to the courts or to any other state agency. Supervisory authorities in Ohio and Iowa could issue cease-and-desist orders, as well as require banks to be closed. Ohio had four banks fail: one in 1852 because of defalcation and three in 1854 because of asset deterioration. While none failed in Iowa, it should be noted that Iowa's program operated during a period of more favorable economic conditions.

Assessments and the insurance funds

Insurance fund assessments were levied on capital stock or insured obligations. To provide a basis for comparison with later assessment rates under federal deposit insurance, previous researchers have computed the equivalent average annual rate on total obligations (*i.e*., deposits plus circulating notes) levied by the five states that had insurance funds (Table 3). On this basis, Michigan's annual rate of one-tenth of 1 percent most closely approximated the statutory rate of one-twelfth of 1 percent (before credits) in effect under federal deposit insurance from 1935 through 1989. Other rates were substantially higher, ranging from one-fifth of 1 percent in Vermont to almost 2 percent in Iowa. Three insurance programs had positive fund balances at the time of their closing (Table 3). The Vermont and Michigan insurance funds

were deficient by $22,000 and $1.2 million, respectively. In both states the first failures occurred before the insurance funds were adequately capitalized. Michigan's program collapsed under the strain. Although Vermont's fund subsequently recovered, it had a negative balance at the time the program closed because of the payment of unauthorized refunds to banks previously withdrawing from the program.

Demise of the insurance programs

Two primary factors contributed to the eventual collapse of the state insurance systems. The first factor was the emergence of the "free banking" movement in the 1830s. This movement developed in response to the void created by the closing of the Second Bank of the United States in 1836. To fill this void, many states enacted laws designed to ease bank entry restrictions. The movement produced an alternative for insurance of bank notes, which permitted a bank to post bonds and mortgages with state officials in an amount equal to its outstanding bank notes. Banks taking advantage of this alternative were excluded from insurance. This exclusion did not apply in Michigan. As the number of "free banks" increased, participation in state insurance programs declined. Consequently, the original intent to include all banks in the individual state insurance programs was thwarted.

Creation of National Banking System

The second factor in the collapse of the state insurance systems was the establishment of the national bank system in 1863. In 1865, Congress levied prohibitive tax on state bank notes causing many state-chartered banks to convert to national charters in order to escape the tax. As conversions increased, membership in the state insurance systems declined, eventually to the point where these programs ceased to exist.

Mechanics- Circulating Bank Notes Guaranteed by the Federal Government

National bank notes were collateralized by United States bonds. More importantly, the primary guaranty for the notes was the credit of the federal government rather than the value of the posted collateral. Holders of notes of a failed national bank were to be paid immediately and in full by the U.S. Department of the Treasury regardless of the value of the bonds backing the notes. The Comptroller of the Currency stated in his first report to Congress.
If the banks fail, and the bonds of the government are depressed in the market, the notes of the national banks must still be redeemed in full at the treasury of the United States. The holder has not only the public securities, but the faith of the nation pledged for their redemption. (U.S., Comptroller of the Currency, *Annual Report*, November 28, 1863)

So long as national bank notes retained their relative importance in the circulating medium, bank-obligation insurance was considered unnecessary. However, bank deposits soon overtook and then eclipsed national bank notes in importance. By 1870, deposits were about twice, and by the end of the century seven times, circulating notes. It was against this backdrop that efforts were renewed to provide for deposit insurance. Various proposals to that effect were introduced at the federal and state levels. Although the first attempts were made in Congress as early as 1886, the states took the lead.

Table 3 Insurance Funds and Assessments for States with Bank-Obligation Insurance Programs, 1829 – 1866 ($ Thousands)

	New York 1829 - 1866	Vermont 1831 - 1866	Michigan 1836 - 1842	Ohio 1845 - 1866	Iowa 1858 - 1865
Average fund size	$192	$19	$0.3	$759	$196
Fund as a percent of –					
Total obligations	0.6%	2.0%	0.09%	7.7%	8.4%
Average insured obligations	1.0%	2.0%	0.09%	11.5%	21.4%
Balance or (deficiency) at close of program	$13	($22)	($1,198)	$815[2]	$338[2]
Assessments and income available for insurance operations:	$3,221	$63	$3	$1,567	$338
Assessments paid[3]	3,120	63	3	1,567	338
Interest received[4]	101	--	--	--	--
Used for insurance operations	3,208	44	--	722[5]	--
Refunded to banks or state[6]	13	19	--	845	338
Assessments necessary to cover insurance costs	$3,208	$68	$1,198	$722[5]	--
Equivalent average annual rate of assessment on total obligations	0.24%	0.2%	0.1%	0.8%	1.8%

Notes:
1 In Indiana the insurance system was one of mutual guaranty with no refund.
2 Amount in fund in last year of full operation of insurance system.
3 Assessments paid and used for insurance operations other than administrative expenses except in Michigan, where
amount paid was completely absorbed by such expenses.
4 In excess of amounts used to pay administrative expenses and amounts paid to banks. In Vermont, Ohio and Iowa,
such expenses absorbed the whole of investment income.
5 Total of special assessments used to redeem notes of failed banks or aid operating banks, plus estimated amounts
secured from assets in insurance funds of failed banks. Recoveries from other assets of such banks by insurance system are not known.
6 In New York, paid into Treasury; in Vermont, refunded to six banks withdrawing prior to close of system; in Ohio, refunded to one bank withdrawing prior to close of system and to all banks at close of system; and in Iowa, refunded
to all banks at close of system.
Source: Federal Deposit Insurance Corporation, *Annual Report*, 1953 (1954), p. 58.

State Insurance of Bank Deposits, 1908 – 1930

From 1908 to 1917, eight states adopted deposit insurance programs. Seven of the eight states were located west of the Mississippi in predominantly agricultural areas. Table 4 summarizes the principal provisions of the eight programs.

Coverage. Insurance coverage in the eight states extended only to deposits. Although the insurance programs were commonly known as “deposit guaranty” programs, the guaranty was that of a fund derived from assessments on the participating banks. In no instance did the state explicitly guarantee the deposits.

Table 4 Principal Provisions of Deposit Insurance Programs Adopted by Eight States, 1907 – 1917

State	Deposits Insured	Banks Participating[1]	Assessment on Insured Deposits[2]	Payment of Depositors
Oklahoma Act of 19083 as amended or modified 1909, 1911, 1913	All deposits not otherwise secured and on which rate of interest was within limits specified by law.	Compulsory for all state banks and trust companies.	Annually 1/5 of 1% until fund equaled 2% of base. If fund reduced, special assessments at same rate annually.4	In cash by Bank Commission immediately upon taking possession of bank. If fund insufficient, in 6% certificates of indebtedness to be paid in order of issue. After 1913, certificates sold at not less than par for purpose of securing cash for depositors.
Kansas Act of 1909 as amended or modified 1911, 1921, 1923	All deposits not otherwise secured and on which rate of interest was within limits specified by law.	Voluntary for all incorporated state banks. Trust companies and private banks excluded. Banks organized after passage of Act eligible to apply after operating one year.	Annually 1/20 of 1% of base less capital and surplus until fund equaled $1 million. If fund reduced below $500,000, special assessment for amount necessary.	In interest-bearing certificates of indebtedness, reduced as proceeds of liquidation become available. Deficiency, if any, paid from fund.
Nebraska Act of 1909 as amended or modified 1911	All deposits except money deposited on a collateral agreement or condition other than an agreement for length of time to maturity and rate of interest.	Compulsory for all incorporated state banks.	Semiannually 1/20 of 1% until fund equaled 1½% of base. If fund reduced below 1%, assessment renewed and special assessments if necessary not to exceed 1% of base in any one year.	In cash from fund immediately after determination by the court of amount due depositors, less cash immediately available to the receiver for such payments.
Texas Act of 1909 as amended or modified 1921, 1923	Noninterest-bearing deposits not otherwise secured. Excluded public deposits, secured deposits, certificates of deposit, deposits made for the purpose of converting a loan into a deposit covered by the fund, and certificates of deposit converted to noninterest bearing deposits within 90 days of failure.	All state-chartered banks required to choose between guaranty fund system or bond security system.	Annually ¼ of 1% of base until fund equaled $5 million. If fund reduced below $2 million, or below level of preceding January 1, special assessments not to exceed 2%.	In cash immediately, out of cash in failed bank and fund.

Mississippi Act of 1914	All deposits not otherwise secured nor bearing interest exceeding 4% per annum.	Voluntary until May15, 1915. Thereafter, compulsory for all banks operating under state law, including trust companies and savings banks.	Annually 1/20 of 1% of average guaranteed deposits, less capital and surplus, until fund approximated $500,000 over and above initial contribution. If fund depleted, special assessments at same rate not to exceed five in any one year.	In interest-bearing certificates of indebtedness, reduced as proceeds of liquidation become available. Deficiency, if any, paid from fund.
South Dakota Act of 1915 as amended or modified 1921	All deposits not otherwise secured. Deposits could not pay interest in excess of 5% unless authorized by the depositors guaranty fund commission, and in no case greater than 5 ½% per annum.	Compulsory for all state and private banks.	Annually ¼ of 1% until fund equaled 1½% of base. Resumed whenever fund reduced to 1% of base.	In cash immediately from fund. If fund deficient, Commissioner to issue certificates of indebtedness at 5% and not to exceed 7% if sold to secure cash for depositors.
North Dakota Act of 1917 as amended or modified 1923	All deposits not otherwise secured and on which interest was within limits specified by law.	Compulsory for every corporation in business of receiving deposits or buying and selling exchange, except national banks.	Annually 1/20 of 1% until fund equaled 2% of base. If fund reduced to 1½% of base, assessments resumed. Special assessments at same rate at option of Bank Commissioners, not to exceed four per year.	In cash from fund after certification of net amounts due depositors. If fund deficient, in certificates of indebtedness.
Washington Act of 1917 as amended or modified 1921	Deposits subject to check or other forms of withdrawal and not otherwise secured. Payment of interest at rates higher than authorized by guaranty fund board subjected bank to loss of insurance.	Voluntary for all state banks including trust companies but excluding mutual savings banks.	Annually 1/10 of 1% until fund equaled 3% of base. If fund reduced, special assessments not to exceed ½ of 1% in any one year.	In warrants on fund issued on proof of claim. If fund deficient, warrants to bear 5% interest until paid.

Notes:
1 National banks were prohibited from participating in state insurance plans by ruling in July 1908 by Attorney General of the United States.
2 In terms of percentage of average daily insured deposits for preceding calendar year, unless otherwise noted. Excludes initial payments or contributions
where applicable.
3 The banking laws of Oklahoma were codified, revised and reenacted May 25, 1908, with little change in guaranty law.
4 Special assessments in addition to regular annual assessments authorized 1914–1916.
Source: Federal Deposit Insurance Corporation, *Annual Report*, 1953 (1954), pp. 68-69

Methods of paying depositors of failed banks

In Kansas and Mississippi the depositors of a failed bank received interest-bearing certificates. Dividends on these certificates were paid from liquidation proceeds. Upon final liquidation of all assets, the balance due on the certificates was paid from the insurance fund. Mississippi law stipulated that if the insurance fund was insufficient to pay the depositors, they were to be paid *pro rata*, and the remainder paid from subsequent assessments. In the remaining six states the deposit insurance law provided for immediate cash reimbursement by the fund, either in full or to whatever extent was practical. In most instances provision also was made for the issuance of certificates of indebtedness in the event there was insufficient money in the fund.

Role of bank supervision

A majority of the eight states granted authority to regulate banks. Semiannual bank examinations were the norm. Banking officials could enforce capital requirements and issue cease-and-desist orders to bring about correction of various infractions. In four of the states, supervisory authorities could order the removal of bank officials for just cause. Despite the powers granted to banking authorities, supervision often proved to be lax. Because of understaffing and insufficient funding, examiner workloads frequently were untenable. In other instances, banking authorities were thwarted when they tried to enforce existing laws. In a few cases, the authorities were the root of the problem. Oklahoma provided the worst example in that the bank commissioner's office itself became corrupt after 1919. An in-depth discussion of the role of bank supervision appears in Clark Warburton's study, *Deposit Insurance in Eight States During the Period 1908-1930* (Washington, D.C.: Federal Deposit Insurance Corporation, 1959).

Assessments on participating banks

All of the insurance programs derived the bulk of their income from assessments. Both regular and special assessments were based on total deposits. The assessments levied ranged from an amount equivalent to an average annual rate of about one-eighth of 1 percent in Kansas to about two-thirds of 1 percent in Texas. Some states permitted participating banks to retain their insurance assessments in the form of deposits, subject to withdrawal by order of the insurer. Other states provided for the physical collection of assessments by the insurer or the state treasurer.

Adequacy and termination of insurance funds

The state insurance funds were unable to cope with the economic events of the 1920s. The depression of 1921, and the severe agricultural problems that persisted throughout much of the decade, resulted in numerous bank failures. The resultant claims on the various insurance funds generally exceeded their size. Although the Texas fund was able to meet all claims, the insured deposits in the other states that were never paid from any source ranged as high as 70 percent. The first fund to cease operations was Washington's in 1921. By early 1930, all of the funds had ceased operation, including the Texas fund, which became insolvent after most of the participating banks withdrew.

Congressional Proposals for Deposit Insurance, 1886 – 1933

A total of 150 proposals for deposit insurance or guaranty were made in Congress between 1886 and the establishment of the Federal Deposit Insurance Corporation in 1933. Financial crises prompted the introduction of many of these proposals. In the 60th Congress, following the panic of 1907, more than 30 proposals for deposit guaranty legislation were introduced. Similarly, in response to the developing banking crisis, more than 20 bills were introduced in the 72nd Congress, which opened in 1931. Another group of bills, similar in principle to deposit insurance, proposed to authorize national banks to issue circulating notes on the basis of various types of assets or as general obligations of the banks, backed by a guaranty or insurance fund to which all national banks would contribute. These proposals were numerous during the 30 years preceding establishment of the Federal Reserve System in 1913.

Three general methods of providing depositor protection were proposed in the bills. Of the 150 bills, 118 provided for the establishment of an insurance fund out of which depositors' losses would be paid, 22 provided for United States government guaranty of deposits, and 10 required banks to purchase surety bonds guaranteeing deposits in full. Most of the deposit insurance bills introduced prior to establishment of the Federal Reserve System authorized participation of national banks only. After 1913, approximately one-half of the deposit insurance bills provided for participation of all members of the Federal Reserve System (national and state member banks). Only a few provided for coverage of deposits in nonmember banks, and then participation usually was optional.

Nearly two-thirds of the bills introduced prior to establishment of the Federal Reserve System provided for administration of the insurance system by the Comptroller of the Currency. After 1913, some of the proposals provided for administration by the Federal Reserve Board or by the Federal Reserve Banks under supervision of the Board. Other proposals called for the establishment of a special administrative board to oversee the insurance system. Eighty percent of the bills provided for insurance or guaranty of all, or nearly all, deposits. The bills that provided for only partial coverage of deposits contained a variety of limitations. Generally, all liabilities not otherwise secured were to be protected by the insurance or guaranty system. In nearly one-half of the bills, the entire cost of deposit insurance, and in about one-fourth of the bills the major part of the cost, was to be met by assessments based upon total deposits or average total deposits. The rates of assessment ranged from one fiftieth of 1 percent to one-half of 1 percent per year, while in a number of cases assessments were to be adjusted to meet the total cost. The most common rate was one tenth of 1 percent. Many of the bills provided for special initial assessments, or for assessments as needed, in addition to those collected periodically.

In a number of bills, assessments upon the banks were to be supplemented by appropriations from the United States government or, particularly in the bills introduced in the later years, by levies on the earnings or surplus of the Federal Reserve Banks. In several cases the cost was to be met solely by the United States government. In cases where the insurance was in the form of surety bonds, the cost of the bonds was to be borne by the banks. Many of the bills called for a limit on the accumulation of funds by the insurance or guaranty system. In a few bills, assessment rates were to be adjusted by the administrative authority and were required to be sufficient to meet all losses to depositors or to maintain the fund at a given size. In some proposals, the fund was authorized to borrow if necessary, and in others to issue certificates to unpaid depositors if the fund were depleted.

Section Summary

The disruption caused by bank failures was a recurrent problem during the 19th century and the first third of the 20th century. Numerous plans were proposed or adopted to address this problem. Many embodied the insurance principle. Insurance of bank obligations by the states occurred during two distinct periods. The first began in 1829 with the adoption of an insurance plan by New York. During the next three decades five other states followed New York's lead. Except for Michigan's insurance plan, which failed after a short period of operation, these plans accomplished their purposes. Nevertheless, the last of these insurance programs went out of existence in 1866 when the great majority of state-chartered banks became national banks. Insurance of bank obligations was not attempted again by the states until the early 1900s. Eight states established deposit guaranty funds from 1908 to 1917. In contrast to the earlier state insurance systems, those adopted from 1908 to 1917 were generally unsuccessful. Most of the eight insurance plans were particularly hard hit by the agricultural depression that followed World War I. The numerous bank failures spawned by that depression placed severe financial stress on the insurance funds. By the mid-1920s, all of the state insurance programs were in difficulty, and by early 1930 none remained in operation. The federal government, in turn, sought to secure the safety of the circulating medium through direct guaranty by the Treasury of national bank notes, beginning in the 1860s. However, the subsequent rapid growth of bank deposits relative to bank notes once again aroused concern regarding the safety of the circulating medium in the event of a bank failure. Consequently, 150 proposals for deposit insurance or guaranty were introduced into Congress between 1886 and 1933. The basic principles of the federal deposit insurance system were developed in these bills and in the experience of the various states that adopted insurance programs. These principles included financing the federal deposit insurance fund through assessments; the use of rigorous bank examination and supervision to limit the exposure of the fund; and other elements, such as standards for failed-bank payoffs and liquidations, intended to minimize the economic disruptions caused by bank failures.

CHAPTER 10 Establishment of the FDIC

The adoption of nationwide deposit insurance in 1933 was made possible by the times, by the perseverance of the Chairman of the House Committee on Banking and Currency, and by the fact that the legislation attracted support from two groups which formerly had divergent aims and interests—those who were determined to end destruction of circulating medium due to bank failures and those who sought to preserve the existing banking structure (Golembe, "The Deposit Insurance Legislation of 1933," p. 182).

Banking Developments, 1930 – 1932

An average of more than 600 banks per year failed between 1921 and 1929, which was 10 times the rate of failure during the preceding decade. The closings evoked relatively little concern, however, because they primarily involved small, rural banks, many of which were thought to be badly managed and weak. Although these failures caused the demise of the state insurance programs by early 1930, the prevailing view apparently was that the disappearance of these banks served to strengthen the banking system. This ambivalence disappeared after a wave of bank failures during the last few months of 1930 triggered widespread attempts to convert deposits to cash. Many banks, seeking to accommodate cash demands or increase liquidity, contracted credit and, in some cases, liquidated assets. This reduced the quantity of cash available to the community which, in turn, placed additional cash demands on banks.

Banks were forced to restrict credit and liquidate assets, further depressing asset prices and exacerbating liquidity problems. As more banks were unable to meet withdrawals and were closed, depositors became more sensitive to rumors. Confidence in the banking system began to erode and bank "runs" became more common.

Liquidity Problems

During this period, the Federal Reserve did little to ease the liquidity problems of banks. The failure of the Federal Reserve to adopt an aggressive stance with respect to either open market purchases of securities or its discount window operations has been ascribed to several factors. A discussion of the Federal Reserve System's attitude appears in Milton Friedman and Anna J. Schwartz, *A Monetary History of the United States, 1867-1960* (Princeton, New Jersey: National Bureau of Economic Research, 1963), pp. 357-359. Much of the discussion relating to the events preceding the nationwide bank holiday is based on this source. Most notably, it was generally believed that bank failures were an outgrowth of bad management and, therefore, were not subject to corrective action by the Federal Reserve. Concern within the Federal Reserve also was muted because most failed banks in 1930 were nonmembers for which Federal Reserve officials felt no responsibility.

In all, 1,350 banks suspended operations during 1930 (Table 5).15 Bank failures during the previous decade had been confined primarily to agricultural areas; this no longer was the case in 1930. In fact, the Bank of United States, one of the nation's largest banks based in New York City, failed that year. The large jump in bank failures in 1930 was accompanied by an even greater increase in depositor losses.

The terms "bank suspensions" and "bank failures" often are used interchangeably. For the most part, this practice is followed throughout the chapter. Technically, however, "suspensions" include all banks that are closed because of financial difficulties, whereas "failures" are limited to those suspended banks that were placed in the hands of receivers and liquidated. Some of the suspended banks were reorganized or restored to solvency and resumed operations. In either instance, the assumption is that the suspended bank actually failed, though rehabilitation later occurred.

Table 5 Commercial Bank Suspensions, 1921 – 1933 ($ Thousands)

Year	Number of Suspensions (1)	Deposits (2)	Losses Borne by Depositors (3)	Losses as a Percent of Deposits in All Commercial Banks (4)
1921	506	$172,806	$59,967	0.21%
1922	366	91,182	38,223	0.13
1923	646	149,601	62,142	0.19
1924	775	210,150	79,381	0.23
1925	617	166,937	60,799	0.16
1926	975	260,153	83,066	0.21
1927	669	199,332	60,681	0.15
1928	498	142,386	43,813	0.10
1929	659	230,643	76,659	0.18
1930	1,350	837,096	237,359	0.57
1931	2,293	1,690,232	390,476	1.01
1932	1,453	706,187	168,302	0.57
1933	4,000	3,596,708	540,396	2.15
Sources: Columns (1), (2) and (3), FDIC; column (4), Friedman and Schwartz.				

As liquidity pressures subsequently eased during the early months of 1931, the number of bank failures declined sharply, but the decrease proved to be short-lived. Bank failures again rose between March and June as the public resumed converting deposits into currency and banks sought to meet withdrawal demands. During the second-half of the year, another, more serious, liquidity scramble occurred. Once again, the Federal Reserve failed to inject sufficient liquidity into the banking system. In 1931, policymakers were primarily preoccupied with international monetary matters. The abandonment by Great Britain of the gold standard in September 1931 aroused general fears that other countries might follow. These fears caused many foreigners with U.S. bank accounts to convert deposits to gold in the New York money market. To stem the ensuing gold outflow, the Federal Reserve Bank of New York sharply increased its rediscount rate. Although this action achieved the desired effect, no steps were taken to augment already depleted bank reserves through extensive open market purchases of securities. By ignoring domestic financial considerations, the Federal Reserve added to the banking industry's woes. The effects of these liquidity crises were reflected in the bank failure statistics. About 2,300 banks suspended operations in 1931. The number of failures thus exceeded the average number for the 1921-1929 period by almost threefold. Losses borne by depositors in 1931 exceeded losses for the entire 1921-1929 period.

In an attempt to ease bank liquidity problems, the National Credit Corporation was organized by private-sector bankers in October 1931 to extend loans to weakened banks. However, the corporation failed within a matter of weeks. Business leaders appealed to the federal government for assistance. The Hoover Administration responded by recommending two measures. The first resulted in the creation, in January 1932, of a new major federal lending agency, the Reconstruction Finance Corporation (RFC). One of its primary functions was to make advances to banks. By the end of 1932, the RFC had authorized almost $900 million in loans to assist over 4,000 banks striving to remain open. The RFC might have assisted more banks had Congress not ordered it to disclose publicly the names of borrowers, beginning in August 1932. Appearance of a bank's name on the list was interpreted as a sign of weakness and frequently led to runs on the bank. Consequently, many banks refrained from borrowing from the RFC.

The second measure supported by the Hoover Administration – the Glass-Steagall Act of February 27, 1932 – broadened the circumstances under which member banks could borrow from the Federal Reserve System. It enabled a member bank to borrow from a Federal Reserve Bank upon paper other than that ordinarily eligible for rediscount or as collateral for loans. Although the amounts subsequently borrowed were not large in the aggregate, the measure did aid individual banks. The generally improved banking situation during the ensuring months was marked by a significant drop in both the number of bank failures and depositor losses. However, other signs suggested that the industry's troubles were far from over. Waves of bank failures still occurred during the year. Another disquieting sign was the emergence of bank moratoria. Initially, they were declared by individual local communities. Later that year, Nevada proclaimed the first statewide moratorium when runs on individual banks threatened to involve banks throughout the state. Similar moratoria were to play a role in the events that culminated in the nationwide bank holiday of 1933.

The Banking Crisis of 1933

During the winter of 1932-1933, banking conditions deteriorated rapidly. In retrospect, it is not possible to point to any single factor that precipitated the calamitous events of this period. The general uncertainty with respect to monetary and banking conditions undoubtedly played the major role, although there were specific events that tended to increase liquidity pressures within the system. Banks, especially in states that had declared bank moratoria, accelerated

withdrawals from correspondents in an attempt to strengthen their position. Currency holdings increased significantly, partially in anticipation of additional bank moratoria.

Additional liquidity pressures were brought about by concern relating to the future of the dollar. With the election of Franklin D. Roosevelt in November 1932, rumors circulated that the new administration would devalue the dollar, which led to an increase in speculative holdings of foreign currencies, gold and gold certificates. Unlike the period of international monetary instability in 1931, a significant amount of the conversions from Federal Reserve notes and deposits to gold came from domestic sources. These demands placed considerable strain on New York City banks and, ultimately, on the Federal Reserve Bank of New York. It was the suddenness of the withdrawal demands in selected parts of the country that started a panic of massive proportions. State after state declared bank holidays. The banking panic reached a peak during the first three days of March 1933. Visitors arriving in Washington to attend the presidential inauguration found notices in their hotel rooms that checks drawn on out-of-town banks would not be honored. By March 4, Inauguration Day, every state in the Union had declared a bank holiday. As one of his first official acts, President Roosevelt proclaimed a nationwide bank holiday to commence on March 6 and last four days. Administration officials quickly began to draft legislation designed to legalize the holiday and resolve the banking crisis. Early in their deliberations they realized that the success of any proposed plan of action primarily would hinge on favorable public reaction. As noted by Raymond Moley, a key presidential adviser who attended many of the planning sessions:
We knew how much of banking depended upon make-believe or, stated more conservatively, the vital part that public confidence had in assuring solvency. (Raymond Moley, *The First New Deal* (New York: Harcourt, Brace & World, Inc. 1966), p. 171)

Formulating an Insurance Plan

To secure public support, officials formulated a plan that relied on orthodox banking procedures. Few members of Congress knew what was contained in the Administration's bill when they convened in extraordinary session at noon on March 9. In fact, Henry B. Steagall, Chairman of the Committee on Banking and Currency, purportedly had the only copy of the bill in the House. Waving the copy over his head, Steagall had entered the House chamber, shouting, "Here's the bill. Let's pass it." After only 40 minutes of debate, during which time no amendments were permitted, the House passed the bill, known as the Emergency Banking Act. Several hours later, the Senate also approved the emergency legislation intact. The Emergency Banking Act legalized the national bank holiday and set standards for the reopening of banks after the holiday. The Act expanded the RFC's powers as a means of dealing with the crisis then threatening the banking system. It authorized the RFC to invest in the preferred stock and capital notes of banks and to make secured loans to individual banks.

To ensure an adequate supply of currency, the Act provided for the issuance of Federal Reserve Notes, which were to be backed by U.S. government securities. The Federal Reserve Banks were empowered to advance the new currency to member banks without requiring much collateral. After the Act was signed into law, the Bureau of Engraving and Printing promptly went into 24-hour production to manufacture the currency. The President subsequently issued a proclamation extending the holiday in order to allow time for officials to reopen the banks. In his first "fireside chat," delivered on March 12, President Roosevelt reviewed the events of the past several days and outlined the reopening schedule. Following proper certification, member banks in the 12 Federal Reserve Bank cities were to reopen on March 13. Member banks in some 250 other cities with recognized clearinghouses were to reopen on March 14. Thereafter, licensed member banks in all other localities were to reopen. The President indicated that the Secretary

of the Treasury already had contacted the various state banking departments and requested them to follow the same schedule in reopening state nonmember banks. Before concluding his radio address, the President cautioned that he could not promise that every bank in the nation would be reopened. About 4,000 banks never reopened either because of the events of the previous two months or the bank holiday itself.

The task of implementing the Emergency Banking Act primarily was the responsibility of the Secretary of the Treasury. Under the Act, licenses for all member banks, both national and state, were to be issued by the Secretary. (State nonmember banks were to be licensed by the state banking departments.) The Treasury, however, demanded that each of the Federal Reserve Banks approve of the reopening of banks in their respective districts. The Federal Reserve Board balked at this demand, preferring instead that the Treasury Department shoulder the entire burden of reopening member banks. The controversy was resolved in the Treasury Department's favor. It was agreed that licenses would be issued by the Secretary of the Treasury upon the recommendation of the district Federal Reserve Bank, the chief national bank examiner and the Comptroller of the Currency. Several hundred banks soon reopened for business on the certification of the Treasury. As the reopening proceeded, public confidence increased significantly and widespread hoarding ceased.

Federal Deposit Insurance Legislation

After some semblance of order had returned to the financial system, efforts were renewed in Congress to enact deposit insurance legislation. Although a deposit insurance bill had been passed by the House in 1932, the Senate had adjourned without acting on the proposal. Insurance proponents hoped that legislative efforts would prove successful this time, since the banking crisis was still fresh in the public's mind. In their view, recent events had shown that a system of federal deposit insurance was necessary to achieve and maintain financial stability. One of the chief proponents of federal deposit insurance in Congress was Representative Steagall. He has been credited with proposing the legislation that created the Federal Deposit Insurance Corporation, leading the fight for its adoption in the House and helping to effect a compromise when chances for passage of the bill appeared doomed. Steagall's achievement was all the more remarkable in view of the formidable opposition confronting the proponents of deposit insurance. Opposition emanated from the Roosevelt Administration, segments of the banking industry and from some members of Congress.

Arguments offered against deposit insurance reflected both practical and philosophical considerations. Opponents asserted that deposit insurance would never work. They pointed to the defunct state-level deposit insurance programs to substantiate their argument. Another widely held view was that deposit insurance would remove penalties for bad management. Critics also charged that deposit insurance would be too expensive and that it would represent an unwarranted intrusion by the federal government into the private sector. Within the Roosevelt Administration, the Secretary of the Treasury Woodin was strongly opposed to the idea of federal deposit insurance. While historians have asserted that the Secretary's views were partially responsible for President Roosevelt's opposition to deposit insurance, accounts differ regarding the nature and extent of Roosevelt's opposition. However, the Administration was not of one mind on the issue. Support was voiced by Vice President John Nance Garner and Jesse H. Jones of the RFC, among others. Prior to Roosevelt's inauguration, Garner, then-Speaker of the House, had appealed to the President-elect to support deposit insurance. When Roosevelt declined, stating that it would never work, Garner predicted that deposit insurance legislation eventually would be passed. Banking interests, particularly those representing the larger banks, generally viewed federal deposit insurance with distaste. The President of the American Bankers Association declared that deposit insurance was "unsound, unscientific and

dangerous." ("Wires Banks to Urge Veto of Glass Bill," *The New York Times*, June 16, 1933, p. 14.)

The banking industry's views had only limited effect since banking at that time was held in low esteem. The industry's already tarnished image was not helped by disclosures of unsavory security market dealings on the part of certain New York banks which came to light when deposit insurance was being considered in Congress. More formidable opposition to deposit insurance came from several influential Congressmen. One of the most vociferous opponents was Carter Glass of Virginia, Chairman of the Senate Banking and Currency Committee. He had been Roosevelt's initial choice to serve as Secretary of the Treasury, but declined the Cabinet offer. Although Senator Glass was intent on passing banking reform legislation, federal deposit insurance was not one of the reforms he supported or sought. In opposing federal deposit insurance, Glass pointed to the record of the defunct state insurance programs. Nevertheless, he subsequently allowed bank deposit insurance to be written into a banking bill that he had sponsored. One business journal during the period reported that Glass simply had yielded to public opinion in saying "It became perfectly apparent that the voters wanted the guarantee [deposit insurance], and that no bill which did not contain such a provision would be satisfactory either to Congress or to the public. Washington does not remember any issue on which the sentiment of the country has been so undivided or so emphatically expressed as upon this." ("Deposit Insurance," *Business Week*, April 12, 1933, p. 3.)

Genesis of Glass-Steagall

In mid-May both Senator Glass and Representative Steagall formally introduced banking reform bills, which included provisions for deposit insurance. The two bills primarily differed with respect to the conditions for membership in the deposit insurance corporation that was to be created. Whereas membership in the Federal Reserve was a precondition for obtaining deposit insurance under the Senate bill, it was not a prerequisite in the House version. Both bills incorporated the demands made by the Roosevelt Administration that deposit coverage be based on a sliding scale, and there be a one-year delay in the start of the insurance corporation.

Later that month, however, the Glass bill was amended to incorporate Senator Arthur Vandenberg's proposal calling for the creation of a temporary deposit insurance fund. Vandenberg opposed a delay in the start of deposit insurance because, as he put it, "…the need is greater in the next year than for the next hundred years." ("Bank Bill Debate to Open in Senate," *The New York Times*, May 19, 1933, p. 4)

On the day Vandenberg introduced his proposal, Vice President Garner was presiding over the Senate, which was sitting as a court of impeachment in the trial of a district judge. Garner had heard that Vandenberg had formulated a deposit insurance plan that would accomplish the same goals as those contained in an insurance bill which Garner had pushed through the House in 1932. Desiring that deposit insurance be implemented as soon as possible, Garner therefore approached Vandenberg during the impeachment proceedings and inquired whether he had the deposit insurance amendment in his possession. After Vandenberg responded affirmatively, Garner instructed him to introduce the amendment when signaled. Several minutes later, Garner suspended the court proceedings and ordered the Senate into regular session to consider more banking legislation. With Garner sitting by his side, Vandenberg then offered his deposit insurance amendment, which was overwhelmingly adopted.

Vandenberg Amendment

The amendment stipulated that, effective January 1, 1934, the temporary fund would provide insurance coverage up to $2,500 for each depositor and would function until a permanent corporation began operations on July 1, 1934. If demands on the temporary fund exceeded available monies, the Treasury would be obligated to make up the difference. The amendment also provided that solvent state banks could join the fund. The inclusion of the Vandenberg amendment in the Senate bill almost resulted in the defeat of deposit insurance in Congress. When the banking reform bills that had been passed by both houses were sent to a joint conference committee for resolution of differences, an impasse promptly developed. The House conferees opposed the Vandenberg amendment contained in the Senate version of the bill, particularly the provision calling for the immediate establishment of a temporary insurance corporation. Another issue that split the conferees was whether Federal Reserve membership should be a precondition for obtaining deposit insurance. A compromise finally was reached on June 12, after the Senate conferees threatened to remove all deposit insurance provisions from the bill. They feared that the impasse over deposit insurance could endanger all of the banking reform measures contained in the bill. In order to save the bill, the House conferees reluctantly accepted the Senate's version as well as an additional provision desired by the Senate conferees to liberalize the branching restrictions governing national banks. This provision reflected widespread public disillusionment with the failure-prone independent banking system. Proponents of branch banking maintained that geographic diversification of lending risks and the deposit base would result in a lower bank failure rate.

The bill agreed to by the conferees passed both houses of Congress on the following day. Some opponents of deposit insurance had not yet thrown in the towel, though. The American Bankers Association wired its member banks, urging them to telegraph President Roosevelt immediately to request his veto of the legislation. Nevertheless, Roosevelt signed the measure, known as the Banking Act of 1933, into law on June 16, 1933. Section 8 of the Act created the Federal Deposit Insurance Corporation through an amendment to the Federal Reserve Act. The Banking Act of 1933 also created the Federal Reserve Open Market Committee and imposed restrictions on the permissible activities of member banks of the Federal Reserve System.

Deposit Insurance Provisions of the Banking Act of 1933

Section 12B of the Federal Reserve Act as amended created the Federal Deposit Insurance Corporation and defined its organization, duties and functions. It provided for two separate plans of deposit insurance: a temporary plan which was to be initiated on January 1, 1934, and a permanent plan which was to become effective on July 1, 1934. Capital necessary to establish the FDIC was to be provided by the United States Treasury and the 12 Federal Reserve Banks. The Treasury was to contribute $150 million. Each of the Federal Reserve Banks was required to subscribe to Class B capital stock in an amount equal to one-half of its surplus as of January 1, 1933.

Management of the FDIC was vested in a Board of Directors consisting of three members. The Comptroller of the Currency was designated a member *ex officio*; the other two members were to be appointed by the President for six-year terms with the advice and consent of the Senate. One of the two appointive directors was to serve as Chairman of the Board, and not more than two members of the Board could be members of the same political party. The temporary plan of deposit insurance was to initially limit protection to $2,500 for each depositor. Banks admitted to insurance under the temporary plan were to be assessed an amount equal to one-half of 1 percent of insurable deposits. One-half of the assessment was payable at once; the rest was payable upon call by the FDIC. All Federal Reserve member banks licensed by the Secretary of

the Treasury under terms of an Executive Order of the President, issued March 10, 1933, were required by law to become members of the temporary fund on January 1, 1934. Other banks were authorized to join the fund upon certification of their solvency by the respective state supervisory agencies and after examination by, and with the approval of, the Federal Deposit Insurance Corporation.

The original permanent plan, while it never took effect and was superseded by a new permanent plan in the Banking Act of 1935, contained certain features of historical interest. Banks participating in insurance under the original plan were to subscribe to capital stock of the FDIC and be subject to whatever assessments might be needed to meet the losses from deposit insurance operations. The plan provided for full protection of the first $10,000 of each depositor, 75 percent coverage of the next $40,000 of deposits, and 50 percent coverage of all deposits in excess of $50,000. In order to retain their insurance, all participating banks were required to become members of the Federal Reserve System within two years. Thus, with regard to financing, degree of protection and supervisory provisions, the original plan differed significantly from both the temporary plan and the permanent plan that became effective with the Banking Act of 1935.

Formation of the Federal Deposit Insurance Corporation

One of the first tasks facing the FDIC was the formation of an operating organization. As provided in the Banking Act of 1933, the Comptroller of the Currency, J. F. T. O'Connor, was designated as a director. He served as the FDIC's chief executive until the appointment of the other two directors. In September, the President appointed as the other directors Walter J. Cummings, then-special-assistant to Secretary of the Treasury Woodin, and E. G. Bennett, a Republican banker and businessman from Utah. The directors organized on September 11, 1933, and elected Cummings to serve as Chairman of the Board. As was his intent, Cummings' chairmanship lasted only through the initial organization of the FDIC. In January 1934, he left the FDIC to assume the chairmanship of Continental Illinois National Bank & Trust Company in Chicago. Bank examination consumed nearly all of the FDIC's efforts in the months before the establishment of the temporary fund on January 1, 1934. The hastily assembled examination force had to examine almost 8,000 state-chartered nonmember banks in three months in order for the FDIC to meet its responsibilities under the Banking Act of 1933. The task of completing these admission examinations was largely accomplished as intended by the end of 1933. Of the 7,834 applicant nonmember banks, 83 percent were approved for insurance, 12 percent were rejected, 4 percent were still pending decisions, and less than 1 percent remained to be examined.

The Temporary Federal Deposit Insurance Fund

Actual insurance of bank deposits became effective on January 1, 1934. The Temporary Federal Deposit Insurance Fund opened with 13,20l banks insured (or approved for insurance). Of these, 12,987 were commercial banks and 214 were mutual savings banks. These represented 90 percent of all commercial banks and 36 percent of all mutual savings banks. The lower participation rate among savings banks was attributable to several factors.

Admission standards

Many savings banks questioned whether they needed deposit insurance. Unlike commercial banks, savings banks had not been seriously affected by bank runs since they legally could restrict deposit withdrawals. In several states mutual savings banks legally could not subscribe to stock in the FDIC. In other instances, savings banks objected to FDIC membership on

philosophical grounds. As summed up by one savings banker, “I for one want none of this FDIC. If it’s New Deal, that damns it as far as I’m concerned.” (Oscar Schisgall, *Out of One Small Chest* (New York: AMACOM, 1975), p. 146)

Pursuant to the intent of Congress, the FDIC accepted for insurance all banks that it found to be solvent. However, it was recognized that a great many banks lacked sufficient capital, which posed a huge risk for the insurance fund. Some banks were admitted upon a commitment to increase their capital, either from the RFC or local interests. A program of reexamination and rehabilitation was carried on throughout the year by the FDIC.

Organizational changes and Legislative developments

Following the departure of Walter J. Cummings, E. G. Bennett served briefly as acting chairman of the FDIC. In February 1934, Leo T. Crowley, a 46-year-old bachelor, became chairman. As former owner of several Wisconsin banks during the Depression, he had organized and headed the Wisconsin Banking Review Board. In December 1933, he journeyed to Washington, D.C., seeking aid for several hundred Wisconsin banks so they could qualify for deposit insurance. His role in restoring the health of Depression-struck banks in his native state brought him to the attention of the Roosevelt Administration. The appointment of Crowley proved to be especially felicitous. An imposing man, he possessed both a witty personality and exceptional administrative skills. He left an indelible imprint on the FDIC during his 12-year term as chairman.

The Banking Act of 1933 provided for termination of the Temporary Federal Deposit Insurance Fund and the inauguration of the permanent insurance plan on July 1, 1934. However, in the early part of 1934, FDIC officials recommended that the Temporary Federal Deposit Insurance Fund be extended for another year and that the law be amended in certain minor respects to facilitate administration. It was considered advisable to give the states additional time to adopt legislation to enable state banks to enjoy the full benefits of federal deposit insurance. FDIC officials also desired to gain more experience with the administration and operation of an insurance plan prior to the inauguration of the permanent plan. Moreover, the capital rehabilitation program for banks could not have been completed by July 1934, as required, to permit all banks insured with the Temporary Federal Deposit Insurance Fund to qualify for insurance under the permanent plan. On June 16, 1934, Congress extended the life of the Temporary Federal Deposit Insurance Fund, and the effective date of the permanent plan was postponed one year, to July 1, 1935. The life of the temporary plan subsequently was extended for an additional two months. The second extension was approved June 28, 1935, while the Banking Act of 1935 was under consideration, and was designed merely to continue the temporary plan until that Act could be approved.

Insured nonmember banks were allowed to terminate their membership in the Temporary Federal Deposit Insurance Fund on July 1, 1934, provided they gave adequate notice to the FDIC. Provision was made for refunding the assessments collected from the banks that withdrew. Only 21 commercial banks elected to withdraw from the fund. There had been some doubt as to the legality of some mutual savings banks qualifying as members of the permanent plan of deposit insurance. Furthermore, many mutual savings banks considered themselves preferred risks and wished to avoid assessment at the same rate as commercial banks. For these and other reasons, 169 mutual savings banks withdrew from the Temporary Federal Deposit Insurance Fund at the end of June 1934. Of these, 133 were located in New York State. Only two New York mutual savings banks, Emigrant Savings Bank and Franklin Savings Bank, kept their insurance with the FDIC.

Effective July 1, 1934, insurance protection was increased from $2,500 to $5,000 for each depositor at an insured institution, except in the case of certain mutual savings banks. Insurance protection remained at $2,500 for each depositor at a mutual savings bank except that any mutual savings bank could, with the consent of the FDIC, elect to be insured up to $5,000. At the discretion of its Board of Directors, the FDIC was authorized to set up a separate fund for mutual savings banks to be known as the Fund For Mutuals. The Temporary Federal Deposit Insurance Fund was not to be subject to the liabilities of the Fund For Mutuals, and *vice versa*. A separate Fund For Mutuals was established by the Board of Directors on July 14, 1934, effective July 1, 1934. Upon inception of the permanent plan in 1935, this fund and the fund for commercial banks were consolidated. Under the previously existing law, insured nonmember banks were required to apply to become members of the Federal Reserve System on or before July 1, 1936, in order to continue their insurance. With the one-year delay in the establishment of the permanent fund, this requirement was changed by pushing the date back to July 1, 1937. Banks in the territories of Hawaii, Puerto Rico, Alaska and the Virgin Islands were made eligible for insurance. In addition, the language authorizing the FDIC to act as receiver in the case of failed insured banks was clarified. By a new provision of the law, each insured bank was required to display signs to the effect that its deposits were insured by the Federal Deposit Insurance Corporation. The intent of this practice, which continues today, was to make the absence of such a sign conspicuous.

Deposit Insurance and Banking Developments in 1934

Total deposits in insured and uninsured licensed commercial banks increased during 1934 by about $7.2 billion dollars, or 22 percent. This growth in deposits had rarely been equaled in the past and restored to the banking system approximately half of the decline in deposits that had occurred during the preceding three years. The growth in bank deposits was accompanied by changes in the character and quality of the assets held by insured banks. Cash, amounts due from other banks and holdings of direct obligations of the United States government increased considerably. The average quality of the assets of insured commercial banks improved as large amounts of worthless and doubtful assets were written off. Increased earnings and new capital, obtained from the RFC and local interests, is what maintained banks' capital positions. At the close of 1934, insured banks held 98 percent of the assets of all licensed commercial banks. The liquidity buildup undertaken by banks during 1934 caused FDIC officials some concern. They feared that excessive holdings by banks of cash and government securities could stifle economic recovery. Speeches given by the FDIC's directors during that period frequently contained exhortations urging bankers to expand their loan portfolios. Only nine insured banks and 52 uninsured licensed banks suspended operations during 1934. All but one of the insured banks and most of the uninsured licensed banks that failed during 1934 were small institutions. More than 900 banks that were not licensed after the holiday were placed in receivership or liquidation. More than half of these banks had a part of their assets and liabilities taken over by successor banks.

In its 1934 *Annual Report*, the FDIC rather modestly attributed the small number of failures of licensed banks to factors other than deposit insurance. It noted that many banks were able to survive because they had received necessary financial assistance from the RFC and other governmental agencies. Secondly, events during 1933 had weeded out many weak banks. Third, improved economic conditions also had played a role in keeping down the failure rate. The FDIC warned that the low rate of failures could not be expected to continue. During 1934, the fierce opposition of the banking industry faded in the face of the success of deposit insurance. The industry's changed attitude was reflected in the public endorsement of the temporary insurance plan by the Executive Council of the American Bankers Association in April of that year. Public sentiment continued to support deposit insurance.

CHAPTER 11 The Early Years of FDIC: 1934 – 1941

The history of the FDIC cannot be considered apart from changes in economic and banking conditions. The early years of the FDIC's existence were not a period of risk-taking by banks. Caution marked the attitudes of both the supervisory agencies and the industry itself. For their part, the supervisory agencies viewed the events that culminated in the nationwide bank holiday as a banking rather than a monetary phenomenon.

Background

The prevailing philosophy was that unfettered competition in the past had resulted in excesses and abuses in banking. Consequently, the supervisory agencies followed what the FDIC later termed as a policy of keeping banks and banking practices within the bounds of rightful competition. The attitude of bankers was similarly circumspect. Those who survived the Depression were chastened by that experience. The effect of the Depression experience on the industry was reflected in the subsequent massive liquidity buildup undertaken by banks. By 1937, for example, cash and holdings of U.S. government securities comprised about 52 percent of the industry's total assets, or more than twice the proportion held in 1929. To the dismay of would-be borrowers, banks continued to stress liquidity for many more years.

Legislation enacted in the 1930s to insulate banks from competing with one another too aggressively also restrained bank behavior. The Banking Act of 1933 outlawed the payment of interest by member banks on demand deposits. The Act also authorized the Federal Reserve Board to set a ceiling on time deposit rates offered by member banks in order to forestall ruinous competition among banks. In addition, the 1933 law ordered the separation of investment from commercial banking to be completed by mid-June 1934. The Banking Act of 1935 similarly incorporated provisions designed to limit bank behavior. The Act expanded the FDIC's supervisory powers and set more rigorous standards for admission to insurance. The 1935 law required the FDIC to prohibit the payment of interest on demand deposits in insured nonmember banks and to limit the rates of interest paid.

While the effects of a still-depressed economy also engendered caution on the part of bankers and regulators, conditions improved from the low point reached in 1933. Unemployment declined significantly, real GNP increased at an average annual compound growth rate of 9.5 percent between 1933 and 1937, and price increases were moderate. The recession of 1937-1938 interrupted this pattern of economic expansion. Owing to the continuous improvement in the banking system that had occurred since the bank holiday of 1933, however, banks were able to meet without difficulty the strains resulting from the decline in business activity that ensued. Following the recession, economic conditions improved once again as real GNP rose and unemployment abated.

Capital Rehabilitation

After the initial admission examinations had been completed, in early 1934 the FDIC shifted the emphasis of its examination function from determining minimal acceptability to the strengthening of weaker banks, particularly in the area of capital adequacy. It was determined that minimal safety required banks to have net sound capital equal to at least 10 percent of deposits. Net sound capital was defined as equity, capital notes, debentures and reserves, less assets classified as worthless or of doubtful value, including bond depreciation. Based upon admission examination findings, all banks not meeting this standard were reexamined during the first six months of 1934. The same cooperation accorded to banks initially rejected for deposit insurance

was given to those banks requiring capital rehabilitation. Of the state nonmember banks admitted to the fund, 35 percent were found to be undercapitalized. Subsequent examinations and rehabilitative efforts reduced this ratio to just 13 percent by the end of 1934. Many other banks recorded significant improvements though they still fell short of the 10 percent standard. For example, 20 percent of the initial applicants had net sound capital of less than 5 percent, but by year-end 1934, only 3 percent were under this level. This improvement in capital was achieved despite the fact that insured nonmember banks wrote off adversely classified assets equal to 20 percent of their total capital. The RFC supplied most of the funds used to offset these write-offs, while the remainder was supplied by local interests and retained earnings. By the end of 1934, the concept of federal deposit insurance was generally accepted, even by most of its detractors. As one measure that public confidence had been restored, bank runs were no longer a significant problem, although they did not disappear altogether. Local concerns about the solvency of an individual bank still gave rise to occasional bank runs. In some instances, fears were aroused when it was felt that bank examiners had overstayed their “normal” visit to a bank, although these fears were usually groundless. (Interview with Neil Greensides, former Chief, FDIC Division of Examinations, Washington, DC, August 16, 1983)

Safety-and-Soundness Examination Policy

After completing its first two examination tasks – admissions and capital rehabilitation – the FDIC again shifted its examination focus and concentrated on developing permanent examination policies and procedures. The purposes of these examinations were fivefold:

- Appraise assets in order to determine net worth;
- Determine asset quality;
- Identify practices that could lead to financial difficulties;
- Appraise bank management; and
- Identify irregularities and violations of law.

In addition to completing and reviewing its own examinations, in 1936 the FDIC began reviewing examination reports of national and state member banks because the FDIC had an insurance exposure for these banks supervised by the Comptroller of the Currency and the Federal Reserve. Some analysts came to the conclusion that supervisory policies in the 1930s were unduly harsh, and that recessionary periods were not the time to pressure banks to sell depreciated assets and reduce risk. Such practices, it was felt, would lead to a restriction of credit as well as otherwise unnecessary bank liquidations and forced mergers. These concerns had been expressed to the Comptroller of the Currency in 1931, but policy directives at that time were generally ineffective. A sharp recession had begun in 1937, rekindling these criticisms of bank examination policy, and in 1938 Secretary of the Treasury Morgenthau called for a conference of bank examiners. This time around, policy changes were strictly translated into examination procedures, resulting in more lenient asset valuation techniques. It was agreed that most bonds would be appraised at book value rather than market value, a policy believed to be more reflective of long-term investment quality. Moreover, a larger portion of classified assets were to be included in the capital ratio calculation. These policy shifts caused only a slight increase in aggregate capital-to-assets ratios – 12.8 percent under the new method *versus* 12.6 percent under the old – but the difference at individual banks, particularly marginal performers, could be critical. The 1938 conference also led to a revision of the nomenclature of asset classification, establishing the four groups that have remained essentially unchanged:
I not mentioned,
II substantial and unreasonable risk,
III loss is probable and
IV uncollectible (immediate charge-off)

Since 1949, categories II, III and IV have been referred to respectively as substandard, doubtful and loss.

The Banking Act of 1935

During the 20 months that the Temporary Federal Deposit Insurance Fund was in operation, the banking situation improved significantly. Attention was shifted to the specific insurance provisions of the 1933 Act. Most of those who had originally opposed deposit insurance legislation apparently had been convinced that the existence of the FDIC was a major contributing factor to the drastic reduction in bank failures. However, various provisions of the original permanent plan were viewed as not being appropriate in the new environment. The banking industry did not like the potential for virtually unlimited assessments and generally felt that the assessment rate should be set at a relatively low level. Large banks took exception to shifting the assessment base from insured to total deposits, contending that they would be unduly penalized because of the relatively large proportion of uninsured deposits held in larger institutions. State-chartered nonmember banks objected to mandatory membership in the Federal Reserve System as a precondition for retaining deposit insurance coverage.

FDIC recommendations

For its part, the FDIC was faced with a dilemma. Although the bank failure rate had dropped precipitously and the capital rehabilitation program of the RFC and the FDIC had been moderately successful, the banking system was not strong and the prospects for bank earnings were not bright. Additionally, the fears and uncertainties regarding the bank failure rate had not been dispelled by 1934 and indeed would not recede for more than two decades. The FDIC thus was faced with the problems of protecting the earnings of insured banks until capital and reserve positions could be rebuilt while, at the same time, conserving what was by historical standards a modest deposit insurance fund. During 1934, FDIC staff began drafting what was to become Title I of the Banking Act of 1935. In hearings beginning in February 1935 before the House Committee on Banking and Currency, FDIC Chairman Leo Crowley articulated his plan for the future of federal deposit insurance. The FDIC had calculated that during the period 1865-1934, an annual average assessment rate of about one-third of 1 percent of total deposits would have been required to cover the actual losses on deposit balances in failed banks. However, if certain “crisis” years in which losses were unusually high were eliminated, the necessary rate would have been lowered to about one-twelfth of 1 percent. Adoption of the lower rate was justified on the grounds that many banking reforms and improvements had occurred to strengthen the banking system and prevent bank failures. In addition to an assessment rate lower than historical experience would suggest, Crowley’s plan consisted of a combination of stricter entrance standards for new banks and expanded authority over the actions of existing banks, expanded powers regarding the handling of failing banks, a reduction in insurance exposure (*i.e.*, retaining the $5,000 insurance coverage rather than the higher limits envisioned in the original permanent plan) and other provisions that would tend to conserve the deposit insurance fund. From a practical point of view, the program advocated by Crowley consisted of attempting to strengthen the banking system, while using every legal means available to conserve FDIC financial resources. This philosophy dominated FDIC behavior until the mid-1960s.

Enactment and Admissions

By early August, the two houses of Congress resolved their differences on changes in the assessment rate, accepting the rate recommended by the FDIC. A compromise also was reached on the Federal Reserve membership issue. In the final conference report, which was accepted by both houses on August 19, only insured banks with more than $1 million in deposits would be required to join the Federal Reserve System, beginning in 1941. The membership requirement was rescinded altogether in 1939. The Banking Act of 1935 became effective August 23, 1935. The deposit insurance provisions of the Act, with few exceptions, were identical to the draft legislation prepared by the FDIC. From a financial point of view, one of the most significant revisions to the original permanent plan related to the calculation of assessments levied on insured banks. The 1935 Act provided that assessments were to be based on a flat annual rate of one-twelfth of 1 percent of *total* (adjusted) deposits. The effect of this change was to shift the relative burden of the deposit insurance system to the larger banks while protecting the level of assessment income to the FDIC.

The Banking Act of 1935 provided for the automatic admission to insurance under the permanent plan of all banks insured at the close of the temporary funds, except banks which signified, within 30 days, their intention to withdraw from insurance and those banks that had failed to file the required certified statement of deposits and to pay the required assessments. Thirty-four banks insured under the temporary plan withdrew within 30 days after the close of the temporary funds. One other bank had its insurance status terminated by reason of failure to file the certified statement. Automatically admitted to insurance under the permanent plan were 14,219 banks. Of these, 14,163 were commercial banks insured in the Temporary Federal Deposit Insurance Fund and 56 were mutual savings banks insured in the Fund For Mutuals. The 1935 Act set more rigorous standards for admission to insurance. In acting on insurance applications from new banks, the FDIC was required to consider the adequacy of the bank's capital, its future earnings prospects, the quality of its management and its usefulness in serving the convenience and needs of the community. The revised law, moreover, provided that any balances to which an insured bank was entitled, upon termination of the temporary federal deposit insurance funds, were to be credited toward the assessment to be levied under the permanent insurance plan. These balances consisted of the unused portion of assessments collected under the temporary plan. Since investment income of the temporary funds was sufficient to pay all of the operating expenses of the FDIC and cover deposit insurance losses and expenses, insured banks received a credit for the full amount of the assessments they had paid.

Supervisory powers

Insured nonmember banks were required to obtain the FDIC's approval before opening new branches or reducing their capital. The Act required all insured banks to obtain approval before merging or consolidating with noninsured institutions. The FDIC was empowered to require any insured bank to provide protection and indemnity against burglary, defalcation and other similar insurable losses. If an insured bank was found by the FDIC to have continued unsafe or unsound practices, the practices were to be reported to the appropriate supervisory authorities. A bank's insurance status could be terminated if the practices were not corrected. In order to strengthen the banking system, the FDIC was given the right to make a loan to, or purchase assets from, an open or closed insured bank to facilitate its merger or consolidation with another insured bank, if the merger would reduce the risk or avert a threatened loss to the FDIC. This power, which was first granted on a temporary basis, later was made permanent. The Banking Act of 1935 required the FDIC to prohibit the payment of interest on demand deposits in insured

nonmember banks and to limit the rates of interest paid on savings and time deposits. The FDIC also was required to prohibit insured nonmember banks from paying any time deposit before its maturity, except as prescribed by the FDIC. In granting these and other regulatory powers to the FDIC, Congress sought to prevent unsound competition among banks. The prevailing philosophy was that unfettered competition in the past had resulted in excesses and abuses in banking as well as other industries. The restrictive powers contained in the Banking Act of 1935 were thus consistent with the tenor of other New Deal legislative programs.

Borrowing authority- The FDIC was authorized to issue notes or other obligations in an amount not to exceed $975 million, and the RFC and the Secretary of the Treasury were directed to purchase up to $500 million of these notes if the funds were needed for the payment of depositors. The FDIC never borrowed under this provision of the Act. The Act also deleted the requirement for initial and subsequent capital subscriptions by insured banks, and the payment of dividends on capital stock held by the U.S. Treasury was eliminated.

Insured-Bank Failures

The Banking Act of 1933 authorized the FDIC to pay up to $2,500 to depositors in insured banks that failed. The only procedure to be used to pay depositors was a Deposit Insurance National Bank (DINB), a new national bank chartered without any capitalization and with limited life and powers. During the period of the temporary deposit insurance plan, January 1, 1934 to August 23, 1935, 24 insured banks were placed into receivership and their depositors paid off through a DINB. The first FDIC insured bank to fail was the Fondulac State Bank in East Peoria, Illinois, which was closed by the state in May 1934. Mrs. Lydia Lobsiger received the first federal deposit insurance payout, a check for $1,250 dated July 3, 1934. This was the only bank to fail while the $2,500 coverage limit was in effect. The 1935 Act gave the FDIC the authority to pay off depositors directly or through an existing bank, and once that authority was granted, the FDIC ceased using the DINB for the next 29 years. The DINB provides a vehicle for a slow and orderly payout, and its use in recent years has been confined to situations where only limited banking services were available in the community or where a regular payoff would have been substantially delayed. In addition to broadening the ways in which a payoff could be effected, the 1935 Act gave the FDIC the authority to make loans, purchase assets and provide guarantees to facilitate a merger or acquisition. This authority had been sought by the FDIC because of its concern that many of the banks that had been granted deposit insurance might not survive, and paying off insured depositors in these banks would be too expensive. In addition, most banking observers felt that there were too many banks in operation and that it would be desirable if the FDIC could facilitate an orderly reduction in their number through increased mergers.

The FDIC handled 370 bank failures from 1934 through 1941, an average of more than 50 per year. Most of these were small banks. Without the presence of federal deposit insurance, the number of bank failures undoubtedly would have been greater and the bank population would have been reduced. The presence of deposit insurance also may have limited the necessity for some banks to merge, and may have indirectly encouraged retention of restrictive state branching laws. Insurance losses totaled nearly $23 million during this period. The FDIC had positive net income in all but its first year of operation, though, and the insurance fund continued to grow. The year-end 1941 fund balance was $553.5 million. This resulted in a ratio of the fund to insured deposits of 1.96 percent, which remains the highest reserve ratio in the history of the FDIC. The end of 1941 marked the completion of eight years of successful operation of the system of federal insurance of bank deposits. It also marked the close of a period of economic recovery under peacetime conditions, which provided especially favorable circumstances for the establishment of deposit insurance and for improvement in the financial condition of banks.

CHAPTER 12 War and Recovery: 1942 – 1970

During World II, government financial policies and private-sector restrictions produced an expanding banking system. Total bank assets at the end of 1945 were nearly double the $91 billion total at the end of 1941. Large-scale war financing of the federal government was the primary factor contributing to the rise in bank assets. Banks played a major role in financing the war effort by lending to other bond buyers, by handling the bulk of the war loan campaign sales volume, and by purchasing government obligations themselves. At the end of 1945, holdings of those obligations accounted for 57 percent of total bank assets.

Loan losses were practically nonexistent during the war years and bank failures declined significantly. Only 28 insured banks failed in the period 1942-1945. The decline in the number of troubled banks can be ascribed primarily to the highly liquid state of bank assets, the absence of deposit outflows, and vigorous business activity. As the war drew to a close and ended, the transfer to peacetime conditions raised questions whether the economy would enter another recession or experience disruptive inflation. Many individuals feared that unemployment, declining income and business failures would ensue. However, inflation rather than deflation ensued. The public had a large volume of liquid assets, there was a tremendous demand for goods, and the immediate problem was one of inadequate production rather than of unemployment.

Effects of the War on the FDIC

The participation by the United States in World War II affected both the FDIC and the state banks it supervised, and some of those effects carried on well past the 1940s. The short-term effects included such things as moving some headquarters personnel to Chicago to vacate Washington office space for the war effort. The FDIC also suffered the same personnel shortage felt by many government agencies resulting from military enlistments and transfers to defense-oriented programs. A shortage of examiners meant that the FDIC was unable to fulfill its policy of annual bank examinations. Even after the war, government hiring restrictions and rapid growth of the economy led to a shortfall of qualified examiners, and it was not until 1951 that the FDIC again was able to examine all of its banks annually. Another temporary effect of the war effort was the transfer to the FDIC of responsibility for the supervision and examination of about 4,000 federal credit unions, though the FDIC did not insure their deposits. Federal credit unions previously had been supervised by the Farm Credit Administration. In 1948, after six years of FDIC supervision, this responsibility was transferred to the Federal Security Agency. FDIC Chairman Leo Crowley had come to be regarded by President Roosevelt as one of the best administrators, in or out of government, and he accepted numerous wartime responsibilities. While retaining his FDIC post, Crowley held nine separate government positions, including those of Alien Property Custodian and head of the Foreign Economic Administration, the latter a cabinet-level post that included the lendlease program. Thus, all foreign economic dealings, and assets and authorizations totaling more than $40 billion, were administered from Crowley's FDIC office in the Press Building on Fourteenth Street.

A more lasting effect of the war was a rapid decline in bank capital ratios, due primarily to the growth of banks' assets. However, the same process that led to rapid bank expansion – government financing – reduced the riskiness of bank portfolios. By the end of 1944, cash and

U.S. government obligations had grown to 79 percent of bank assets. Between 1934 and year-end 1944, the aggregate capital-to-assets ratio of banks had declined from 13.2 percent to 5.9 percent. Despite the decline in capital ratios, bank examiners were not particularly critical of bank behavior because of the quality and liquidity of bank assets.

Post-World War II Developments

The banking industry had emerged from World War II in very liquid condition and was in a favorable position to finance the spending spree that was poised to occur. Yet, many individuals expressed doubts whether banks were up to the task of resuming their traditional lending function. These concerns proved groundless. In 1947 alone, bank lending increased from 16 percent to 25 percent of the industry's assets. Lending subsequently did reach 40 percent of assets in the mid-1950s, and 50 percent in the early 1960s. This resurgence of lending did not produce a concomitant increase in loan losses. Throughout this period, loan losses remained relatively small. Net charge-offs averaged considerably less than one-tenth of 1 percent of outstanding loans during the 1950s. Several factors accounted for the relatively low level of loan losses during the postwar years. First, banking behavior by present standards continued to be very conservative. In addition, the economy remained strong. Recessions were reasonably mild and short. This was a period of general prosperity, with a secularly increasing real GNP and relatively low unemployment.

Bank lending had increased, but banks were still operating within traditional markets, and risks to the soundness of the banking system and to the deposit insurance fund were minimal, even during recessionary periods. Bank failures that did occur often received a great deal of attention, including Congressional hearings in some instances. This concern was reflected in the strict supervisory posture that prevailed during this period, but most bankers were content to accept tight regulation in exchange for the restraints it placed upon competition among banks and with nonbank competitors. During the late 1940s and 1950s there were no more than five bank failures in any single year. However, the low incidence of failures was regarded by some as a sign that the bank regulators were overly strict, operating with policies and practices rooted in the banking crises and economic chaos of the 1930s. In a speech marking the dedication of the headquarters building of the FDIC in 1963, Wright Patman, then-Chairman of the House Banking and Currency Committee, declared:

. . . I think we should have more bank failures. The record of the last several years of almost no bank failures and, finally last year, no bank failure at all, is to me a danger signal that we have gone too far in the direction of bank safety.

Until about 1960, banks continued to operate in this safe, insulated environment. Then banks gradually began to change the way they operated. The Depression experience ceased to be a dominant influence on bank management. The new generation of bankers who came to power in the 1960s abandoned the traditional conservatism that had characterized the industry for many years. Instead, they began to strive for more rapid growth in assets, deposits and income. Intensified competition and higher costs of funds put pressure on interest margins, and greater risks were assumed in order to increase portfolio yields. The trend was particularly pronounced among large banks. These banks also began pressing at the boundaries of allowable activities. They expanded into fields considered by some to involve more than the traditional degree of risk for commercial banks. Banks in general had become more susceptible to the effects of business downturns (as reflected in loan-loss rates) and interest-rate fluctuations. Before the 1970s, banks were not noticeably harmed by the movement toward increased risk-taking. Generally favorable economic conditions enabled many otherwise marginal borrowers to meet their obligations. With the exception of relatively mild recessions, the economy produced high levels of production, employment and income during most of the period.

There were other changes during the 1960s that had an effect on banking. States began to liberalize branching laws. The use of the bank holding company corporate structure was expanded as an alternative form of multioffice banking and as a means to enter new product markets. With the introduction of the large, negotiable certificate of deposit, banks' reliance on purchased money increased. In addition to the bank regulatory agencies having to monitor these developments, federal legislation gave them additional enforcement responsibilities in the areas of securities disclosure, antitrust and consumer protection. As banking entered the 1970s, it was on a new course that had brought it out of the period of post-war stability and into a period of increasing volatility and change.

Insured-Bank Failures

After 20 insured banks failed in 1942, fewer than 10 banks failed in each of the next 32 years. In 1962, one insured bank failed, but it required no disbursement by the FDIC, the only year in the FDIC's history with no failure-related disbursements. Because most of the banks that failed during the period 1942 to 1970 were small institutions, insurance losses remained low. In just four of these years did losses exceed $1 million, and losses averaged only $366,000 per year.

Financial Operations

The deposit insurance fund continued to grow during the 1940s, surpassing $1 billion at year-end 1946. Because of the highly liquid condition of the banking industry, the legislation passed in the 1930s to reduce risks in many sectors of the economy and the low bank failure rate, many observers felt that a $1-billion fund was sufficient to cover almost any economic contingency. Apparently, Congress also felt that the fund was adequate at that time and legislatively mandated repayment of the original capital subscriptions. The $150 million contributed by the Treasury and the $139 million in capital stock purchased by the Federal Reserve Banks was fully repaid by the end of 1948. Bankers also had voiced concern that the assessment rate was too high. By 1950 the fund had reached a balance of $1.2 billion, despite the repayment of capital completed two years earlier. Assessment income had been growing at a high rate, reflecting the rapid growth in bank deposits during the war and post-war years. Moreover, because of low interest rates during this same period, bank earnings lagged increases in prices and deposit insurance expenses.

The FDIC was reluctant to support a permanent reduction in the basic assessment rate. There still was concern that accumulated earnings would be insufficient to handle the increased rate of bank failures that many thought would occur during the 1950s. This fear was reinforced by the decrease in capitalization of the banking industry because of low earnings and rapid asset expansion since 1940. As a compromise, deposit insurance charges were effectively reduced by the Federal Deposit Insurance Act of 1950. Rather than lowering the basic assessment rate, however, the reduction was accomplished through a rebate system. After deducting operating expenses and insurance losses from gross assessment income, 40 percent was to be retained by the FDIC, with the remainder to be rebated in the form of assessment credits to insured banks. This procedure meant that losses were to be shared by insured banks and the FDIC on a 60/40 basis. This procedure tended to stabilize FDIC earnings despite periods of fluctuating loss experience.

From 1934 to 1949, insured banks had paid an assessment rate of one-twelfth of 1 percent, or 8.3 cents per $100 of assessable deposits. As a result of the 1950 Act, the effective assessment rate fell to 3.7 cents per $100. In 1960, the rebate scheme was modified slightly to adjust for a change in the calculation of an institution's assessable deposits, and the rebate proportion was

increased from 60 percent to 66-2/3 percent. From 1950 to 1980, the effective assessment rate stayed in the range of 3.1 cents to 3.9 cents per $100 of assessable deposits, except for a slight blip in 1974 (4.4 cents). Higher insurance losses after 1980 soon eliminated the assessment credits, restoring the effective rate to 8.3 cents

The 1950 Act also required the FDIC to reimburse the Treasury for interest foregone on the initial capital contributions by the Treasury and the Federal Reserve Banks. This requirement was the result of an exchange between FDIC Chairman Maple T. Harl and Senator Paul Douglas of Illinois during hearings on the 1950 Act. The exchange went as follows:
Senator Douglas: ...Mr. Harl, on page 2 [of your prepared statement] you speak of making final payment to the Treasury on August 30, 1948, when you paid the Treasury out in full for the loans [capital] which were advanced. Do I understand that to be your statement?
Mr. Harl: We paid them for the money advanced.
Senator Douglas: Would that include the interest upon the Government loan which was made?
Mr. Harl: It did not. The law provided that there should be no dividend upon the capital stock.
Senator Douglas: In practice, the Government has made an advance to the FDIC which has not been repaid; namely, the interest on the bonds which the Government issued, but for which it was not reimbursed.
. . .
Mr. Harl: ...This Corporation stands ready to reimburse the Government, or anyone else, provided it is legally authorized to do so.
Senator Douglas: You are ready to pay the interest, is that right?
Mr. Harl: If we have an obligation we are ready to pay it.
. . .
Senator Douglas: That is a possible source of revenue that I had not thought of. This brief conversation, which I at first thought was going to be unprofitable, might yield the Government as much as $40,000,000. I first thought it was love's labor lost. It may turn out there was gold in "them there hills."
(U.S., Congress, Senate, Committee on Banking and Currency, Hearings before a subcommittee of the Senate Committee on Banking and Currency on Bills to Amend the Federal Deposit Insurance Act, 81st Cong., 2d sess., January 11, 23 and 30, 1950, pp.27-29)

The amount estimated by Senator Douglas was somewhat low. During 1950 and 1951, the FDIC paid approximately $81 million to the Treasury for the interest foregone on the initial contribution of both the Treasury and the Federal Reserve Banks. An interesting benchmark was passed in 1961 when investment income ($73.9 million) surpassed assessment revenue ($73.4 million) for the first time. This remained so until the late 1980s, when insurance losses had eliminated assessment credits, thus increasing assessment revenue, and depleted the fund's investment portfolio and earnings. With the low insurance-loss experience of the 1950s and 1960s, and despite the implementation of the assessment credit program in 1950, the insurance fund continued to grow, reaching $4.4 billion at the end of 1970. The fund's growth rate trailed that of insured deposits, though, and the reserve ratio declined to 1.25 percent by the end of 1970. There were three increases in the insurance coverage limit during the years 1942 to 1970. Coverage was raised from $5,000 to $10,000 in 1950, to $15,000 in 1966 and to $20,000 in 1969.

CHAPTER 13 A Costly Evolution: 1971 – 1991

The economic environment affecting banks began to change during the 1970s and the pace of change accelerated during the 1980s. Also, the market for financial services became far more competitive as nonbanking companies began to encroach on traditional banking markets and banks sought to enter new product markets. As a result, banking became a riskier and more demanding business than ever before. The ramifications of unforeseen market developments or bad decisions were greatly magnified.

Economic Variables Affecting Deposit Insurance

This chapter documents some major changes in the banking environment that occurred from 1971 to 1991, a period that included record insured-bank failures and insurance losses and ended with the Bank Insurance Fund technically insolvent by $7 billion. The period of remarkable post-World War II stability came to an end in the 1970s.

Foreign exchange-rate volatility

An important change resulted from the movement to a floating exchange-rate system from a fixed-rate system that occurred in 1973. As international trade expanded in the post-World War II era, the maintenance of fixed exchange rates required adjustments to trading relationships and domestic economic policies of trading nations that were not optimal. With the Smithsonian Agreement (Washington, DC, 1971), exchange rates among all of the major currencies of the world were realigned and permitted to float without upper and lower bounds. This development predictably gave rise to considerably greater exchange-rate volatility at a time when world trade was expanding rapidly. Since 1970, there have been periods of relative calm in the exchange rates – for example, 1976 and 1977 – interspersed with periods of substantial volatility, some considerably extended, and periods with volatility varying among currencies. Markets for forwards and futures exchange-rate contracts were developed to permit firms to manage foreign exchange-rate risk more effectively. For example, the Chicago Mercantile Exchange formed the International Money Market in 1972 and began offering the first foreign exchange futures contracts on major currencies. Without well-developed markets for forwards and futures contracts for foreign exchange, this volatility would be less manageable and would significantly lessen foreign trade.

Interest-rate volatility

Interest-rate volatility also increased considerably in the 1970s. Oil embargo shocks in 1973 and 1978 resulted in accelerating inflation and contributed considerably to interest-rate volatility. The Federal Reserve dramatically changed monetary policy in October 1979 by switching from an interest-rate target to a monetary aggregates target, such as nonborrowed reserves, with the objective of reducing inflation. The result of this policy was a highly volatile interest-rate period from October 1979 until late 1982. Interest-rate volatility can give rise to volatility in bank earnings to the extent that banks face gaps between interest-sensitive assets and interest-sensitive liabilities. The causes of this volatility in interest rates have been linked to expectations of changes in future short-term interest rates, fed by the volatility in the rate of inflation and inflation expectations. The yield curve – *i.e.*, the relation between interest rates and maturity – has been volatile and at times has become inverted, such as 1972 through late 1974 and early

1978 through 1982, when the one-year Treasury bond yield was higher than the 10-year yield. This required considerable caution in funding long positions in long-term assets or fixed-rate assets with short-term, variable-rate liabilities. This was a particularly difficult period for FDIC-insured savings banks, which held proportionately more fixed-rate, long-term assets (residential mortgages) than did the typical commercial bank

Economic conditions

Volatility in the 1970s and 1980s also arose from general economic activity. To a considerable extent, the volatility in general economic activity can be traced to real shocks, such as the oil embargoes of the 1970s, wars, dissolution of the Soviet Union, and the fiscal and monetary policies of the major industrialized nations. These shocks caused considerable volatility in commodity prices and real output. The record inflation of the late 1970s was followed by a period of slower inflation, but greater commodity-price volatility. The 1980s also witnessed a surge in the number of newly issued commercial bank charters, which began operations at a time when inexperience was a distinct liability. (George Hanc, “The Banking Crisis of the 1980s and Early 1990s,” *FDIC Banking Review* 11, no. 1 (1998), p. 19)

The volatility of prices and general economic activity can have a substantial effect on banking performance, as the experience of the 1980s made clear. The sectoral inflation and subsequent deflation of agricultural prices in the late 1970s and early to mid-1980s were major contributors to the failure of hundreds of agricultural banks. Similarly, the boom and subsequent collapse of oil prices caused significant problems for banks in states whose economies had important energy sectors. The declines in real estate markets in the 1980s and early 1990s caused major problems for many banks. These problems can be traced in part to unanticipated changes in regional economic conditions, as the behavior of real-estate prices departed sharply from past patterns.

Developments in the Banking Industry

The business of banking changed considerably during this period. As noted above, risks increased as interest rates, exchange rates and commodity prices became more volatile and as economic shocks were transmitted more widely *via* the globalization of markets. Meanwhile, competition in the financial marketplace greatly intensified. The traditional intermediation function of banks assumed a smaller role in aggregate economic activity, largely because financial and technological innovations increased the funding options for firms that formerly were restricted to bank loans. Banks were forced to seek new sources of income and to implement untested business strategies, and such experimentation carried inherent risks. Dramatic evidence that banking became riskier is evident in the annual rates of bank failures. Although annual bank failures exceeded single digits only rarely between 1940 and 1980, failure rates rose rapidly thereafter, to a record high of 280 in 1988. A similar picture emerges from the data on FDIC insurance losses relative to insured deposits. Annual insurance losses were quite stable and extremely low, on average, before 1980, at less than half a basis point (0.005 percent) of insured deposits. Losses for the period from 1980 to 1991 averaged nearly 16 basis points (0.16 percent) and were highly variable.

Net loan charge-offs as a percent of average total loans trended upward beginning in the early 1970s and accelerated rapidly in the 1980s. This ratio was 0.34 percent in 1970 and 0.37 percent in 1980 before soaring to a peak of 1.59 percent in 1991. Over the same period, bank stocks substantially underperformed the Standard & Poor’s 500 index. The effects of increased competition and innovation are inextricably intertwined. Both played a role in the banking industry's declining share of financial-sector credit market assets since 1971. U.S.-chartered

commercial banks held a 37.6-percent share in 1971, but this share declined to 23.2 percent by the end of 1991. Many larger companies found that they could raise money more efficiently by issuing their own commercial paper. In 1971, outstanding commercial paper equaled just 4 percent of banks' commercial and industrial (C&I) loans, but by 1991 this ratio had risen fourfold, to nearly 17 percent. This development had added significance because many of these larger companies had been banks' most creditworthy, "prime" borrowers. During this period, banks also were losing business borrowers to finance companies. In 1971, finance companies' business loans were 15 percent of banks' C&I loans, but by 1991 this ratio had grown to more than 50 percent.

Asset-Backed Securities

The growth of asset-backed securities represents another dimension of the competitive pressures faced by depository institutions. By increasing the liquidity and efficiency of the credit markets, securitization produces a narrowing of the spreads available to traditional lenders such as banks and thrifts. The outstanding example of this process occurred in the mortgage market, where the proportion of consumer mortgages that had been securitized grew from about 8 percent in 1971 to more than 40 percent as of year-end 1991. On the liability side, banks faced increasing competition from many nonbank financial institutions. Foremost among these were the money-market mutual funds (MMMFs), which rose from obscurity in 1975 to prominence by 1981. Because of interest-rate regulations, banks were unable to match the high, market interest rates offered by these instruments. The ratio of MMMF balances to comparable commercial bank deposits (small time and savings deposits) was virtually zero in the mid-1970s, but reached 36 percent by 1981. Despite the elimination by 1983 of most interest-rate controls, MMMFs had established a durable presence. By 1991, the ratio of MMMFs to banks' small time and savings deposits had risen to 39.5 percent. These developments forced changes in the strategies of commercial bankers. Faced with diminished opportunities for C&I lending, banks shifted into real-estate lending.

This new portfolio composition exacerbated the adverse effects on banks of downturns in regional real-estate markets, including the Southwest in the mid-1980s and the Northeast a few years later. This typified other periodic, large-scale movements in and out of particular types of lending, and these portfolio shifts suggested that many banks embarked on a widening search for new profit opportunities in response to the competitive pressures undermining their traditional niche in the financial marketplace. The behavior of banks in the regions and sectors that suffered recessions during the 1980s exhibited some common elements. Recessions occurred in the Midwest in the early 1980s, in the Southwest in the mid-1980s, in the Northeast in the late 1980s and in California in the early 1990s. In the economic expansions that preceded these recessions, banks generally responded aggressively to rising credit demands. Banks that failed generally had assumed greater risks, on average, than those that survived, as measured by the ratios of total loans and commercial real-estate loans to total assets. Banks that failed generally had not been in a weakened condition, as measured by equity-to-assets ratios, in the years preceding the regional recessions.

Safety-and-Soundness Examination Policy

In 1936, the problems cited most frequently by bank examiners were inadequate capital, excessive insider lending, excessive volume of poor loans, inadequate credit documentation and incompetent management. In a survey 40 years later (1976), these same problems were cited by examiners, along with inadequate liquidity and violations of consumer credit law. Some people recognized, though, that it was becoming increasingly difficult in the 1970s to effect

adequate supervision within the confines of policies and procedures designed for the less diversified, less dynamic industry of previous decades. Edward Roddy, who served as the FDIC's Director of Bank Supervision from 1971 until his death in 1975, was credited by many as being particularly aware of the changes that were taking place and the growing inadequacy of existing supervisory policies. It was largely through his efforts that policies were overhauled in the early and mid-1970s, the first substantive changes in several decades. In an important shift in FDIC policy, it was decided that smaller, sound, well-managed banks did not require annual full-scope examinations and that it would be more effective to concentrate examination resources on those banks presenting greater risks to the insurance fund. This concept was furthered in the late 1970s and early 1980s with the expanded use of off-site monitoring systems to identify institutions posing unacceptable risks and to target supervisory resources.

Insured-Bank Failures

. In 1971, the FDIC utilized for the first time powers granted under the 1950 Act to provide "open-bank assistance" to a failing insured bank.

Open-bank assistance

Section 13(c) of the Federal Deposit Insurance Act authorized the FDIC to provide financial assistance to an insured operating bank in danger of closing whenever, in the opinion of the Board of Directors, the continued operation of such a bank is essential to providing adequate banking services to the community. Unity Bank, with deposits of $9.3 million, was established in 1968 as a community venture to serve the black community of the Roxbury-Dorchester area of Boston, Massachusetts. The bank received a loan from the FDIC in the amount of $1.5 million, but Unity did not remain viable and in 1982 was merged into another bank with FDIC assistance.

Failures

Many of the economic and banking developments described above encouraged banks to take greater risks, but the new environment also provided harsh punishment for their mistakes. The *number* of bank failures during the 1970s and early 1980s remained within historical parameters, but the failed-bank assets and insurance losses soon began to escalate beyond historical levels. When Bank of the Commonwealth (Detroit, Michigan) failed in 1972 and United States National Bank (San Diego, California) failed in 1973, they each had total assets greater than $1 billion and were by far the largest FDIC-insured banks to fail. Bank of the Commonwealth received open-bank assistance from the FDIC, in consultation with the Federal Reserve Board and the State of Michigan, because of its essentiality in providing banking services to minority neighborhoods in Detroit. In 1984, Bank of the Commonwealth was acquired by another bank, without FDIC assistance.

Insurance losses for 1973 totaled $67.5 million, nearly double the losses incurred by the FDIC in its previous 39-year history. However, much larger losses were soon to come. From 1982 through 1991, more than 1,400 FDIC-insured banks failed, including 131 that remained open only through FDIC financial assistance. In Texas alone, more than 500 insured banks failed. Total insurance losses exceeded $1 billion in each of these 10 years, topping $6 billion in 1988, 1989 and 1991. The insurance fund had grown to $18.3 billion by year-end 1987, but these crushing losses quickly exhausted the fund. At the end of 1991, the balance of the Bank Insurance Fund, excluding loss reserves, was *negative* $7 billion. A succession and overlapping of regional and sectoral problems combined temporarily to overwhelm the system's ability to

absorb losses. There was a sharp increase in the number of new charters issued in the 1980s, and these institutions suffered a disproportionately high rate of failure. Of the 2,800 banks chartered from 1980 to 1990, 16.2 percent had failed by the end of 1994. By comparison, of the banks that already were in existence at the beginning of 1980, just 7.6 percent had failed by year-end 1994. In New England in the early 1990s, mutual savings banks that converted to the stock form of ownership suffered a similar high rate of failure. After conversion, these institutions had large amounts of new cash to invest, just at the time the region was plunging into a recession. Twenty-one percent of stock savings banks failed in the early 1990s, compared to 8 percent of mutual savings banks.

Financial Operations

Insurance coverage

In 1974, deposit insurance coverage was increased from $20,000 to $40,000, and to $100,000 for deposits held by states and political subdivisions. Coverage was increased to $100,000 for IRA and Keogh accounts in 1978. In 1980, despite the reservations of the FDIC, deposit insurance coverage for all accounts was increased to $100,000 by provisions of the Depository Institutions Deregulation and Monetary Control Act. This last increase represented a departure from previous changes in insurance coverage, which generally had been more modest and more or less reflected changes in the price level. The increase to $100,000 was not designed to keep pace with inflation but rather was in recognition that many banks and savings-and-loan associations, facing disintermediation in a high interest-rate climate, had sizable amounts of large certificates of deposit (CDs) outstanding. The new limit facilitated retention of some of these deposits and attraction of new deposits to offset some of the outflows. In 1980, only time accounts with balances in excess of $100,000 were exempt from interest rate ceilings. Disintermediation is the removal of intermediaries or "cutting out the middleman". Instead of going through traditional distribution channels, which had an intermediate (such as a bank or savings and loan), consumers began to place discretionary funds directly into stocks, bonds, mutual funds or other investment (as opposed to savings) vehicles.

Assessments

In 1980, the assessment credit percentage was reduced from 66-2/3 percent to 60 percent, the level that had been in effect from 1950 to 1960. At this time, there also was established a range in which the reserve ratio of the fund was to be maintained. The assessment credit percentage was to be adjusted if the reserve ratio either exceeded 1.40 percent or fell below 1.10 percent. Because of mounting losses, reduced assessment credits were paid in 1981 through 1983, and no assessment credits were paid thereafter. Effective assessment rates generally ranged under 4 basis points during the 1970s. Thereafter, rates grew rapidly as insurance losses mounted throughout the 1980s and early 1990s. When the full statutory rate of one-twelfth of 1 percent (8.3 basis points) proved too low, Congress mandated an increase to 12 basis points in 1990 and gave the FDIC board more flexibility to raise rates. With losses continuing at record levels, rates were increased twice in 1991, first to 19.5 basis points and then to 23 basis points.

FIRREA

Congress enacted the Financial Institution Reform, Recovery, and Enforcement Act (FIRREA) in 1989 in a largely successful effort to resolve the savings and loan crisis of the 1980s. Many provisions of FIRREA drastically affected FDIC operations. The former Federal Deposit

Insurance Fund was renamed the Bank Insurance Fund (BIF), and the FDIC assumed responsibility for the new Savings Association Insurance Fund (SAIF), which replaced the defunct Federal Savings and Loan Insurance Fund. A third fund was placed under FDIC management – the FSLIC Resolution Fund – which consisted of the remaining FSLIC receivership assets. The FDIC also was charged with organizing and, initially, managing the new Resolution Trust Corporation (RTC), which was created to resolve failed and failing savings associations and to manage savings association receiverships.

Investment policy

By law, FDIC investments essentially are limited to Treasury securities. Before the mid-1970s, the FDIC assumed a passive role in managing its portfolio, allowing the Treasury to invest FDIC funds in whatever issues the Treasury felt appropriate. About this time, though, the FDIC started to shorten the average maturity of its portfolio and began to achieve a better maturity balance with respect to anticipated bank failures and liquidity needs.

CHAPTER 14 FDIC; A Remarkable Turnaround: 1992 - 1998

In 1991, the commercial banking industry was struggling. A recession in 1990 and early 1991 had trimmed loan demand, losses related primarily to commercial real estate lingered, and the Bank Insurance Fund was insolvent by $7 billion. More than 1,000 commercial banks, with aggregate assets exceeding $500 billion, were on the FDIC's "problem bank" list, many of which were expected to fail. The industry earned a return on assets of just 0.53 percent, well below the profitability benchmark of 1 percent. These hardly were measures of an industry on the verge of an unprecedented run of prosperity, but events already were underway that would reverse banks' fortunes. Short-term interest rates began to plummet in the latter part of 1990. The three-month Treasury bill had an average yield of 7.75 percent in the second quarter of 1990. The yield fell to 4.54 percent by the end of 1991, and it would continue to fall, remaining near 3 percent throughout 1993. Following the 1990-1991 recession, the U.S. economy began an expansion that continued well into 1998.

Developments in the Banking Industry

Performance

Commercial banks earned an industry record $32 billion in 1992, compared to $18 billion in 1991. Their earnings would improve in each of the following five years, reaching $59 billion in 1997. In 1991, one of every nine banks was unprofitable, but by 1997 that figure had fallen to less than one in 20. Part of this earnings improvement was attributable to the overall growth of the industry: total assets were up from $3.4 trillion at the end of 1991 to $5 trillion at year-end 1997. However, banks' average return on assets also improved markedly, surpassing 1 percent in each year from 1993 through 1997, including a record 1.23 percent in 1997. Despite this rapid growth in total assets, the growth of bank capital more than kept pace. The ratio of total equity to assets rose from 6.75 percent in 1991 to 8.33 percent at the end of 1997. Important changes also were underway in the composition of bank earnings. Banks became less reliant on spread-based revenues (*i.e.*, net interest income) and more reliant on noninterest income. Banks and their holding companies diversified into new activities that were less affected by interest-rate

swings than were traditional banking products. In 1997, noninterest income was 60 percent of net interest income, up from 49 percent in 1991.

Banks also used this period to improve the quality of their assets. The proportion of noncurrent loans fell from a crippling 3.70 percent in 1991 to under 1 percent in 1997. The level of foreclosed assets also fell dramatically, from $28 billion in 1991 to $4.5 billion by the end of 1997. Banks also maintained a high level of loan-loss reserves. Coupled with the decline in noncurrent loans, banks had nearly $2 in reserves for each dollar of noncurrent loans at year-end 1997, up from 73 cents in 1991. At the end of 1997, the number of institutions on the FDIC's "problem bank" list had fallen to just 71 banks, with total assets of $5 billion.

Consolidation

The number of FDIC-insured commercial banks remained remarkably constant from 1934 to 1988, ranging from 13,000 to 14,500. In 1989, the number of banks fell below 13,000 for the first time and continued to fall, to 9,143 at the end of 1997. Part of this consolidation was attributable to bank holding companies combining their bank subsidiaries, which was facilitated by the Riegle-Neal Interstate Banking and Branching Efficiency Act of 1994. This Act, which became fully phased in by June 1997, also enabled interstate combinations between unaffiliated banks. The most dramatic effects have been mergers between some of the nation's largest banking companies. Some concerns were raised about the ability of smaller banks to compete with these enormous financial conglomerates, but there are many reasons to believe that well-managed community banks will continue to prosper independently. Additional concerns were raised about the ability of the FDIC to handle the failure of one of the "megabanks."

FDICIA

The Federal Deposit Insurance Corporation Improvement Act (FDICIA) was enacted in December 1991 as Congress addressed the insolvent Bank Insurance Fund. The Act was comprehensive in nature, covering both insurance funds and their finances as well as supervisory and resolution practices. Its most important provisions are summarized here.

Risk-based premiums

By statute, the FDIC had always charged a flat rate for deposit insurance. FDICIA required the FDIC to have in place by 1994 an assessment system wherein each bank's assessment would be reflective of the risks it posed to its insurance fund. The FDIC had backed such a change and implemented a risk-based premium system on January 1, 1993, a year ahead of schedule. Assessment rate schedules were adopted separately for the BIF and the SAIF. Each schedule was composed of a nine-cell matrix, with rates ranging from 23 cents per $100 of assessable deposits to 31 cents. Institutions were categorized according to a capital subgroup (1, 2 or 3) and a supervisory subgroup (A, B or C). Thus, the best-rated institutions were in cell 1A, and the weakest institutions were in cell 3C. FDICIA set the minimum assessment at 23 basis points until each fund was fully capitalized at 1.25 percent of insured deposits. It required the FDIC to adopt a recapitalization schedule for the BIF to achieve full capitalization with 15 years. Such a schedule was adopted in 1992. Because nearly half of SAIF assessments were diverted by law to other purposes, that fund was expected to take even longer to become fully capitalized. A capitalization schedule for the SAIF was not required until 1998.

Prompt corrective action

The law required federal regulators to establish five capital zones ranging from well-capitalized to critically undercapitalized that serve as the basis for mandatory prompt corrective active by regulators. Increasingly harsh restrictions apply to institutions that are less than well-capitalized. Institutions whose tangible capital ratio falls below 2 percent are critically undercapitalized and face closure if the situation is not corrected within 90 days. It was expected that by closing institutions before their capital was totally depleted, losses to the deposit insurance funds would be mitigated. Until FDICIA, the FDIC did not have the authority to close a failing insured bank; that power rested with the chartering authority, which was the Comptroller of the Currency or the state.

Least-cost resolution- FDICIA required the FDIC to select the resolution alternative for failing institutions that results in the lowest cost to the insurance fund. Previously, the FDIC could select any resolution alternative if it was less costly than a payout of insured deposits and liquidation of assets. Thus, if two resolution alternatives were less costly than a payout, previously the FDIC could have chosen either method; under FDICIA, the FIDC must choose the least costly of the two. Beginning in the mid-1960s, the FDIC had routinely protected all depositors, when possible, by transferring all deposits of a failed bank to an acquiring institution, thus protecting even uninsured depositors. That policy was no longer an option.

Too big to fail

Before FDICIA, the FDIC had the authority under the open-bank assistance provisions of the 1950 Act to determine that a failing institution was so large that its failure could result in a systemic risk to the banking system by undermining public confidence. This authority was used only two times, in 1980 with First Pennsylvania Bank (total assets $8 billion) and in 1984 with Continental Illinois National Bank (total assets $45 billion). Both instances required a finding of essentiality. FDICIA requires that, in situations threatening systemic risk, the FDIC Board, the Board of Governors of the Federal Reserve System and the Secretary of the Treasury, in consultation with the President, must agree that the closure of the insured institution would have a serious effect on economic conditions or financial stability. Any loss to an insurance fund under this exception must be recovered through a special assessment paid by members of that fund. This authority has not yet been used.

Borrowing authority- FDICIA also increased from $5 billion to $30 billion the amount the FDIC is authorized to borrow from the Treasury to cover insurance losses. Any borrowings were to be repaid through deposit insurance assessments. In 1990, the FDIC was authorized to borrow money for working capital from the Federal Financing Bank. Any borrowings were to be repaid by the sale of receivership assets. These provisions were necessary because when an institution fails, the FDIC has large initial expenses – the payment of insured deposits – and relatively slow recovery through the sale of receivership assets. Working capital borrowings, which amounted to about $10 billion at year-ends 1991 and 1992, were repaid in full in 1993.

Depositor Preference

The Omnibus Budget Reconciliation Act of 1993 included provisions that established a uniform order for distributing the assets of failed insured depository institutions. Previously, federal and state laws often set different priorities in terms of the hierarchical order for payment of receivership claims. Under the national depositor preference law, a failed institution’s assets are to be distributed in the following order:

The administrative expenses of the receiver;
The claims of all depositors, including the FDIC in the place of insured depositors;
General creditor claims;
Subordinated creditor claims; and
The claims of shareholders

The law was expected to reduce the cost of resolutions and thus conserve the deposit insurance funds.

Insured-Bank Failures

The profitability of the overall banking industry recovered quickly in 1992, but some banks did not survive the travails of the preceding years. One hundred twenty-seven banks failed in 1992, resulting in estimated insurance losses of $3.6 billion. Insurance losses for any given year include estimated losses for institutions that failed during that year as well as adjustments to estimated losses for institutions that failed in previous years. The industry's financial health was evident in the lower numbers of failures and losses in subsequent years. From 41 failures in 1993, the numbers fell to 13, six, five and one in the years 1994 through 1997, respectively, and insurance losses declined proportionately. The low failure experience has continued in 1998. Through the first eight months of the year, just three commercial banks failed, resulting in estimated losses of $33 million.

Financial Operations

The Bank Insurance Fund recovered far more quickly than was anticipated from its insolvency at year-end 1991. With declining insurance losses and substantially higher assessment revenue mandated by FDICIA, the fund balance became positive in 1993 and reached full capitalization in May 1995. At midyear 1995, the fund's balance was $24.7 billion, which represented 1.29 percent of insured deposits. It is important to note that the recovery of the BIF was aided significantly by a reduction in the reserves previously set aside for anticipated failures. Failures projected by the FDIC and the General Accounting Office in the early 1990s did not materialize as the banking industry went on to seven years of record profits. In 1992, 1993 and 1994, the FDIC recorded *negative* loss provisions totaling $12.8 billion, which increased net income and the fund balance. Much smaller – though still negative – loss provisions were recorded in 1995 through 1997.

BIF assessment rates- With the BIF recapitalized in 1995, the FDIC was able to reduce deposit insurance assessments for BIF members. In recognizing the legislative safeguards recently implemented, the FDIC Board concluded that the insurance losses of the 1980s and early 1990s were atypical of what could be expected in the foreseeable future. The staff determined that an assessment rate of 4 to 5 basis points would have been sufficient to balance revenues and expenses – and capitalize deposit growth – in the period from 1950 to 1980. Interestingly, this was the same exercise undertaken by FDIC staff 60 years earlier, based on the period 1865 to 1934, in recommending an assessment rate when Congress was drafting the Banking Act of 1935. The results were not widely dissimilar. However, the Board also wanted to maintain risk-based pricing, so rates were reduced from a range of 23 to 31 basis points to a range of 4 to 31 basis points, effective June 1, 1995. Because of incentives in the risk-based premium system and improvements in the health of the industry, the vast majority of banks – nearly 92 percent – were in the 1A rate cell and qualified for the lowest rate. The average assessment rate was 4.4 basis points, down from 23.2 basis points before recapitalization of the BIF. Also, by increasing the spread from 8 basis points (23 to 31) to 27 basis points (4 to 31), the Board hoped to provide additional financial incentive to weaker banks to improve their condition. Later in 1995,

the Board lowered BIF rates again, to a range of 0 to 27 basis points, effective at the start of 1996. Because of the low level of projected insurance losses and receivership activity, the Board determined that investment earnings would be sufficient to cover the BIF's expenses. To maintain the incentives provided by risk-based pricing, though, it was decided to retain higher rates for banks presenting greater risks to the fund. In 1997, BIF assessment revenues totaled just $25 million, compared to $5.6 billion in 1994.

SAIF assessment rates- At the time the BIF became recapitalized in 1995, the SAIF still was substantially short of the designated reserve ratio of 1.25 percent. On June 30, 1995, the fund balance was $2.6 billion, and its reserve ratio was just 0.36 percent. Therefore, SAIF assessment rates could not be set lower than 23 basis points, 32 and there existed a sizable differential between SAIF assessment rates and the new BIF rates. It soon became apparent that this provided sufficient incentive to SAIF members to shift deposits to BIF insurance. Despite legislative and regulatory prohibitions, some SAIF members succeeded to some extent. Concern arose that if SAIF-assessable deposits continued to shrink, it eventually would not be able to meet its insurance and other financial obligations. Moreover, it was likely to be the stronger institutions that would be successful in shifting deposits, leaving the SAIF with a higher risk profile. Under FIRREA, the FDIC Board had the option of reducing SAIF assessment rates to 18 basis points during the period from January 1, 1994 to December 31, 1997. However, the Board opted to maintain the minimum rate at 23 basis points until the SAIF was fully capitalized.

Congress responded with the Deposit Insurance Funds Act of 1996 (Funds Act). It called for a special assessment – later set by the FDIC at 65.7 basis points – on all SAIF-assessable deposits in order to bring the fund to full capitalization. The special assessment brought in $4.5 billion and raised the fund balance to $8.7 billion. The SAIF faced another significant problem, however. SAIF assessments of up to $793 million annually were diverted to cover interest payments by the Financing Corporation (FICO) on 30-year bonds issued in the 1980s in an effort to end the savings-and-loan crisis. This amounted to nearly half of all SAIF assessments and was the primary reason why the fund's growth lagged behind that of the BIF. Even when fully capitalized, SAIF assessment rates of 12 basis points or more would have been needed to cover expenses and fund FICO interest payments. The Funds Act allocated the FICO expense to all FDIC-insured institutions. Beginning in 1997, BIF members became subject to FICO assessment, though at a lower initial rate than SAIF members. SAIF members' costs were reduced significantly, and beginning in 2000, all insured institutions will pay a *pro rata* share of the FICO expense, expected to be about 2 basis points annually. With the SAIF fully capitalized, the FDIC was able to lower SAIF assessment rates to a range of 0 to 27 basis points, the same as paid by BIF members, effective October 1, 1996.

CHAPTER 15 Issues in Deposit Insurance

Federal deposit insurance was an extremely important factor in restoring public confidence in the banking system in the 1930s. Deposit insurance may play a smaller role in today's relatively stable economic environment, but in periods of adversity or change, deposit insurance gains consequence. As recounted in the 'A Costly Evolution' segment previously, financial markets in the United States and around the world, in many respects, have become and are expected to remain more volatile than in the past. The effects of this volatility on depository institutions may have been masked, to some extent, by the recent favorable environment, with low and stable interest rates and a prolonged economic expansion. As well, the huge returns earned in the stock market in recent years have reduced for many investors the attractiveness of bank deposits and, thereby, the perceived value of deposit insurance. In periods of relative stability as in periods of economic peril, consumers remain quite concerned about deposit insurance. The FDIC constantly receives inquiries from consumers about certain banks' insurance status, and the Division of Compliance and Consumer Affairs recently added an option to determine "Is my bank insured?" on the FDIC's Web site. Consumers also call frequently to determine the amount of insurance coverage on various types of accounts.

Attempts to Reduce Risk

Many banks have reduced the risks that they faced in the past. Interest-rate risk management has improved, banks in general are less dependent on spread-based income, and bank supervisors have implemented new programs that are expected to be more effective in identifying and addressing emerging risks. Only 16 FDIC-insured institutions failed in the period 1995-2005, including 15 BIF members and one SAIF member. There is no evidence, though, that the business cycle has ceased to exist, and these improvements in bank and supervisory practices have yet to be tested in an adverse environment. Perhaps more significantly, some behaviors of the past remain unchanged. As an economic expansion wanes, profit margins narrow, competition for creditworthy borrowers increases, and underwriting standards are compromised in many instances. At the end of 1997, for all FDIC-insured banks and thrifts, insured deposits comprised less than half of total liabilities for the first time. This proportion fell from more than 60 percent earlier in the 1990s to 49.6 percent at year-end 1997. This likely is attributable, in part, to the favorable environment. In a choppy or adverse economic climate, bank deposits in general, and insured deposits in particular, are likely to gain favor. It also has been the FDIC's experience that when an insured institution encounters difficulties, uninsured depositors quickly seek protection. This can be accomplished in many ways, such as by withdrawing uninsured deposits or by obtaining or increasing loans against which to offset uninsured deposit claims in the event of a failure. Overall, the federal deposit insurance program has served the nation well. However, a number of deposit insurance issues currently face the FDIC, the Congress and the banking industry. The FDIC sponsored a symposium on deposit insurance on January 29, 1998, in order to facilitate a discussion of the role and nature of deposit insurance in the current financial services environment. The symposium addressed the issues related to deposit insurance and financial modernization, in light of the recent rapid pace of banking evolution and the prospect of newly permissible activities for banking organizations; the various deposit insurance reform proposals that would curtail the role of the federal government in protecting depositors; and the right balance between the pursuit of safety and soundness and the need to allow banks to compete and evolve. Some current issues are summarized below.

The Year 2000 Date Change

Although it seems like ancient history now in the 1990's one of the more immediate deposit insurance issues involved the Year 2000 date change. Attention was focused on the potential for computer systems to encounter problems handling the date change into the next century. Many older computer applications stored the year as a two-digit number and, unless corrected, these programs are likely to interpret January 1, 2000, as January 1, 1900. The financial-services industry was viewed as particularly vulnerable to this problem. In addition to making certain their own systems were "Y2K-compliant," bank regulators incorporated Y2K standards into the bank examination process. Banks not making adequate progress in evaluating, fixing and testing their systems were subject to regulatory sanctions. Vendors providing information processing and services to banks also were subject to these requirements. The FDIC expected some number of "technological" bank failures to occur shortly before or after the Year 2000 date change. The actual number of Y2K failures was impossible to predict, however. Because of the uncertainties, the FDIC and the other federal banking agencies were be prepared if the problems and failures became widespread. In addition to other Y2K initiatives, the FDIC established a Failed Financial Institutions Y2K Action Plan. The problem presented some unprecedented challenges. At the end of the 20th Century, banking was much more interconnected than it was the last time a major crisis was faced. This meant, more than ever, that regional problems would not be as typical. With Y2K, a failure in North Carolina could impact institutions in Idaho in a way that would have been unthinkable in previous decades. As an example of the potential problems identified by the group, the traditional methods used to verify deposit records would be complicated if a failed bank's computer systems are inoperable or unreliable. A critical need in this contingency planning process was to identify all people within the FDIC with experience in handling failed institutions because, with the decline in failures in the decade of the '90's, many former resolution specialists had moved to other positions. To be prepared for a worst-case Y2K scenario, the group identified other FDIC employees with applicable experience, personnel at the other federal banking agencies and contractors.

Consolidation and Bank Failures

The five largest banking company mergers in U.S. history all were announced or completed in 1998. The largest of these – Travelers Group and Citicorp – resulted in a company with total assets of approximately $700 billion, more than double the assets of the largest U.S. banking company at the end of 1997. The combination of NationsBank and BankAmerica resulted in a company with total assets of approximately $525 billion. These and other large, complex financial conglomerates present new challenges to the FDIC and other bank regulators. The consolidation of banks serving different product and geographic markets can diversify risk and decrease earnings volatility, thereby decreasing the likelihood of failure. Regional recessions and sectoral downturns contributed to many of the bank and thrift failures in the late 1980s and early 1990s. Many of the institutions that failed or were troubled tended to have either geographic or product concentrations. Broader diversification of risk through mergers of institutions serving different markets can moderate the effects of economic downturns on these institutions. Consolidation of banking organizations also may be able to reduce duplicative back-office and other administrative costs, although the actual value of these cost savings remains uncertain.

The resources and broader array of activities of these banks should enable them to compete more effectively in international markets. However, no banking organization is immune to failure. Certainly, the deposit insurance funds face larger potential losses from the failure of a single

large, consolidated institution. Insurance is based on the concept of diversifying risk. If an institution gets too large relative to the industry as a whole, it becomes increasingly difficult to diversify risk. Larger institutions also are more complex and tend to be involved in more nontraditional activities. Large banks pose more challenges when they fail, and the failure of a very large bank has the potential for creating systemic risk, although measures enacted in FDICIA, though as yet untested, were designed to improve the ability of the government to handle situations involving systemic risk. The unprecedented failures of a number of very large financial institutions simultaneously would be more problematic, but it is questionable whether it would be appropriate to maintain insurance funds that are large enough to address an absolute worst-case scenario.

Effective supervisory oversight remains the regulators' most important tool. The recent implementation of risk-focused examinations by the federal banking agencies and the programs already in place for coordinated oversight of large, complex institutions provide a strong foundation for addressing the challenges of industry consolidation. Regulators ensure that proper controls and practices are in place and assess management's ability to identify, measure, monitor and control risk within an institution. Going forward, the agencies will determine whether examiners needed additional training to address new activities and whether supervisory programs needed to be modified. (Testimony of Andrew C. Hove, Jr., Acting Chairman, Federal Deposit Insurance Corporation, on Mergers in the Financial Services Industry before the Committee on Banking and Financial Services, United States House of Representatives, April 29, 1998)

Merger of the Insurance Funds

The Deposit Insurance Funds Act of 1996 contained provisions to merge the BIF and the SAIF, effective January 1, 1999. However, the merger can become effective only if there are no insured savings associations in existence on that date. This condition apparently was included to force consideration of bank and thrift charter issues and the perceived unfair advantages of the thrift charter. Thus, Congress recognized the desirability of merging the two deposit insurance funds, but it tied the merger to largely unrelated issues. Arguments against a merger of the funds emanate primarily from bankers who are opposed to exposing their insurance fund to a repeat of the thrift losses of the 1980s.

The FDIC consistently has supported a merger of the two insurance funds. The FDIC has argued that the SAIF insures far fewer, and more geographically concentrated, institutions than does the BIF and consequently faces greater long-term structural risks. A combined BIF and SAIF would have a larger membership and a broader distribution of geographic and product risks and would be stronger than either fund alone. In 1998, both funds were fully capitalized and their members were healthy and profitable, and the BIF and SAIF reserve ratios were very close and are were expected to remain so in the near future. That meant that a merger of the funds at that time would not result in a material dilution of either. (Testimony of Donna Tanoue, Chairman, Federal Deposit Insurance Corporation, on Financial Modernization before the Committee on Banking, Housing and Urban Affairs, United States Senate, June 25, 1998)

The FDIC was required to set assessment rates independently for each of the insurance funds. At the time, the assessment rate schedules for the two funds were identical. However, the funds' memberships had quite different risk profiles, and it was likely that rates would differ at some time in the future. Before the capitalization of the SAIF in 1996, the FDIC had experience with differing rates for BIF- and SAIF-assessable deposits. The result was the shifting of deposits

between BIF- and SAIF-insured institutions. Such market distortions have an economic cost as institutions devote resources to countering artificial statutory distinctions. As well, the maintenance of two insurance funds resulted in additional administrative costs to the FDIC and to the insured institutions that hold both BIF- and SAIF-insured deposits, which must be tracked, reported and assessed separately.

FDIRA

In February, 2006, the Federal Deposit Insurance Reform Act of 2005 was signed into law. The FDIRA contained technical and conforming changes to implement deposit insurance reform, as well as a number of study and survey requirements. Among the highlights of this law was merging the Bank Insurance Fund (BIF) and the Savings Association Insurance Fund (SAIF) into a new fund, the **Deposit Insurance Fund** (DIF). This change was made effective March 31, 2006. The amount each institution is assessed for the fund is based both on the balance of insured deposits as well as on the degree of risk the institution poses to the insurance fund. A March 2008 memorandum to the FDIC Board of Directors showed a 2007 year-end Deposit Insurance Fund balance of about $52.4 billion, which represented a reserve ratio of 1.22% of its exposure to insured deposits totaling about $4.29 trillion. The 2008 year-end insured deposits were projected to reach about $4.42 trillion with the reserve growing to $55.2 billion, a ratio of 1.25%. As of September 2008, the DIF had a balance of $45 billion.

Definition of the Assessment Base

Assessment rates are set semiannually, and institutions pay assessments at the end of each quarter. The deposit base against which assessments are charged can be defined simply as total domestic deposits, less a downward adjustment for “float.” Since float is more applicable to transaction accounts than to time and savings accounts, commercial banks typically have a larger float adjustment than do thrifts. The float adjustment, which is performed by the FDIC rather than reported by insured institutions, is quite complex. Also, because the assessment base is derived from total domestic deposits, institutions pay assessments on deposits in accounts that exceed the insurance coverage limit, currently $100,000. Assessable deposits are measured at the end of each quarter. The FDIC has expressed concern that this gives institutions and their depositors the opportunity to “sweep” deposits out of their accounts on the last day of the quarter and thereby lower the institution’s assessment base. Some insured institutions pass deposit insurance costs directly to business account holders, so the depositors would have incentive to sweep the account each quarter. This practice would be discouraged, or eliminated, if the assessment base were measured using average daily deposits or some similar measure. It also would result in an assessment base measurement more closely correlated with the FDIC’s risk exposure. The FDIC is considering a number of alternatives for measuring the assessment base.

Optimal Size of the Insurance Fund

The Deposit Insurance Funds Act of 1996 set the Designated Reserve Ratio (DRR) for both insurance funds at 1.25 percent. The FDIC Board has the authority to raise either fund’s DRR for a calendar year if the Board foresees a significant risk of loss. The Act requires the Board to set assessment rates at a level that maintains the reserve ratio at the DRR. If the ratio falls below the DRR and remains there for more than one year, assessment rates must be set at a minimum of 23 basis points until the fund recovers. If the BIF reserve ratio exceeds the DRR, there are provisions to refund assessments to the best-rated banks. There are no refund

provisions for the SAIF. As of March 31, 1998, the balance of the BIF was $28.6 billion and its reserve ratio stood at 1.37 percent. The amount of the “excess” fund above 1.25 percent was $2.6 billion. However, assessment refunds currently are not possible because the best-rated banks are not paying assessments. There are two related concerns. First, should the law be modified to permit refunds of amounts above the DRR regardless of assessments paid? Second, is 1.25 percent the appropriate target for the size of the fund?

Refunds- If the refund law were liberalized, the result could be a “pay-as-you go” insurance system. This would permit rates to fluctuate widely during periods of adversity, and banks would be forced to pay significantly higher rates at times when many could least afford it. FDIC staff determined that assessment rates as high as 62 basis points would have been required during the 1980s if such a policy had been in effect. If there were some cushion in the fund above the DRR, assessment-rate increases could be forestalled or lessened when a downturn occurs. Rate increases also could be forestalled or lessened if the FDIC had more flexibility in setting rates when the reserve ratio falls below 1.25 percent.

Reserve ratio- In 1980, legislation established 1.25 percent as the midpoint of the range in which the reserve ratio was to be maintained. If the ratio surpassed 1.40 percent, refunds were required; and if the ratio fell below 1.10 percent, additional assessments were required. The 1996 Act eliminated the range and set the specific target at 1.25 percent. This topic has engendered much discussion – and disagreement – among regulators, bankers and analysts. The issue is at the heart of proposals to reform deposit insurance, both by those who wish fundamental changes and those who wish more modest improvements. Recent FDIC research found that in periods of very high losses, with assessment rates at 23 basis points, there is only a small chance of the BIF becoming insolvent. However, the reserve ratio is likely to fall well below the statutory minimum. It also was determined that increasing the minimum reserve ratio (to 1.50 percent, for example) would not permit substantially lower assessment rates in these circumstances. (Kevin P. Sheehan, “Capitalization of the Bank Insurance Fund,” *FDIC Working Paper 98-1*, Federal Deposit Insurance Corporation, Division of Research and Statistics (1998), pp. 29-31)

The paper cautions that the research was based on the BIF’s historical loss experience and that there is no guaranty that future banking crises will mirror historical events, given industry consolidation and other developments. If the industry were to encounter severe problems, it may be preferable to allow a deficient insurance fund to recapitalize more slowly and with lower assessment rates than are possible under current law.

TROUBLED ASSET RELIEF PROGRAM

On October 3, 2008, the Emergency Economic Stabilization Act was signed into law. The act established the Office of Financial Stability (OFS) within the Department of the Treasury (Treasury) and authorized the Troubled Asset Relief Program (TARP). Under the law, every 60 days, the U.S. Comptroller General is required to report on a variety of areas associated with oversight of TARP. The report reviewed (1) the activities undertaken through TARP as of November 25, 2008; (2) the structure of OFS, its use of contractors, and its system of internal controls; and (3) preliminary indicators of TARP’s performance.

Steps Taken

The U.S. Treasury took a number of steps to stabilize U.S. financial markets and the banking system, including injecting billions of dollars in financial institutions. Through the capital purchase program (CPP)—a preferred stock and warrant purchase program—Treasury

provided more than $150 billion in capital to 52 institutions as of November 25, 2008. As of December 2008, Treasury had yet to address a number of critical issues, including determining how it will ensure that CPP is achieving its intended goals and monitoring compliance with limitations on executive compensation and dividend payments. Moreover, further actions were needed to formalize transition planning efforts and establish an effective management structure and an essential system of internal control.

As of 12/08 it could not be determined whether the program was having the intended effect on credit and financial markets. Moreover, given that U.S. regulators as well as foreign governments were continuing to take a variety of actions aimed at stabilizing markets and the economy, separately evaluating the impact of Treasury's efforts under TARP was difficult.

Treasury Strategies to Mitigate Mortgage Foreclosures

Having decided against large purchases of troubled mortgage assets under TARP, Treasury stated that the agency was considering other ways to meet Congress' expectation that Treasury would work with lenders "to achieve aggressive loan modification standards" to mitigate foreclosures. As of November 25, 2008, it had not yet announced any specific programs. OFS established and hired a chief for the Office of the Chief of Homeownership Preservation within OFS. They stated that the OFS was working with other federal agencies, including FDIC, HUD, and FHFA, to explore alternatives to help homeowners under TARP. As OFS reviewed foreclosure mitigation program options, it considered a number of factors, including the cost of the program, the extent to which the program minimizes the recidivism of borrowers helped out of default, and the number of homeowners the program helped or was projected to help remain in their homes. A senior OFS official stated that the agency had considered loan modification strategies such as the program FDIC developed to convert nonperforming mortgages owned or serviced by IndyMac Federal Bank into affordable loans. Possible loan modification measures under such programs include interest rate reductions, extended loan terms, and deferred principal.

Sorry, I Cannot Pay

A Wall Street Journal story of 12/03/08 asked what you do if you've spent your career encouraging mortgage loans to people who can't repay them. This question was aimed at the creators of the (latest) mortgage mess. Now comes the time to pay the piper. At a hearing of the Financial Services Committee, FDIC Chair Sheila Bair outlined a plan to prevent an estimated 1.5 million foreclosures by the end of 2009. The idea was to modify more than two million loans at an estimated cost to taxpayers of $24 billion. The article observes that the real-world evidence suggests it will be far more difficult and expensive.
The live-fire test had been going on at failed lender IndyMac Bank since August. IndyMac hurt itself with sloppy underwriting and then was wounded further when Senator Charles Schumer released letters warning that "the bank could face a failure." A subsequent wave of withdrawals killed IndyMac, and the FDIC took over. The FDIC soon launched a program to modify IndyMac's troubled mortgages, and this was the basis for what Ms. Bair wanted to do nationwide.

Marketwatch.com reported on the FDIC's experience at IndyMac as well as industry-wide data from Lender Processing Services (LPS), which manages payments for much of the banking industry. It turned out that the FDIC was moving very slowly in modifying loans, but perhaps not slowly enough, because of the likelihood of further defaults. Three months into the IndyMac experiment, the FDIC modified 5,400 delinquent loans. Even the modified monthly payments

could consume up to 38% of borrowers' pretax income, a lot of failures were expected. The FDIC uses a re-default rate of 40% in its models but believes the actual rate will be lower. LPS says more than 50% of loans typically go delinquent again after modification.

To roll out its plan nationwide, the FDIC wanted to offer private loan servicers a new incentive to modify troubled loans. The private firms would do the same thing the feds have been doing at IndyMac, except they would move the monthly payment down to 31% of pretax income, instead of 38%. The FDIC would pay servicers $1,000 for every loan they modify, and taxpayers would share the losses if loans re-default. To get to 31%, lenders could offer borrowers lower rates, longer terms or even "principal forbearance." This means that part of the original loan would be converted to an interest rate of zero, and it would not have to be repaid until the home is sold or refinanced -- or the loan matures. In other words, the borrower gets lower payments now but may have a problem again later if home values don't rise and he needs to sell. Other modifications might create a lower interest rate now that rises over time, again squeezing borrowers at some future date. The article goes on to observe that this sounds like "subprime" loans.

Under the FDIC plan, a borrower would have to stay current for at least six months under the modified terms to make sure that lenders aren't just dumping their losers on taxpayers. Well, not all of their losers anyway. The FDIC is still assuming a 33% re-default rate, even at the lower debt-to-income ratio. All of this is why the White House estimates Ms. Bair's plan could cost as much as $70 billion next year -- not $24 billion.

Some may ask why anybody who borrowed or lent above the payment maximum of 33% of income threshold should receive assistance from taxpayers. Especially from those who are still paying the rent or mortgage on time. Others might wonder how lenders will know what a borrowers' income is in order to set the new ratio. False or undocumented income is the reason many of these loans failed the first time. At IndyMac, the feds were checking reported incomes against IRS data, but private lenders who participate in the new program will have more flexibility in "verifying" income. Such ‘flexibility’ lead to the Great Mortgage Market Meltdown. The article observes that this is another uncharted voyage into the land of taxpayer risk, and for little economic gain. It was hoped that news of the FDIC program did not encourage more people to stop paying their mortgages as they await rescue from Sheila Bair.

Insurers Adopt Thrift Holding Company Structure

On November 14, the deadline for financial institutions to file an application for the Department of the Treasury’s Capital Purchase Program (the “CaPP”), as authorized under the Emergency Economic Stabilization Act of 2008 (EESA), four large insurance companies announced proposed acquisitions of distressed thrifts. Hartford Financial Services Group acquired Federal Trust Corporation, which had been ordered by the Office of Thrift Supervision (the “OTS”) to find a buyer by November 15. The acquisition is contingent upon Hartford being able to secure approval to participate in the CaPP. Hartford has agreed that, if the acquisition is finalized, it would inject a significant amount of capital into the thrift. In addition, Genworth Financial agreed in principle to acquire Inter Savings Bank while Lincoln National Corp. will acquire Newton County Savings Bank. Similarly, Aegon NV’s U.S. subsidiary, Transamerica Corp., will acquire Suburban Federal Savings and Loan. Each of these insurers filed an application to participate in the CaPP. In addition, Phoenix Cos., a life and annuity insurer, filed a “placeholder” application with the OTS prior to the deadline, indicating that it would like to acquire a thrift in order to participate in the CaPP, but has not yet worked out the details of doing so.

Eligible for FDIC Liquidity Guarantee

As thrift holding companies, the insurance companies became eligible to apply to receive capital infusions under the CaPP and also to participate in the FDIC's Temporary Liquidity Guarantee Program (the "TLGP"). By acquiring a thrift institution and filing an application to become a thrift holding company, these insurance companies become "eligible institutions" under the TLGP. The TLGP is open to FDIC-insured depository institutions (banks and thrifts), U.S. bank holding companies (BHCs), U.S. financial holding companies, and U.S. thrift holding companies that engage in activities that are permissible for financial holding companies under Section 4(k) of the Bank Holding Company Act (which excludes primarily commercial activities). Affiliates of insured depository institutions also may participate, upon application to, and acceptance by, the FDIC in consultation with the institution's primary federal banking regulator.

The TLGP consists of two basic components: a temporary guarantee of newly issued senior unsecured debt (the "Debt Guarantee Program") and a temporary unlimited guarantee of funds in noninterest-bearing transaction accounts at FDIC-insured institutions (the "Transaction Account Guarantee Program"). Under the Debt Guarantee Program, the FDIC guarantees senior unsecured debt newly issued by an eligible institution. The maximum guaranteed amount is 125 percent of the par or face value of senior unsecured debt outstanding as of September 30, 2008 that is scheduled to mature by June 30, 2009. The guarantee will remain in place until the earlier of the debt's maturity or June 30, 2012. Under the Transaction Account Guarantee Program, the FDIC provides an unlimited guarantee until December 31, 2009 of all funds, regardless of amount, held in non-interest bearing transaction accounts. Both guarantees initially are automatic; however, eligible institutions must notify the FDIC by December 5, 2008 whether they wish to opt out of the programs. All commonly controlled institutions must make the same decision. By choosing to remain in the programs, participants, including the newly-eligible insurance companies, will be able to take advantage of the guarantees until the programs terminate, subject to payment of the applicable fees to the FDIC in exchange for the coverage.

In addition, through the CaPP, in light of their new status as thrift holding companies, insurers will be eligible to apply to receive infusions of capital from Treasury equal to 1% to 3% of their risk-weighted assets. To qualify for the CaPP, an institution must be an FDIC-insured depository institution which includes U.S. banks and savings associations not controlled by a BHC or thrift holding company, U.S. BHCs and U.S. thrift holding companies that are engaged predominately in Section 4(k) activities under the Bank Holding Company Act (BHCA), or whose depository institution subsidiaries are the subject of an application under Section 4(c)(8) of the BHCA. These capital injections will take the form of shares of preferred stock and warrants to purchase common stock. In connection with such infusions, the insurers also will be subject to the executive compensation and other limitations associated with the CaPP. For insurance companies, becoming a thrift holding company, even in order to access the EESA programs, will have certain potentially negative consequences that need to be considered. Conversion subjects the insurers and their non-thrift subsidiaries to regulation by the OTS, and limits the activities in which the insurers may participate. Moreover, inter-affiliate transactions will be constrained under applicable banking law, under a different and more rigorous regime than inter-affiliate transactions under applicable insurance law. As a result of their holding company status, the insurance companies and their non-thrift insurance subsidiaries will be subject to dual regulation by the OTS and state insurance commissioners.

Financial Holding Companies

Even prior to these decisions to convert to thrift holding company structure, several other insurance companies were already members of organizations that were financial holding companies, subject to federal regulation. Financial holding companies are a type of BHC that, in addition to the activities permitted for BHCs, can engage, through their affiliates, in certain enumerated financial activities, including insurance. In addition, many insurance companies already hold savings and loans as subsidiaries, again, subjecting them to additional regulation. Considering this, there should be considerable experience with this dual regulation and it is unlikely to raise significant conflicts. The recent decisions by insurance companies to adopt thrift holding company structures in order to become eligible for federal assistance follows the determination of several other companies to adopt BHC structures for the same or similar purposes--the most recent of which was American Express.

The federal bailout of American International Group and the conversion of Goldman Sachs and Morgan Stanley (each of which have insurance company subsidiaries) to BHCs have expanded the numbers of insurance company organizations subject to the consequent regulation by a federal regulator, such as the OTS or the Federal Reserve. Although there is no direct regulation of the insurance operations of such institutions, exposure to these regulators may ease concerns over federal oversight of insurance in place of traditional state insurance regulation. Familiarity with federal regulation also may strengthen calls for a consolidated form of federal insurance regulation. In addition to centralized information-sharing, such proposals include the issuance of optional federal charters to insurers. Generally, insurance industry trade associations representing large multi-state insurance companies favor such an approach, although state insurance regulators, concerned that a federal regulator would not be in a position to monitor consumer protection in a targeted fashion, oppose such suggestions. Thus, although regulation by federal bank regulators will not resolve the efficacy of uniform insurance regulation across state boundaries, proponents are likely to seize upon the economic and financial factors underlying these conversions to federally regulated status and any positive experience under such regimes as additional support for consolidated regulation

Bank Practices and Supervisory Ratings

In the discussion of risk-based premiums mentioned previously, it was stated that institutions are categorized in the rate-cell matrix according to their capital subgroup and their supervisory subgroup. The former is determined semiannually, using the most recent Report of Condition. The latter is determined primarily from an institution’s most recent examination rating, although other factors sometimes are considered. As required by law, institutions generally are examined every 12 to 18 months. Those undertaking unacceptable risks, therefore, would not be penalized by the assessment system unless and until the risk-taking resulted in a supervisory rating downgrade. At this time, the FDIC is concerned about eroding underwriting standards and other such practices that often appear late in a business cycle in an effort to sustain high profits. However, this has not yet been reflected in any appreciable movement of institutions out the best-rated, 1A cell of the assessment rate matrix. This may be due, in part, to the unavoidable lag in the examination process. The FDIC is considering ways to identify in a more timely manner changes in bank practices that result in greater risks to the deposit insurance funds.

Chart FDIC Key Statistics

Estimated Insured Deposits and the Deposit Insurance Fund, December 31, 1934, through September 30, 2007[1]

		Deposits in Insured Banks ($ Millions)				Insurance Fund as a Percentage of	
Year[4]	Insurance Coverage	Total Domestic Deposits	Estimated Insured Deposits [2]	Percentage of Insured Deposits	Deposit Insurance Fund	Total Domestic Deposits	Estimated Insured Deposits
2007	**$100,000**	**$6,881,843**	**$4,241,307**	**61.6**	**$51,754.4**	**0.75**	**1.22**
2006	100,000	6,595,357	4,151,966	63.0	50,165.3	0.76	1.21
2005	100,000	6,168,146	3,890,911	63.1	48,596.6	0.79	1.25
2004	100,000	5,686,680	3,623,713	63.7	47,506.8	0.84	1.31
2003	100,000	5,182,016	3,451,117	66.6	46,022.3	0.89	1.33
2002	100,000	4,857,327	3,387,799	69.7	43,797.0	0.90	1.29
2001	100,000	4,481,888	3,210,727	71.6	41,373.8	0.92	1.29
2000	100,000	4,149,355	3,054,360	73.6	41,733.8	1.01	1.37
1999	100,000	3,802,744	2,868,881	75.4	39,694.9	1.04	1.38
1998	100,000	3,747,809	2,850,227	76.1	39,452.1	1.05	1.38
1997	100,000	3,507,493	2,746,006	78.3	37,660.8	1.07	1.37
1996	100,000	3,350,856	2,690,537	80.3	35,742.8	1.07	1.33
1995	100,000	3,318,513	2,663,560	80.3	28,811.5	0.87	1.08
1994	100,000	3,184,636	2,588,686	81.3	23,784.5	0.75	0.92
1993	100,000	3,220,109	2,602,043	80.8	14,277.3	0.44	0.55
1992	100,000	3,273,180	2,675,081	81.7	178.4	0.01	0.01
1991	100,000	3,330,738	2,734,073	82.1	(6,934.0)	(0.21)	(0.25)
1990	100,000	3,415,668	2,759,640	80.8	4,062.7	0.12	0.15
1989	100,000	3,414,066	2,756,757	80.7	13,209.5	0.39	0.48
1988	100,000	2,330,768	1,750,259	75.1	14,061.1	0.60	0.80
1987	100,000	2,201,549	1,658,802	75.3	18,301.8	0.83	1.10
1986	100,000	2,167,596	1,634,302	75.4	18,253.3	0.84	1.12
1985	100,000	1,974,512	1,503,393	76.1	17,956.9	0.91	1.19
1984	100,000	1,806,520	1,389,874	76.9	16,529.4	0.92	1.19
1983	100,000	1,690,576	1,268,332	75.0	15,429.1	0.91	1.22
1982	100,000	1,544,697	1,134,221	73.4	13,770.9	0.89	1.21
1981	100,000	1,409,322	988,898	70.2	12,246.1	0.87	1.24
1980	100,000	1,324,463	948,717	71.6	11,019.5	0.83	1.16
1979	40,000	1,226,943	808,555	65.9	9,792.7	0.80	1.21
1978	40,000	1,145,835	760,706	66.4	8,796.0	0.77	1.16
1977	40,000	1,050,435	692,533	65.9	7,992.8	0.76	1.15
1976	40,000	941,923	628,263	66.7	7,268.8	0.77	1.16
1975	40,000	875,985	569,101	65.0	6,716.0	0.77	1.18
1974	40,000	833,277	520,309	62.5	6,124.2	0.73	1.18
1973	20,000	766,509	465,600	60.7	5,615.3	0.73	1.21
1972	20,000	697,480	419,756	60.2	5,158.7	0.74	1.23
1971	20,000	610,685	374,568	61.3	4,739.9	0.78	1.27

1970	20,000	545,198	349,581	64.1	4,379.6	0.80	1.25
1969	20,000	495,858	313,085	63.1	4,051.1	0.82	1.29
1968	15,000	491,513	296,701	60.2	3,749.2	0.76	1.26
1967	15,000	448,709	261,149	58.2	3,485.5	0.78	1.33
1966	15,000	401,096	234,150	58.4	3,252.0	0.81	1.39
1965	10,000	377,400	209,690	55.6	3,036.3	0.80	1.45
1964	10,000	348,981	191,787	55.0	2,844.7	0.82	1.48
1963	10,000	313,304	177,381	56.6	2,667.9	0.85	1.50
1962	10,000	297,548	170,210	57.2	2,502.0	0.84	1.47
1961	10,000	281,304	160,309	57.0	2,353.8	0.84	1.47
1960	10,000	260,495	149,684	57.5	2,222.2	0.85	1.48
1959	10,000	247,589	142,131	57.4	2,089.8	0.84	1.47
1958	10,000	242,445	137,698	56.8	1,965.4	0.81	1.43
1957	10,000	225,507	127,055	56.3	1,850.5	0.82	1.46
1956	10,000	219,393	121,008	55.2	1,742.1	0.79	1.44
1955	10,000	212,226	116,380	54.8	1,639.6	0.77	1.41
1954	10,000	203,195	110,973	54.6	1,542.7	0.76	1.39
1953	10,000	193,466	105,610	54.6	1,450.7	0.75	1.37
1952	10,000	188,142	101,841	54.1	1,363.5	0.72	1.34
1951	10,000	178,540	96,713	54.2	1,282.2	0.72	1.33
1950	10,000	167,818	91,359	54.4	1,243.9	0.74	1.36
1949	5,000	156,786	76,589	48.8	1,203.9	0.77	1.57
1948	5,000	153,454	75,320	49.1	1,065.9	0.69	1.42
1947	5,000	154,096	76,254	49.5	1,006.1	0.65	1.32
1946	5,000	148,458	73,759	49.7	1,058.5	0.71	1.44
1945	5,000	157,174	67,021	42.4	929.2	0.59	1.39
1944	5,000	134,662	56,398	41.9	804.3	0.60	1.43
1943	5,000	111,650	48,440	43.4	703.1	0.63	1.45
1942	5,000	89,869	32,837	36.5	616.9	0.69	1.88
1941	5,000	71,209	28,249	39.7	553.5	0.78	1.96
1940	5,000	65,288	26,638	40.8	496.0	0.76	1.86
1939	5,000	57,485	24,650	42.9	452.7	0.79	1.84
1938	5,000	50,791	23,121	45.5	420.5	0.83	1.82
1937	5,000	48,228	22,557	46.8	383.1	0.79	1.70
1936	5,000	50,281	22,330	44.4	343.4	0.68	1.54
1935	5,000	45,125	20,158	44.7	306.0	0.68	1.52
1934 [3]	5,000	40,060	18,075	45.1	291.7	0.73	1.61

[1] For 2007, the numbers are as of September 30, and prior years reflect December 31.
[2] Estimated insured deposits reflect deposit information as reported in the fourth quarter *FDIC Quarterly Banking Profile*. Before 1991, insured deposits were estimated using percentages determined from the June 30 *Call Reports*.
[3] Initial coverage was $2,500 from January 1 to June 30, 1934.
[4]For 1989 through 2005, amounts represent sum of separate BIF and SAIF amounts.

Recoveries and Losses by the Deposit Insurance Fund on Disbursements for the Protection of Depositors, 1934 through 2007 (Dollars in Thousands)							
All Cases [1]							
Year[3]	**Number of Banks/ Thrifts**	**Total Assets**	**Total Deposits**	**Disbursements**	**Recoveries**	**Estimated Additional Recoveries**	**Estimated Losses**
Total	**2,237**	**$304,015,397**	**$248,393,951**	**$116,900,087**	**$77,665,701**	**$797,140**	**$38,437,246**
2007	**3**	**2,614,928**	**2,026,648**	**1,909,549**	**1,315,770**	**474,240**	**119,539**
2006	0	0	0	0	0	0	0
2005	0	0	0	0	0	0	0
2004	4	165,866	145,885	138,895	134,978	0	3,917
2003	3	1,096,724	903,504	883,772	812,933	4,852	65,987
2002	11	2,557,811	2,175,043	2,068,519	1,628,771	63,928	375,820
2001	4	2,234,253	1,610,474	1,605,147	1,113,270	220,457	271,420
2000	7	407,618	340,533	297,313	265,175	0	32,138
1999	8	1,486,775	1,331,578	1,307,045	685,154	6,324	615,567
1998	3	370,400	335,076	286,678	52,248	8,388	226,042
1997	1	25,921	26,800	25,546	20,520	0	5,026
1996	6	215,078	200,973	201,533	140,904	0	60,629
1995	6	753,024	632,700	609,043	524,571	0	84,472
1994	13	1,392,140	1,236,488	1,224,769	1,045,718	0	179,051
1993	42	4,405,373	3,827,177	3,841,658	3,199,024	9,884	632,750
1992	122	44,231,922	41,184,366	14,175,372	10,506,614	1,772	3,666,986
1991	127	63,203,713	53,832,141	21,196,493	15,197,510	2,636	5,996,347
1990	169	15,676,700	14,488,900	10,817,419	8,041,634	4,659	2,771,126
1989	207	29,168,596	24,090,551	11,445,829	5,248,247	0	6,197,582
1988	280	70,065,789	45,499,102	12,163,006	5,244,866	0	6,918,140
1987	203	9,366,300	8,399,500	5,037,871	3,015,215	0	2,022,656
1986	145	7,710,400	7,056,700	4,790,969	3,015,252	0	1,775,717
1985	120	8,741,268	8,059,441	2,920,687	1,913,452	0	1,007,235
1984	80	3,276,411	2,883,162	7,696,215	6,056,061	0	1,640,154
1983	48	7,026,923	5,441,608	3,807,082	2,400,044	0	1,407,038
1982	42	11,632,415	9,908,379	2,275,150	1,106,579	0	1,168,571
1981	10	4,863,898	3,829,936	888,999	107,221	0	781,778
1980	11	244,117	221,302	152,355	121,675	0	30,680
1934-79	562	11,081,034	8,705,984	5,133,173	4,752,295	0	380,878

Recoveries and Losses by the Deposit Insurance Fund on Disbursements for the Protection of Depositors, 1934 through 2007 (Dollars in Thousands)							
Deposit Assumption Cases							
Year[3]	**Number of Banks/ Thrifts**	**Total Assets**	**Total Deposits**	**Disbursements**	**Recoveries**	**Estimated Additional Recoveries**	**Estimated Losses**
Total	**1,487**	**$225,210,798**	**$187,228,603**	**$89,334,347**	**$60,163,198**	**$734,127**	**$28,437,022**
2007	**3**	**2,614,928**	**2,026,648**	**1,909,549**	**1,315,770**	**474,240**	**119,539**
2006	0	0	0	0	0	0	0
2005	0	0	0	0	0	0	0
2004	3	150,520	132,880	132,781	128,864	0	3,917
2003	3	1,096,724	903,504	883,772	812,933	4,852	65,987
2002	6	569,332	511,782	483,461	342,991	5,574	134,896
2001	4	2,234,253	1.610,474	1,605,147	1,113,270	220,457	271,420
2000	7	407,618	340,533	297,313	265,175	0	32,138
1999	8	1,486,775	1,331,578	1,307,045	685,154	6,324	615,567
1998	3	370,400	335,076	286,678	52,248	8,388	226,042
1997	1	25,921	26,800	25,546	20,520	0	5,026
1996	6	215,078	200,973	201,533	140,904	0	60,629
1995	6	753,024	632,700	609,043	524,571	0	84,472
1994	13	1,392,140	1,236,488	1,224,769	1,045,718	0	179,051
1993	37	4,098,618	3,556,005	3,580,297	3,036,275	9,884	534,138
1992	95	42,147,689	39,132,496	12,280,562	9,104,192	1,772	3,174,598
1991	103	61,593,332	52,274,435	19,938,700	14,410,415	2,636	5,525,649
1990	148	13,138,300	12,215,600	8,629,084	6,397,473	0	2,231,611
1989	174	26,811,496	21,931,451	9,326,725	3,985,855	0	5,340,870
1988	164	34,421,089	23,652,902	9,180,495	4,232,545	0	4,947,950
1987	133	4,311,700	4,020,700	2,773,202	1,613,502	0	1,159,700
1986	98	5,657,100	5,217,200	3,476,140	2,209,924	0	1,266,216
1985	87	2,235,182	2,000,044	1,631,166	1,095,601	0	535,565
1984	62	1,905,924	1,603,923	1,373,198	941,674	0	431,524
1983	35	3,194,452	2,275,313	2,893,969	1,850,553	0	1,043,416
1982	25	681,025	552,436	268,372	213,578	0	54,794
1981	5	4,808,042	3,778,486	79,208	71,358	0	7,850
1980	7	218,332	199,846	138,623	110,248	0	28,375
1934-79	251	8,671,804	5,528,330	4,797,969	4,441,887	0	356,082

Recoveries and Losses by the Deposit Insurance Fund on Disbursements for the Protection of Depositors, 1934 through 2007 (Dollars in Thousands)							
Deposit Payoff Cases[2]							
Year[3]	**Number of Banks/ Thrifts**	**Total Assets**	**Total Deposits**	**Disbursements**	**Recoveries**	**Estimated Additional Recoveries**	**Estimated Losses**
Total	**609**	**$18,687,250**	**$17,157,091**	**$15,935,384**	**$11,302,628**	**$63,013**	**$4,569,743**
2007	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2006	0	0	0	0	0	0	0
2005	0	0	0	0	0	0	0
2004	1	15,346	13,005	6,114	6,114	0	0
2003	0	0	0	0	0	0	0
2002	5	1,988,479	1,663,261	1,585,058	1,285,780	58,354	240,924
2001	0	0	0	0	0	0	0
2000	0	0	0	0	0	0	0
1999	0	0	0	0	0	0	0
1998	0	0	0	0	0	0	0
1997	0	0	0	0	0	0	0
1996	0	0	0	0	0	0	0
1995	0	0	0	0	0	0	0
1994	0	0	0	0	0	0	0
1993	5	306,755	271,172	261,361	162,749	0	98,612
1992	25	2,049,320	2,018,402	1,893,324	1,401,186	0	492,138
1991	21	1,526,538	1,477,328	1,251,676	784,002	0	467,674
1990	20	2,522,500	2,257,700	2,183,400	1,641,564	4,659	537,177
1989	32	2,280,100	2,086,100	2,116,556	1,262,140	0	854,416
1988	36	1,276,700	1,278,400	1,252,160	822,612	0	429,548
1987	51	2,539,000	2,260,800	2,103,792	1,401,000	0	702,792
1986	40	1,334,500	1,253,900	1,155,981	739,659	0	416,322
1985	29	610,156	548,986	523,789	411,175	0	112,614
1984	16	855,568	784,597	791,838	699,483	0	92,355
1983	9	164,037	160,998	148,423	122,484	0	25,939
1982	7	585,418	538,917	277,240	206,247	0	70,993
1981	2	51,018	47,536	35,736	34,598	0	1,138
1980	3	17,832	16,454	13,732	11,427	0	2,305
1934-79	307	563,983	479,535	335,204	310,408	0	24,796

Recoveries and Losses by the Deposit Insurance Fund on Disbursements for the Protection of Depositors, 1934 through 2007 (Dollars in Thousands)							
Assistance Transactions							
Year [3]	**Number of Banks/ Thrifts**	**Total Assets**	**Total Deposits**	**Disbursements**	**Recoveries**	**Estimated Additional Recoveries**	**Estimated Losses**
Total	**141**	**$60,117,349**	**$44,008,257**	**$11,630,356**	**$6,199,875**	**$0**	**$5,430,481**
2007	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2006	0	0	0	0	0	0	0
2005	0	0	0	0	0	0	0
2004	0	0	0	0	0	0	0
2003	0	0	0	0	0	0	0
2002	0	0	0	0	0	0	0
2001	0	0	0	0	0	0	0
2000	0	0	0	0	0	0	0
1999	0	0	0	0	0	0	0
1998	0	0	0	0	0	0	0
1997	0	0	0	0	0	0	0
1996	0	0	0	0	0	0	0
1995	0	0	0	0	0	0	0
1994	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0
1992	2	34,913	33,468	1,486	1,236	0	250
1991	3	83,843	80,378	6,117	3,093	0	3,024
1990	1	15,900	15,600	4,935	2,597	0	2,338
1989	1	77,000	73,000	2,548	252	0	2,296
1988	80	34,368,000	20,567,800	1,730,351	189,709	0	1,540,642
1987	19	2,515,600	2,118,000	160,877	713	0	160,164
1986	7	718,800	585,600	158,848	65,669	0	93,179
1985	4	5,895,930	5,510,411	765,732	406,676	0	359,056
1984	2	514,919	494,642	5,531,179	4,414,904	0	1,116,275
1983	4	3,668,434	3,005,297	764,690	427,007	0	337,683
1982	10	10,365,972	8,817,026	1,729,538	686,754	0	1,042,784
1981	3	4,838	3,914	774,055	1,265	0	772,790
1980	1	7,953	5,002	0	0	0	0
1934-79	4	1,845,247	2,698,119	0	0	0	0

[1] Totals do not include dollar amounts for the five open bank assistance transactions between 1971 and 1980. Excludes eight transactions prior to 1962 that required no disbursements. Also, disbursements, recoveries, and estimated additional recoveries do not include working capital advances to and repayments by receiverships.
[2] Includes insured deposit transfer cases.
[3] For 1989 through 2005, amounts represent sum of separate BIF and SAIF amounts.
Note: Total Assets and Total Deposits data is based upon the last Call Report filed by institution prior to failure.

Beginning with the 1997 Annual Report, the number of banks in the Assistance Transactions column for 1988 was changed from 21 to 80 and the number of banks in the All Cases column was changed from 221 to 280 to reflect that one assistance transaction encompassed 60 institutions. Also, certain 1982, 1983, 1989 and 1992 resolutions previously reported in either the Deposit Payoff or Deposit Assumption categories were reclassified.

Income and Expenses, Deposit Insurance Fund, from Beginning of Operations, September 11, 1933, through December 31, 2007
Dollars in Millions

Income						Expenses and Losses					
Year[7]	Total	Assessment Income	Assessment Credits	Investment and Other Sources	Effective Assessment Rate[1]	Total	Provision for Losses	Administrative and Operating Expenses[2]	Interest and Other Insurance Expenses	Funding Transfer from the FSLIC Resolution Fund	Net Income/ (Loss)
Total	**$110,388.7**	**$62,909.8**	**$6,709.1**	**$54,777.0**		**$59,216.0**	**$36,191.8**	**$15,834.3**	**$7,195.9**	**$139.5**	**$51,312.2**
2007	**3,196.2**	**642.9**	**0.0**	**2,553.3**	**0.0094%**	**1,090.9**	**95.0**	**992.6**	**3.3**	**0**	**2,105.3**
2006	2,643.5	31.9	0.0	2,611.6	0.0005%	904.3	(52.1)	950.6	5.8	0	1,739.2
2005	2,420.5	60.9	0.0	2,359.6	0.0010%	809.3	(160.2)	965.7	3.8	0	1,611.2
2004	2,240.4	104.3	0.0	2,136.1	0.0019%	607.6	(353.4)	941.3	19.7	0	1,632.8
2003	2,174.0	95.2	0.0	2,078.8	0.0019%	(67.7)	(1,010.5)	935.5	7.3	0	2,241.7
2002	1,795.9	108.0	0.0	2,276.9	0.0022%	719.6	(243.0)	945.1	17.5	0	1,076.3
2001	2,729.7	82.8	0.0	2,646.9	0.0019%	3,123.4	2,199.3	887.9	36.2	0	(393.7)
2000	2,569.9	64.1	0.0	2,505.8	0.0016%	945.2	28.0	883.9	33.3	0	1,624.7
1999	2,416.6	48.3	0.0	2,368.3	0.0013%	2,047.0	1,199.7	823.4	23.9	0	369.6
1998	2,584.3	36.7	0.0	2,547.6	0.0010%	817.5	(5.7)	782.6	40.6	0	1,766.8
1997	2,165.6	38.7	0.0	2,126.9	0.0015%	247.3	(505.7)	677.2	75.8	0	1,918.3
1996	7,157.3	5,294.7	0.0	1,862.6	0.1627%	353.6	(417.2)	568.3	202.5	0	6,803.7
1995	5,229.1	3,876.9	0.0	1,352.2	0.1242%	202.2	(354.2)	510.6	45.8	0	5,026.9
1994	7,682.0	6,722.6	0.0	959.4	0.2185%	(1,825.1)	(2,459.4)	443.2	191.1	0	9,507.1
1993	7,356.8	6,684.3	0.0	672.5	0.2146%	(6,744.4)	(7,660.4)	418.5	497.5	0	14,101.2
1992	6,480.5	5,759.8	0.0	720.7	0.1807%	(596.8)	(2,274.7)	614.8[3]	1,063.1	35.4	7,112.7
1991	5,887.0	5,254.5	0.0	632.5	0.1605%	16,925.3	15,496.2	326.1	1,103.0	42.4	(10,995.9)
1990	3,856.3	2,873.3	0.0	983.0	0.0867%	13,059.3	12,133.1	275.6	650.6	56.1	(9,146.9)
1989	3,496.6	1,885.0	0.0	1,611.6	0.0001%	4,352.2	3,811.3	219.9	321.0	5.6	(850.0)
1988	3,347.7	1,773.0	0.0	1,574.7	0.0833%	7,588.4	6,298.3	223.9	1,066.2	0	(4,240.7)
1987	3,319.4	1,696.0	0.0	1,623.4	0.0833%	3,270.9	2,996.9	204.9	69.1	0	48.5
1986	3,260.1	1,516.9	0.0	1,743.2	0.0833%	2,963.7	2,827.7	180.3	(44.3)	0	296.4

1985	3,385.4	1,433.4	0.0	1,952.0	0.0833%	1,957.9	1,569.0	179.2	209.7	0	1,427.5
1984	3,099.5	1,321.5	0.0	1,778.0	0.0800%	1,999.2	1,633.4	151.2	214.6	0	1,100.3
1983	2,628.1	1,214.9	164.0	1,577.2	0.0714%	969.9	675.1	135.7	159.1	0	1,658.2
1982	2,524.6	1,108.9	96.2	1,511.9	0.0769%	999.8	126.4	129.9	743.5	0	1,524.8
1981	2,074.7	1,039.0	117.1	1,152.8	0.0714%	848.1	320.4	127.2	400.5	0	1,226.6
1980	1,310.4	951.9	521.1	879.6	0.0370%	83.6	(38.1)	118.2	3.5	0	1,226.8
1979	1,090.4	881.0	524.6	734.0	0.0333%	93.7	(17.2)	106.8	4.1	0	996.7
1978	952.1	810.1	443.1	585.1	0.0385%	148.9	36.5	103.3	9.1	0	803.2
1977	837.8	731.3	411.9	518.4	0.0370%	113.6	20.8	89.3	3.5	0	724.2
1976	764.9	676.1	379.6	468.4	0.0370%	212.3	28.0	180.4[4]	3.9	0	552.6
1975	689.3	641.3	362.4	410.4	0.0357%	97.5	27.6	67.7	2.2	0	591.8
1974	668.1	587.4	285.4	366.1	0.0435%	159.2	97.9	59.2	2.1	0	508.9
1973	561.0	529.4	283.4	315.0	0.0385%	108.2	52.5	54.4	1.3	0	452.8
1972	467.0	468.8	280.3	278.5	0.0333%	59.7	10.1	49.6	6.0[5]	0	407.3
1971	415.3	417.2	241.4	239.5	0.0345%	60.3	13.4	46.9	0.0	0	355.0
1970	382.7	369.3	210.0	223.4	0.0357%	46.0	3.8	42.2	0.0	0	336.7
1969	335.8	364.2	220.2	191.8	0.0333%	34.5	1.0	33.5	0.0	0	301.3
1968	295.0	334.5	202.1	162.6	0.0333%	29.1	0.1	29.0	0.0	0	265.9
1967	263.0	303.1	182.4	142.3	0.0333%	27.3	2.9	24.4	0.0	0	235.7
1966	241.0	284.3	172.6	129.3	0.0323%	19.9	0.1	19.8	0.0	0	221.1
1965	214.6	260.5	158.3	112.4	0.0323%	22.9	5.2	17.7	0.0	0	191.7
1964	197.1	238.2	145.2	104.1	0.0323%	18.4	2.9	15.5	0.0	0	178.7
1963	181.9	220.6	136.4	97.7	0.0313%	15.1	0.7	14.4	0.0	0	166.8
1962	161.1	203.4	126.9	84.6	0.0313%	13.8	0.1	13.7	0.0	0	147.3
1961	147.3	188.9	115.5	73.9	0.0323%	14.8	1.6	13.2	0.0	0	132.5
1960	144.6	180.4	100.8	65.0	0.0370%	12.5	0.1	12.4	0.0	0	132.1
1959	136.5	178.2	99.6	57.9	0.0370%	12.1	0.2	11.9	0.0	0	124.4
1958	126.8	166.8	93.0	53.0	0.0370%	11.6	0.0	11.6	0.0	0	115.2
1957	117.3	159.3	90.2	48.2	0.0357%	9.7	0.1	9.6	0.0	0	107.6
1956	111.9	155.5	87.3	43.7	0.0370%	9.4	0.3	9.1	0.0	0	102.5
1955	105.8	151.5	85.4	39.7	0.0370%	9.0	0.3	8.7	0.0	0	96.8

1954	99.7	144.2	81.8	37.3	0.0357%	7.8	0.1	7.7	0.0	0	91.9
1953	94.2	138.7	78.5	34.0	0.0357%	7.3	0.1	7.2	0.0	0	86.9
1952	88.6	131.0	73.7	31.3	0.0370%	7.8	0.8	7.0	0.0	0	80.8
1951	83.5	124.3	70.0	29.2	0.0370%	6.6	0.0	6.6	0.0	0	76.9
1950	84.8	122.9	68.7	30.6	0.0370%	7.8	1.4	6.4	0.0	0	77.0
1949	151.1	122.7	0.0	28.4	0.0833%	6.4	0.3	6.1	0.0	0	144.7
1948	145.6	119.3	0.0	26.3	0.0833%	7.0	0.7	6.3[6]	0.0	0	138.6
1947	157.5	114.4	0.0	43.1	0.0833%	9.9	0.1	9.8	0.0	0	147.6
1946	130.7	107.0	0.0	23.7	0.0833%	10.0	0.1	9.9	0.0	0	120.7
1945	121.0	93.7	0.0	27.3	0.0833%	9.4	0.1	9.3	0.0	0	111.6
1944	99.3	80.9	0.0	18.4	0.0833%	9.3	0.1	9.2	0.0	0	90.0
1943	86.6	70.0	0.0	16.6	0.0833%	9.8	0.2	9.6	0.0	0	76.8
1942	69.1	56.5	0.0	12.6	0.0833%	10.1	0.5	9.6	0.0	0	59.0
1941	62.0	51.4	0.0	10.6	0.0833%	10.1	0.6	9.5	0.0	0	51.9
1940	55.9	46.2	0.0	9.7	0.0833%	12.9	3.5	9.4	0.0	0	43.0
1939	51.2	40.7	0.0	10.5	0.0833%	16.4	7.2	9.2	0.0	0	34.8
1938	47.7	38.3	0.0	9.4	0.0833%	11.3	2.5	8.8	0.0	0	36.4
1937	48.2	38.8	0.0	9.4	0.0833%	12.2	3.7	8.5	0.0	0	36.0
1936	43.8	35.6	0.0	8.2	0.0833%	10.9	2.6	8.3	0.0	0	32.9
1935	20.8	11.5	0.0	9.3	0.0833%	11.3	2.8	8.5	0.0	0	9.5
1933-34	7.0	0.0	0.0	7.0	N/A	10.0	0.2	9.8	0.0	0	(3.0)

[1]The effective rates from 1950 through 1984 vary from the statutory rate of 0.0833 percent due to assessment credits provided in those years. The statutory rate increased to 0.12 percent in 1990 and to a minimum of 0.15 percent in 1991. The effective rates in 1991 and 1992 vary because the FDIC exercised new authority to increase assessments above the statutory rate when needed. Beginning in 1993, the effective rate is based on a risk-related premium system under which institutions pay assessments in the range of 0.23 percent to 0.31 percent. In May 1995, the BIF reached the mandatory recapitalization level of 1.25 percent. As a result, BIF assessment rates were reduced to a range of 0.04 percent to 0.31 percent of assessable deposits, effective June 1995, and assessments totaling $1.5 billion were refunded in September 1995. Assessment rates for BIF were lowered again to a range of 0 to 0.27 percent of assessable deposits, effective the start of 1996. In 1996, the SAIF collected a one-time special assessment of $4.5 billion that fully capitalized the fund. Consequently, assessment rates for SAIF were lowered to the same range as DIF, effective October 1996. This range of rates remained unchanged for both funds through 2006. As part of the implementation of the Federal Deposit Insurance Reform Act of 2005, assessment rates were increased to a range of 0.05 percent to 0.43 percent of assessable deposits effective at the start of 2007, but many institutions received a one-time assessment credit ($4.7 billion in total) to offset the new assessments.

[2] These expenses, which are presented as operating expenses in the Statements of Income and Fund Balance, pertain to the FDIC in its corporate capacity

only and **do not** include costs that are charged to the failed bank receiverships that are managed by the FDIC. The receivership expenses are presented as part of the "Receivables from Resolutions, net" line on the Balance Sheets. The information presented in the "FDIC Expenditures" table on page 108 of this report shows the aggregate (corporate and receivership) expenditures of the FDIC.

[3] Includes $210 million for the cumulative effect of an accounting change for certain postretirement benefits.

[4] Includes $105.6 million net loss on government securities.

[5] This amount represents interest and other insurance expenses from 1933 to 1972.

[6] Includes interest paid on capital stock.

[7] For 1989 through 2005, amounts represent sum of separate BIF and SAIF amounts.

CHAPTER 16 ETHICS AND THE PROFESSIONAL

For a society to function, rules are necessary. Without rules and enforcement, there can only be anarchy. Ideally, the values basic to a civilized society are handed down to individuals through customs. These are rules of behavior that over generations have been found to help make it possible for people to live together peacefully. Observing these rules is largely a result of family training and peer pressure.

ETHICS AND THE LAW

There are always individuals who through ignorance, lack of training, or sheer perversity will not follow the rules. Penalties for rule-breakers make up the basic legal system of a society, backing up customs with force. Every civilized society is founded on law, and none has ever survived without it.

Ethics goes further than law in determining everyday behavior. Law cannot cover every aspect of human relationships. Personal ethics, or individual morality, has been called "what one does when nobody is looking." Law, on the other hand, sets standards for behavior in situations involving other people, and backs those standards with the power invested in law enforcement.

The subject of ethics has been prevalent in the insurance industry since the early days of insurance. In Europe, regulation was found to be a means of enforced ethics within the industry.

RISE OF REGULATION

In America, the original pattern of expansion filled legitimate needs. The insurance industry, as well as of other forms of business, grew eventually into a relentless drive for more and more success.

The results of this uncontrolled expansion and unethical practices brought on a demand for regulation. In the insurance business, state laws and licensing practices gradually developed to set required standards for companies and agents.

At the beginning of the 19th century there were only five million people in the United States, 90 percent of them farmers. There were only six cities in the country with a population of more than 8,000.

The growing cities produced an increasingly complex society in 19th century America. Individuals working for wages in a cash economy could no longer live the self-sufficient lives of their rural ancestors. In this setting, insurance rapidly became a recognized necessity for the protection of families and property.

Early insurance companies had waited for customers to come to them. As time went on and more insurers competed for business. It became the practice to advertise and send out agents in an aggressive effort at expansion. Many of these agents had little training or understanding of the principles involved in the policies they were selling.

Insurance stock companies were organized to take advantage of the growing market, and unregulated expansion continued. From 1830 to 1850, insurance in force increased by more than 3,000 per cent. After the Civil War, the growth rate of the industry was even faster. The amount of

insurance in force increased at 50 per cent a year, reaching a total of two billion dollars by the end of the 1860s.

The Civil War brought unprecedented demand for manufactured goods. After the war American enterprise continued at a fast pace. New industries sprang up. Railroads crossed the continent. Cables crossed the oceans. Coal, copper, iron mines fed the factories. America was on its way to becoming the industrial colossus of the world.

STANDARDS DECLINE

In the excitement, attitudes changed. Business and political life were no longer governed by the ethical standards once taken for granted. Tax and other scandals rocked Washington during the Grant administration. Business was drawn into wildcat schemes, stock-watering, and embezzlement.

Insurance executives and agents concentrated on achieving personal power and prestige through business success. There were exaggerated advertising claims, carelessly written risks, and recklessly raised commissions.

ETHICS MADE INTO LAWS

The Massachusetts legislature in 1858 was the first to pass a law making a version of Wright's legal reserve principle a requirement for insurers. A state insurance department was created to enforce the new law and Elizur Wright became its head.

As the western part of the country was settled, the insurance industry again expanded its horizons. New companies grew up to offer insurance in the growing western cities as transportation and manufacturing facilities followed the trails blazed by the pioneers.

People moved about more, and travel restrictions were removed from insurance policies. Prudential pioneered insurance for low-income groups and it became widely accepted. By the end of the 19th century, the total of insurance in force in the United States had risen to seven and a half billion dollars.
Rapid growth again led to difficulties. Since insurance companies were the custodians of much of the nation's wealth, attention focused on them as a new "muckraking" phase of attacks on questionable business practices began shortly after the turn of the century. There was a renewed public demand for investigation of the insurance industry.

The Armstrong Investigating Committee in 1905, with Charles Evans Hughes as its chief counsel, turned its attention to insurance practices in New York. Its recommendations, backed by responsible insurance companies, resulted in the adoption of the New York Insurance Code in 1906. State supervision of insurance practices was tightened by this code, and eventually public confidence in the insurance industry was restored. Throughout the 20th century insurance regulation has grown.

The National Association of Insurance Commissioners (NAIC), a group made up of insurance officials from all states, has drafted model legislation which has been widely adopted by state legislatures.

The unfair trade practices act recommended by the NAIC defines unfair claims settlements, false advertising, defamation, and unfair discrimination and prohibits all these practices. This NAIC model has been adopted by nearly every state.

The resulting laws give state insurance commissioners the power to investigate when such practices are suspected and to levy fines and suspend or revoke licenses when violations are found. Marketing and disclosure standards for life insurance agents also are recommended by the NAIC. These make deceptive practices designed to mislead clients not only unethical but also illegal.

Any statement misrepresenting the benefits or coverage offered by a policy is a deceptive practice which can lead to the loss of an agent's license. Implying that future dividends provided by a participating policy will be enough to take care of premium payments would be such a misrepresentation. So would an implication that future policy dividends are guaranteed.

To tell a prospect that certain benefits in a policy being offered cannot be found in any other policy, or that an offer must be taken at once or the opportunity will be lost, would be considered unacceptable tactics. Any misleading use of figures as to cost comparisons or other significant policy features would come under the guidelines. So would statements defamatory to competing agents or insurers.

Legitimate agents recognize such actions as unethical.
They also have been made illegal in states that have adopted the NAIC recommendations. There are other prohibitions, such as offering a rebate to make a sale, or persuading a client to drop a policy just for the sake of selling a replacement that will be discussed later in detail.

While an ethical agent would not knowingly violate these guidelines, it is necessary for any insurance professional to be aware of the particular legal provisions in effect in the state with jurisdiction. The laws are to be followed first, supplemented by one’s own ethical standards.

LICENSING

Insurers must be licensed by a state to issue policies there. A state's guarantee fund usually covers only insurers authorized to do business in that state. An agent representing an unauthorized company may be held personally liable for losses on a contract placed with an unauthorized insurer. The agent needs to be sure the company being represented is authorized to do business in that state.

It is also important for both the agent and the company office to be aware that laws can change. Actions of the state legislature and regulations issued by the state insurance commission both can vary with time and the pressure of public opinion.

Court decisions in insurance cases can make a change in liability affecting those in the industry. The legal system in this country is not static, but fluid. Company officials need to keep abreast of such developments and let their agents in the field know about them.

COURT DECISIONS

Suits to recover damages in cases of disputes over insurance coverage are increasingly frequent. The growing tendency to consider insurance practitioners as professional people carries with it increased legal responsibility.

Court decisions in many cases do not take into account any responsibility on the part of the insurance purchaser to be aware of policy provisions, even of easy-to-read policies. The outcome

in many liability suits has made the agent or insurance company responsible for providing adequate coverage.

In a Louisiana case a plaintiff, the operator of a Laundromat in a leased building, asked his insurance agent to get as much property damage liability for him as possible. The agent told him $100,000 was the maximum coverage obtainable, and the plaintiff told the agent to get that amount. Through an error, the policy was written for only $10,000. A boiler explosion caused $18,500 in damages at the Laundromat, and the plaintiff sued to recover the $8,500 that was not covered by the $10,000 policy.

The court appeared to place no responsibility on the owner for reading the policy, the declarations page, or the bill for the premium on the $10,000 coverage. The decision was that the insured was justified in believing that the agent had obtained the limit of liability they had discussed. The resulting point of case law is that an insurance provider cannot count on having any responsibility placed on the insured to analyze the coverage provided.

The issue of professional responsibility on the part of insurance agents and agencies is playing an increasingly important part in court cases. In a Georgia decision involving business interruption policies, an insurance agency had been provided with a client's books to use in determining what coverage limit was needed. The agency used the gross profits figure rather than gross earnings to determine the coverage needs, leaving the client underinsured.

Professional Responsibility

The plaintiff's argument in the court case was that the insurance agency had held itself out as an expert in the field with the needed qualifications to examine the books and determine coverage limits. The agency agreement with the client was to maintain adequate business interruption insurance based on yearly audits, and this agreement, the court held, was violated.

Such court decisions set the precedent of requiring a high standard of competence on the part of insurance professionals. Both agents and agencies need to be aware of this situation.

In addition to staying well informed and exercising due care, the responsible insurance practitioner can have professional representation available for claims protection by carrying Errors and Omissions (E & O) insurance. The E & O carrier will investigate claims situations and provide legal representation if necessary.

In the case of claims, the insurance professional needs to be prepared to deal with the claimant in a calm and competent way without overstepping limits on giving legal advice or otherwise prejudicing the case. Quick adjustment and settlement procedures are desirable in case of claims to uphold the reputation of the insurance provider, but it is important to have all the facts at hand before action is taken.

In dealing with a claimant, the insurance provider needs to remember not to give advice or promise to get the claim paid. It is also important, however, not to deny a claim without positive knowledge that it is invalid. Also, a claim should never be paid without certain authority. Any of these actions can create legal liability.

It is helpful in avoiding legal difficulties for the agent to maintain friendly relations with clients and establish a reputation for being trustworthy over the long term. A personal relationship of trust and confidence between agent and client may help avoid lawsuits and make settlements easier.

ETHICS COMMISSIONS

In addition to court cases, changes in the law can be brought about by an increasingly important agent, the ethics commission. Under pressure from activists, consumer protection groups and others, Ethics Commissions have been set up in state and national legislative bodies as well as in local government agencies.

Ethics Commissions tend to focus on lobbying, gifts to officials, conflicts of interest, and election procedures. They also, however, can consider other areas of public concern and produce legislation in response to consumer complaints.

An ethics commission can hold public hearings. It can determine what legislation needs to be passed in order to prevent abuses. It can investigate whether behavior of a public official has violated existing laws.

Congressional committees in both the Senate and the House conducted investigations into insurance cases with a view to possible federal legislation supplementing state level regulation of the industry. A Senate committee probe centered on offshore insurers and reinsurers which are not subject to state regulation.

One reinsurer listed as its primary assets $22 million in "treasury bills" claimed to have been issued by a Texas Indian tribe. Senate investigators believed this group to be fictitious. The leader of this and other scams at the time was Alan Teale, a British citizen. (*Global Pirates,* R. Tillman, 2001).

The House investigation that followed the failures of large domestic insurance companies focused on the possibility of setting up a federal support mechanism similar to the banking industry's Federal Deposit Insurance Corporation in order to protect policy holders beyond state agencies' limits.
It is important for insurance professionals to keep abreast of such legal developments affecting the industry and its traditional standards.

SEC REQUIREMENTS

Financial planning, a relatively new field for insurance providers, requires some specialized knowledge relating to securities and investment regulations. The Securities and Exchange Commission through the Investment Advisers Act sets high ethical standards for professional providers of investment advice.

Any transaction or business practice intended to deceive a client or prospective client is strictly forbidden under the act. The agent acting as a securities representative is legally required to act with due diligence, meaning that documented financial information must be furnished on companies whose stocks or bonds are being sold.

Guidelines

In contrast to due diligence for securities salesmen, the standard established in court cases for agents only involved in selling insurance is due care. The client is given financial information on request, but the state insurance department is the agency responsible for requiring reports from companies authorized to do business in that state. The agent's legal obligation is to sell policies of insurance companies licensed in that state and not to sell policies of companies the agent knows to be insolvent.

Claims Defense

An agency can establish a back-up line of defense against claims arising from insurance company insolvency. This can be done by showing proof that the agency has maintained a system for tracking financial conditions in the industry through figures from the various reporting agencies and by other means available.

It is important for the insurance agent to know the specific do's and do not's that constitute ethical behavior. Specifics that will be discussed are advertising, commissions (rebates), agent conduct, clients' files, illustrations and underwriting.

Nature of Insurance

The very nature of insurance raises ethical questions. Insurance can be seen as a human attempt to control and influence an environment that is, depending on one's philosophy, controlled by the hand of the Almighty or subject to the arbitrary whims and caprices of nature. As a result, the attempt by humans to "insure" anything will only meet with limited success. Insurance is the spreading of risk- a pooling of money to provide limited reassurance for a limited set of assets or circumstances. Insurance is perceived as a panacea. When insurance is purchased, some people think, "Oh, now I don't have to worry, everything will be taken care of."

With the help of advertising, the insurance industry has often nurtured this warm and fuzzy yet incorrect notion. Insurance is only a partial or stopgap measure to deal with the uncertainties that the world presents. Insurance does not control the fates. Insurance does not provide the kind of universal coverage and assurance that many people look for. Ethical concerns about insurance are created because of this gap between consumer expectations and genuine insurable risk. Policyholders are often disappointed, angry or disillusioned to find that the insurance they have been paying for does not cover a particular situation. This can leave consumers feeling that insurance is a bad bargain.

AGENT COMPLIANCE

ADVERTISING

When the agent advertises, he/she is making the product known to the public at large. There are many different ways to advertise. The following are the major methods, of advertising.

- Printed and/or published materials.
- Newspaper, radio, television, computers, billboards.
- Ads, circulars, leaflets, descriptive literature.
- Business cards, business brochures, prepared sales talks.
- Telephone solicitations.
- Any material used to sell, modify, update or retain a policy of insurance.

Agents wishing to advertise must obtain approval from their respective insurance company. All advertisements for life, accident, and health insurance must include and identify the insurance company the agent represents.

Advertisement that would not require prior insurance company approval would be one in which the only information given is the agent's name, address, telephone number, and description of the services being offered. Agency history and a simple statement of products offered, such as life, health, and/or annuities would also apply. There must be no reference made to specific policies, benefits or cost.

Requirements

The agent must do the following in all advertising:

- Make clear that insurance is the subject of the solicitation; clearly identify the type of insurance being sold, and the full name of the insurer.
- Include all limitations and exclusions affecting the payment of benefits or cost of a policy, as well as disclose any charges or penalties, such as administrative fees, and surrender charges contained in a life or annuity policy, or withdrawals made during the duration of the contract years.
- If a policy offers optional benefits or riders, disclose that each optional benefit or rider is available for an additional cost.
- For a life insurance policy with accelerated death benefits, clearly disclose the conditions, care or confinement which will initiate any acceleration of payment of the death benefit and/or other values under the life policy.
- If a policy includes a payment endorsement, disclose that fact.

Proscriptions

The agent MUST NOT do the following in all advertising:

- Be deceptive or misleading by overall impression or explicit information.
- Refer to considerations paid on an individual policy or annuity, including policy fees.

- Use terms such as "Financial Planner", "Investment Advisor", "Financial Consultant", or "Financial Services" in such a way as to imply the engagement in an advisory business in which compensation is unrelated to insurance sales, unless this is actually the case.
- Use a service mark, trade name or group designation without disclosing the name of the actual insurer, if specific coverages benefits or costs are described.
- Make unfair or incomplete comparisons of policies.
- Disparage competitors, their products, their policies, their services, business or marketing methods.
- Make untrue or misleading statements with respect to another company's insured assets, financial standing or relative position in the insurance business.
- Imply group coverage, certificate or enrollment when the policy offered is actually an individual policy.
- State that the policy is a limited offer and the applicants will receive advantages by accepting the offer, and that such advantages will not be available at a later date, if this is not the fact.
- Advertise a free gift, bonus, or anything of value outside of -the policy contract, which is an inducement to buy and considered rebating.
- Advertise for life, health, accident or annuities, use the existence of the GUARANTEE ASSOCIATION as an inducement to buy.
- Use misleading words or symbols or imply the material is being sent by a government entity.
- Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.

Advertising can be one of the best career enhancing tools, when utilized effectively, legally and ethically.

COMMISSIONS

REBATING

Commissions are the direct result of work performed by the agent with a new or existing policy owner. The agent’s compensation is paid direct from the respective insurance company for the type of product and services recommended and are willing to provide. In addition to the initial commission, most insurance companies provide "renewal commissions", as an inducement to continue servicing the existing policy owners.

The Concept

This concept, initiated many decades ago, was intended to accomplish two primary objectives:

1. Compensate the agent for future servicing needs the policy owner will require -- such as beneficiary changes, bank draft changes, endorsements, etc.
2. Provide the agent with an opportunity to perform periodic reevaluations of the policy owners' needs, thereby resulting in additional sales opportunities.

The agent, as a licensed insurance person, shall not directly or indirectly rebate or attempt to rebate all or any part of a commission for insurance. Rebating is illegal in most states, and is strictly prohibited. It can be punishable by fine, cancellation of contract with insurance company, and loss of license, or a combination of all three. Rebating can be described as offering any type of inducement other than what is contained in the policy itself, in exchange for purchase of insurance. Examples include, but are not limited to the following:

- Any verbal or written agreement for the agent to pay any part of a policy owner's premium.
- Any payment, allowance, or gifts of any kind offered or given as an inducement to purchase insurance.
- Any paid employment or contract for services.
- Returning any part of the premium to the policy owner.
- Offering any special advantage regarding the dividend, interest, or other policy benefits to the policy owner which are not specified in the policy.
- Offering to buy, sell, or give any type of security (stocks, bonds, etc.) or property, or any dividends or income from securities or property, to the policy owners' benefit.
- Giving anything of value to the policy owner in return for buying an insurance product.

Borderline Situations

Rebating, or the attempt to rebate, is an offense not only under the Code of Ethics, but also under state insurance laws. There may be borderline situations in which it is difficult to determine whether rebating has taken place.

It is fairly common practice, as an example, for an insurance agent to entertain policy owners or prospective purchasers with a meal and perhaps give a nominal or token gift such as a policy wallet. Such things are considered to be normal business practice, and not in the nature of a rebate. However, should the agent contemplate anything more than such token gestures of appreciation, then the greatest caution and good judgment must be exercised. Excessive benefits or gifts conferred upon policy owners or prospective purchasers, will at the very least be considered in bad taste, and at the worst, depending on all the circumstances, may expose the licensee to a charge of rebating. In no circumstances should a gift of anything of value be given as an inducement to purchase insurance.

The rules for rebating do not apply to splitting of business with another licensed insurance agent. Joint case work is very common throughout the industry, and splitting of commissions is normal business practice. This practice does not apply to equity and variable life products, since they are sold under the rules and guidelines of the Securities Exchange Commission.

AGENTS' CONDUCT

As an insurance professional, the agent becomes part of the insurance industry's public relations arm. The agent meets the public every day, and the manner and conduct exhibited leaves a lasting impression with everyone with whom that agent had contact.

A big part of professionalism is the attitude toward competition; therefore, agents should avoid criticizing other agents. Such activity is detrimental to everyone in the business. Any criticism of

another company's policies should be avoided. An incomplete comparison is not only misleading and harmful to the public, it can also result in license revocation for the guilty party. Respect for competitors helps to keep policy owners satisfied.

The agent is under an obligation to make accurate and complete disclosure of all information which policy owners or prospective purchasers should have, in order for them to make a decision in their best interest.

Representing the Insurance Product

The agent is called upon daily to make many statements and representations, oral and written, upon which policy owners and prospects are entitled to rely. Such statements and representations must not only be accurate, but must also be sufficiently complete to prevent any wrong or misleading conclusions from being made by policy owners or prospects. It is just as wrong for a life underwriter to omit giving essential information, such as, failing to correct a mistaken impression which is known to exist, as it is to give inaccurate or misleading information. Representing insurance products as exclusively "retirement plans", "college education plans" or "savings plans", without noting that the life insurance is primary and the cash value features are secondary, can result in serious charges of misrepresentation of insurance products. Use of the word "deposit" versus "premium" can have a like effect.

Deceptive Practices

Deceptive practices as they pertain to our industry have countless examples, a few of which are:

- Passing off the agent’s own goods or services as someone else's.
- Misrepresenting the benefits, uses, or characteristics of the product.
- Making disparaging remarks pertaining to someone else's products, services, company, by making false or misleading representations.
- Advertising the product or rates while intending not to sell them as advertised.
- Misrepresenting the agent’s authority as a sales person, representative, or agent to negotiate the final terms of the contract with the policy owner.
- Offering, in connection with an insurance purchase, participation in a "multi-level distributorship" under which payments are conditioned on the recruitment of additional sales people rather than the proceeds from the product sales.
- Using the terms "corporation" or "incorporated" or their abbreviations in the name of a non-incorporated business.
- Failing to disclose information during a transaction with the intent of inducing a prospect or policy owner to do something he or she would not do otherwise.
- The law allows courts to award an insured triple damages, court costs, and attorney fees, for deceptive insurance trade practices.
- Insurance is not only a complex product, it is an extremely complex industry. The insurance agent must be very careful not to mislead the consumer regarding any aspect of an insurance transaction.
- Misrepresentations can be in the form of an oral or written statement, advertisement in any media, use of a business logo or advertising slogan, or anything else that communicates a false or misleading idea. A few examples of misrepresentation include:

- False or misleading statements about a particular policy.
- False or misleading statements about the financial condition of a respective insurance company.
- Telling a prospect or policy owner that dividends or current assumption mortality charges are guaranteed.
- Identifying a term life policy by a name that implies cash value accumulation, or vice-versa.
- Indicating that premiums on a policy are payable for a shorter time period, when the premiums may be payable for life.
- Indicating that the agent represents several insurance companies, when in fact the agent represents only one.

A high degree of ethical representation is good solid business. The agent's insurance career can provide financial gain and personal growth. Practicing as an ethical professional will bring both. The agent's actions will gain the respect of the policy owners as well as that of the insurance carriers. The agent's reputation will be significantly enhanced, and people in the community will want to do business with that agent.

DOCUMENTING CLIENTS' FILES

Documenting the client files involves keeping track of the actions taken in dealing with the policy owner. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the agent to properly assess the need for insurance and substantiates the reason for the sale.

Paper Trail

After the fact-finding meeting, the agent should send a discovery agreement to the prospective policy owner summarizing the initial meeting and outlining the agent's understanding of the policy owner's short-term and long-term financial goals. This document should also contain information about the policy owner's salary and expenses, and the amount of money in savings accounts and investments. It should also reiterate the amount of insurance in force and the amount of money the policy owner would be able to allocate for insurance premiums. In addition to this, the discovery agreement should thank the policy owner for the chance to work with them, and confirm the date of the agent's next meeting.

The agent should always keep on file a proper ledger illustration. This should be an approved insurance company ledger, a sales proposal/idea that contains the following elements:

1. Insurance company name.
2. A full dividend/interest rate crediting disclaimer.
3. A clear description of the product.
4. The agent's name and illustration date.
5. Guaranteed values.
6. A page containing full explanation of any assumptions or special instructions.

Data Note and Log

Effective case notes should also be kept in the policy owner's file. These should list the date and time of contact with the policy owner and concise summaries of all interactions. It is also recommended that the agent document the level of service provided to the policy owner.

An effective log of all telephone calls should be kept, listing the date, time, reason, and follow-up action of all telephone conversations with the policy owner. The agent should also note all unsuccessful calls to the policy owner in order to verify the attempts to provide proper service, thus, once again, documenting the level of service provided.

A delivery letter should be sent to each policy owner with a copy kept in their file. This letter would reinforce the information already discussed, such as the reason for purchasing the insurance, and the type of plan as well as the face amount of coverage. The agent should reiterate the amount and duration of premium payments, as well as the premium payment method. The agent should also restate the impact on policy values as it relates to borrowing, partial surrenders, advanced premiums, interest requirements, dividend usage, and if appropriate, interest or dividend crediting performance.

Many companies provide a delivery receipt with the policy that must be signed by the policy owner upon delivery. If the company does not, it is recommended that the agent prepare such a document to be signed upon delivery to the policy owners. It should list the date the policy was received by the agent, the policy number, and the insurance company's name. It should also contain the owner's signature and the date they signed for delivery of the policy. All of this should be kept in the policy owner's file.

ILLUSTRATIONS

Illustrations have been used extensively in the insurance industry for several decades to help secure sales. In the past, they were obtained from the respective insurance company, and were fairly bland and standardized for many years. They were straight forward and represented a close approximation of actual future performance.

Changes Cause Problems

Beginning in the early 1980's, a radical change began, primarily due to three events occurring simultaneously:

1. A significant reduction in mortality charges, due to advancement in medical technology.
2. Significant advancement in electronic technology -- also known as low cost personal computers.
3. A significant economic change resulting in double-digit market interest rates.

These three events, coupled with consumer demand, helped produce a product called Universal Life -- an unbundled, interest sensitive, whole life policy with a high degree of flexibility.

Insurance was viewed more as an investment product consisting of "mortality" and "side funds". Illustrations began to change and use historically high double-digit interest rates as the basis for projected values. As interest rates began to fall in the late 80's, projected values did not hold up to reality. Many policy owners received notices that premiums would have to be increased or death

benefits reduced to keep policies in force. Policy owners became angry, and many accused agents and companies of unethical behavior.

It cannot be overemphasized that illustrations are mere projections based on current interest rates, current mortality charges and other expenses. These conditions are not contractual obligations. Agents who have competed on the basis of high interest returns will produce projections that are unrealistic. This blatant misuse of illustrations has led to policy owner confusion and dissatisfaction. Agents, companies, and the insurance industry have suffered tarnished reputations.

The results have been fierce disciplinary actions backed by a series of heavy fines on some insurance companies by state regulators. Some examples of illustration abuse are as follows:

- Falling prey to the allure of high interest returns.
- Use of "assumed" interest rates in competitive situations.
- The sales technique of "Vanishing Premiums".
- Heavy emphasis on accumulated values verses death benefits.
- Poor emphasis of contractual guaranteed values and the potential problems that could exist in the future.

Remember, the policy owner does not necessarily see the illustrations as hypothetical. Policy owner dissatisfaction has resulted in increased demands by state regulators for heavy regulations regarding illustrations. Some insurance departments are considering the elimination of current assumptions, and only allowing illustrations based on guaranteed values. The parameters of an illustration under these proposals would be strictly monitored. They have also suggested that disclosure of past performance will be all that is permissible.

Understanding the Hypothetical

Many companies provide guidelines regarding interest rates to be used in product illustrations. The agent is advised to stay within the company guidelines to avoid policy owner dissatisfaction. Policy owners should be aware that current illustrations are a snap shot of how a policy might work if the current rates remained unchanged. To help with this awareness, illustrations should have three distinct columns:

1. Guaranteed Values.
2. Current Return Values.
3. Current Return Minus 1%.

This type of diligence will reward the agent with greater policy owner understanding of how interest rates and dividend scales can affect cash values and premiums.

Illustrations are rarely valid for policy comparisons. They are designed to show how a particular product of a particular company works. There are too many inconsistent variables from one company to another to allow for valid comparison. Policy selection should be made on knowledge of the product and analysis of assumptions underlying each policy. Policy provisions, company financial condition, and quality of service are valid considerations. Illustrations only, can be a dangerous criterion for policy selection without additional considerations.

Transparency and Self-Policing

The vanishing premium concept has been particularly damaging to the public perception of insurance industry ethics. This concept is based on the premise that premiums may be discontinued after a certain number of years through the use of cash value or dividends. It was used as a marketing tool extensively in the 1980's. Projections of vanishing premiums (typically in six to eight years) were based on high interest rates in effect at that time. Many policy owners did not understand that a continuation of high interest rate was necessary to fulfill illustrated projections. When interest rates fell, policy owners charged that no one explained the fact that the illustrated "vanish" was not guaranteed. This disappointment can be avoided with proper disclosure of illustrated concepts and the effect of changing interest rates. Good ethics and business practice dictates that illustrations show both guaranteed and non-guaranteed values with the difference clearly explained to the policy owner. Any illustrations showing non-guaranteed values may be incorrect after the first year. The agent should be thoroughly informed about "assumptions" and "hypothetical" and the effect of fluctuating interest rates and mortality charges. This additional risk should be communicated to the policy owner in written as well as verbal form.

There are many types of new generation policies which require due care and full disclosure. These include Blended Policies (permanent and term), Adjustable Policies, First-to-Die Policies, and Second-to-Die Policies. When two or more lives are insured under the same contract, particular care should be taken to explain to the policy owners that the death benefit is paid on the death of only one of the insureds.

Falling interest can create a climate where actual performance falls short of illustrated projections. Very often, policy owners do not understand the difference between hypothetical projections and contractual guarantees. This can lead to policy owner dissatisfaction, complaints and potential litigation. Increased policy owner complaints lead to adverse insurance department rulings, state regulations, fines and lawsuits against companies and agents. This affects the public perception of ethical conduct of the entire insurance industry. The solution lies in ethical business practices, particularly concerning policy owner understanding of illustrations. Self-policing through education, discretion and common sense will lead to field practices of a high ethical standard. It is important to remember that the policy owner will retain that information they see as most beneficial. As a professional community, our watch words are, tell the policy owner the truth.

Replacement of a contract of life insurance means any transaction which includes a:

- Rescinded, lapsed or surrendered policy.
- Charge to paid-up insurance, continued as extended term insurance or placed under automatic premium loan.
- Change in any manner to effect a reduction of benefits.
- Change so that cash values in excess of 50% are released.
- Policy subjected to substantial borrowing of cash value, but does not include the purchase of an additional life insurance contract.

The agent should not, when it could be detrimental to the interest of the policy owner, replace an existing contract of life, health, disability and annuity contracts with a new insurance contract. Every reasonable effort should be made to maintain the existing contract in force.

Where it appears that, due to a change in circumstances, an existing contract of insurance should be amended or changed, the agent should ensure that the policy owner is fully informed of any

values, credits, or privileges in the existing contract which can be transferred to an amended or changed contract of insurance.

SERVICE

One study indicated that the average insured purchases insurance seven times during their lifetime -- from six different agents. Is part of the reason because of poor or lackluster service?

The insurance industry employs and contracts nearly two million people. It is quite evident that insurance is an intricate and essential service in our society. It is a field upon which our society depends more and more for financial protection. Life and health insurance purchases continue to increase each year. Property and casualty insurance is a part of every mortgage contract, auto ownership, and business coverage. Life insurance in force at the end of 1993 was nearly $11 trillion. On a daily basis a large group of people will die, enter retirement, experience a cash emergency, or have a physical asset damaged or destroyed. This is the real world -- it affects everyone! These are critical times. The agent's insurance company, the agent, and the policy sold, stand between the client and financial disaster.

Value Added

The insurance agent must be the "value added" benefit for the insured as well as the insurance company. In the decade of high tech mega information highway, the agent has to be the interpreting guide and the analyst for the general public to solve financial problems with an insurance purchase. The agent must also become the motivator, leading a prospect to action.

People like to do business with people they trust. Trust is built on ethical behavior. When potential prospects and existing policy owners find an agent with high ethical standards, they tend to do more business with the agent -- therefore becoming a client. In perhaps no other industry is the element of trust more important.

Charging fees for service is common practice in most occupational groups; however, Texas has an exception for insurance agents. Group I licensed agents are not allowed to charge fees for service unless they are properly licensed as a Certified Insurance Counselor (CIC). Property and casualty licensed agents are also allowed to charge fees for certain services.

Service Essentials

The service to a policy owner/client is not only qualitative, but also quantitative. Periodic contact is essential, but can take various forms:

- Daily phone contact with the same policy owner would not only be extremely expensive and cumbersome, but also non productive and obnoxious. Most policy owners tend to accept three to six months intervals as a good basis for agent contact. This could be in the form of telephone calls, letters, informative announcements, as well as birthday and Christmas cards. Many agents use

Thanksgiving cards as an alternative to the more commonplace Christmas card mailing.

- Annual reviews are extremely important with many policy owners, simply because their needs change. This is particularly obvious with business clients.
- It is definitely recommended that the agent staff her/his office with people able to handle day to day service needs, such as change of beneficiary designations, bank draft changes, policy amendments or endorsements, etc. If the agent elects to refer all of these tasks to the respective insurance company home office, it would significantly reduce the "value added" benefit that serve the policy owner. It would also enhance the likelihood of future replacement from another insurance agent -- who specializes in service.

Generally speaking, policy owners want convenience and immediate response. An agent who refers policy owner service duties directly to the insurance company, is missing tremendous future sales opportunities, alienating themselves from building the trusted relationship necessary to maintain a strong business practice, and presenting themselves in less than an exemplary fashion.

UNDERWRITING

Perhaps no other area pertaining to compliance and ethics deserves as much attention as agent underwriting. When any type of claim occurs, the insurance application becomes the basis for a claim dispute, denial or acceptance. An agent who compromises part of the underwriting process with false or misleading information, as it pertains to the prospective insured, is creating potential wealth for litigating attorneys.

Part of the Contract

The agent must always remember that an underwritten application becomes part of any insurance contract. It is critical that all questions be answered completely and honestly. Too often it is tempting for an agent to "trim" ten or twenty pounds off a rather overweight insured or help them grow one or two inches, in order to assure a standard issue from the respective insurance company. Asking a potential policy owner to discard a lit cigarette during the application process may create non-smoker discounts, but in all likelihood would initiate a claim denial. Insurance companies have challenged fraudulent non-smoker rated policies through the court system, and won. It is also naive for the agent to believe that a two-year incontestability clause will exempt him/her or the insured from blatant, fraudulent underwriting. Insurance companies may pay a claim, but they can and do pursue legal action against the insured's estate.

The agent should make every effort to provide the insurance company with all accurate information pertaining to the prospective insured. Cover letters should be submitted with the application to provide details of unusual or extensive medical history or information; unusual business uses of insurance; foreign travel and residence; unusual financial situations; unusual beneficiary and ownership arrangements to clarify the insurable interest; unusual occupational duties; and any case discussions with an underwriter prior to the application submission.

Many insurance agents order medical examinations, attending physician statements, and financial information through third party sources and upon receipt forward these items to the insurance company. This is not an illegal practice, but it may be against the company's practice. Since underwriting information is highly confidential, both the originals and photocopies of financial

statements, attending physician statements, hospital abstracts and other confidential records that have been obtained by agency personnel require safeguarding.

Protect Confidentiality

To comply with state and federal privacy laws, and to control and protect confidential information provided to the company by applicants, guidelines need to be followed to insure the strictest handling of these documents. Examples to follow are:

- Access to files containing confidential material must be restricted to employees who have legitimate "need to know" in order to perform their assigned duties.
- Confidential information stored in personal files, should be retained only as long as there is legitimate need.
- Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.
- It is up to the agent to know what the insurance company's practices are.

Since the application is such an integral part of the insurance contract, care should be utilized in presenting all information to the insurance company in a professional manner. One of the most consistent complaints with insurance company underwriters is illegible applications. Not only does this impair the underwriting process, but it could be grounds for significant dispute during the processing of a claim.

Generally, changes or alterations to the application must be initialed by the insured/applicant. This is specifically important in changes in plan, face amount, owner, beneficiary, medical or financial representations and dates. Some companies are more lenient and allow amendment signatures at the contract delivery.

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The National Association of Insurance Commissioners has a Model Privacy Act that requires any applicant/insured to be notified of any adverse action taken in regard to their application. This Act allows an insured the right to know the details of the personal information about themselves in the company files, and has the right to request an insurance company to amend, delete, and correct such information.

Litmus Test

Labeling a decision as an "ethical decision" may disguise the fact that almost every decision holds some ethical issue or impact. Perhaps a better approach would be to develop an ability to judge the ethical implications. What role do ethics play in this decision? How does one recognize an ethical situation or problem? What are the warning signs that this may be a tougher decision with deeper issues and wider impact? Here are some guidelines. Not all apply every time, but they should raise understanding and improve the decision-making process.
Do I put a monetary value on this decision? Would I make this decision differently if cost were not a factor? Am I putting a monetary value on my ethics?
Do words such as right, fairness, truth, perception, values, or principles appear in my reasoning when I am making my decision?

- Do I feel as if I need to search through a standard policies and procedures or contact a legal representative for help with my decision?
- Do questions of fair treatment arise?
- Do my personal goals or values conflict with my professional ones?
- Could this decision generate strong feelings or other controversy?
- What does my heart tell me? Do I ponder this decision on the way home?
- Do I offer myself excuses such as everybody does it, or no one will find out, or I did it for “The Company”?
- Does this decision really need to be made by someone else? Did I inherit it because someone else doesn't want to make it?
- How am I going to feel tomorrow if I do this?

If an individual faces a tough decision and feels as if some guidance is needed, sometimes there is no place else to turn. One must have an internal compass, a value system for guidance. That is why an ethical standard is important for everyone in the insurance industry.