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SECOND INTERIM REPORT ON U.S. GOVERNMENT EFFORTS TO COMBAT FRAUD AND ABUSE IN THE INSURANCE INDUSTRY: PROBLEMS WITH THE REGULATION OF THE INSURANCE AND REINSURANCE INDUSTRY

**DATE:** July 1, 1992. Ordered to be printed

**SPONSOR:** Mr. Glenn, from the Committee on Governmental Affairs, submitted the following

REPORT

I. INTRODUCTION

**TEXT:**

The business of insurance in the United States is, clearly, big business. More than 5,000 companies, both foreign and domestic, are engaged in it. These companies range in size from corporate multinational giants to small "mom and pop" operations and collectively control almost $2 trillion in assets. The Insurance Information Institute recently estimated that nearly $218 billion in net premiums are paid each year by U.S. citizens for property and casualty coverage. Although nearly 2 million Americans rely upon the industry for their direct employment, almost every American, in one way or another, is touched by the industrys impact upon our economy.

It is within this context, that the Senate Permanent Subcommittee on Investigations undertook its still ongoing inquiry into fraud and abuse in the United States insurance industry. After receiving reports of skyrocketing insolvencies and increasing instances of fraudulent activity within the industry, the Subcommittee determined that it was necessary to review the ability of the current regulatory scheme to ensure the industrys stability and, in particular, its solvency. As Senator Nunn stated at the opening of the April 24, 1991, hearing:

Be it health insurance or professional disability insurance, what all of these individuals have in common is that they were sold a promise, a promise that there would be something to fall back on when hard times hit, a promise, which in the end, turned out to be empty.

The Senate Permanent Subcommittee on Investigations initiated its first in a series of public hearings on May 15, 1990. That hearing focused on abuses in employee health care and benefit plans known as multiple employer welfare arrangements, or MEWAs. The testimony received at that hearing examined a number of vulnerabilities in both state and federal regulations which made this area ripe for abuse by fraudulent insurance brokers who preyed upon unsuspecting, small and medium size businesses.

On March 12, 1992, the Subcommittee issued a report, entitled, "Interim Report on Combating Fraud and Abuse In Employer Sponsored Health Benefit Plans," (Report 102-262), which summarizes that portion of the Subcommittees investigation and contains recommendations and conclusions based upon the Subcommittees MEWA investigation and the May 15th hearing record.

Continuing with its overall inquiry, on April 24, 1991, the Subcommittee turned its attention to other loopholes in the state regulatory system that allowed certain organizations and individuals to market their insurance product with little, if any, regulatory oversight. Those hearings focused upon the collapse of the Victoria Insurance Co., Ltd., which was controlled by Alan Teale and his wife, Charlotte Rentz. While licensed only in Georgia, it was able to sell insurance throughout most of the United States. This was accomplished, for the most part, under the apparent authority of the Liability Risk Retention Act of 1986 (LRRA), 15 USC 3901 et seq., which facilitates the purchase of liability insurance by groups or individuals engaged in similar activities by exempting them from certain state regulatory requirements. Although Victoria was licensed for only 18 months before being placed into receivership, the Subcommittee heard testimony indicating that the company fraudulently collected over $16 million in insurance premiums, ultimately leaving over $20 million in unpaid claims.

Some of the witnesses at the hearing included: James E. Long, North Carolina Commissioner of Insurance and President of the National Association of Insurance Commissioners; Susan Gallagher, Director of the Arizona Department of Insurance; James Schacht, Acting Director of the Illinois Department of Insurance; Tim Ryles, Georgia Commissioner of Insurance; and Andrew J. Ekonomou, Special Assistant Attorney General for the State of Georgia. In addition, the Subcommittee heard from three victims of the Victoria Insurance scam Jim Kelly, Quarterback for the Buffalo Bills; Roynell Young, former Cornerback for the Philadelphia Eagles; and Kenny Flowers, former Runningback for the Atlanta Falcons. John Whittier, an insurance wholesaler specializing in "sportsman policies" for Victoria was also called to testify but refused, based upon his constitutional protection against self-incrimination. He later supplied a statement for the record.

Two months later, on June 26, 1991, the Subcommittee once again focused on the operations of Alan Teale and a host of insurance-related companies that he and his wife operated throughout the United States from their base of operations in Atlanta, Georgia. In particular, the Subcommittee looked at their activities in providing dubious reinsurance coverage to World Life and Health Insurance Company of Pennsylvania and how this led to its ultimate demise.

Some of those who testified at that hearing included: Paul Hawksworth, Chairman, Reinsurance Association of America and President, Mercantile & General Reinsurance of America; Frank Nutter, President, Reinsurance Association of America; Robert B. Mangino, Vice President & General Counsel, North American Reassurance Company (New York); Tom Gallagher, Commissioner, Florida Department of Insurance; and Ronald Chronister, Deputy Commissioner, Pennsylvania Insurance Department. In addition, Blaine Scott, President of World Life and Health Insurance Co., and Ronald Meyer, President of WORLCO of Pennsylvania, the parent company of World Life, testified. Matthew Bonar, President of World Re Inc., the reinsurance broker for World Life, refused to testify, invoking his constitutional protection against self-incrimination.

To illustrate the particular regulatory pitfalls of reinsurance in general, and offshore alien reinsurance in particular, the Subcommittee dissected the operations of four offshore reinsurance companies tied to the Teale/Rentz organization in its next hearing on July 19, 1991. Three of these companies were shown to be directly involved with the failure of World Life and Health of Pennsylvania. The operation of all four reinsurers revealed the largely unregulated and, in most instances, totally secretive nature of the offshore reinsurance industry. The hearing underscored the difficulties that state regulators faced in assessing the financial soundness of offshore reinsurers who perform an important role in the functioning of the U.S. insurance industry. It also highlighted the profound difficulties state regulators face in tracking the massive flow of U.S. premium dollars from the policyholder through his insurer to his reinsurance broker and other intermediaries, and ultimately to a potentially endless array of offshore reinsurers.

At that hearing, the Subcommittee heard testimoney from, among others, Paul F. Altruda, Counsel of the International Association of Insurance Fraud Agencies; Sandra A. Autry, Director of the Unauthorized Insurance Division of the Texas Insurance Commission; Richard D. Baum, Chief Deputy Commissioner of the California Insurance Department; and Dennis C. Ward, Chief Investigator of the California Insurance Department. William M. Fry, Jr. and Dallas Bessant, two associates of Alan Teale, as well as Mr. Teale, himself, and his wife, Charlotte Rentz, all refused to testify on grounds of self-incrimination.

On October 17, 1991, the Subcommittee focused upon the extent to which fraudulent insurance companies use fraudulent assets to enhance their financial pictures. The Subcommittee examined the use of government-backed securities, particularly Government National Mortgage Association bond certificates, or Ginnie Maes, by insurance companies to bolster their alleged financial strength. Witnesses testified that given the respectability and legitimacy of U.S. Government securities, the Ginnie Maes were minimally scrutinized by state insurance regulators.

The Subcommittee learned that at least 17 insurance companies claimed assets of Ginnie Mae securities while none of the companies actually owned the securities. Instead, the insurers leased the rights to the Ginnie Mae bonds for a fee paid to a "broker". When regulators subsequently demanded production of the actual Ginnie Mae bonds, the insurance companies produced only lease agreements and bogus trust receipts. The "brokers", the Subcommittee learned, also did not own the Ginnie Maes and did not have the authority to lease an assignment of interest in the securities.

Witnesses included Lewis Melahn, Commissioner of Insurance for the State of Missouri; Randall Smart, Deputy Insurance Commissioner for the State of Utah; George Estok, President, Integral Insurance Company, which leased $10 million in fraudulent Ginnie Maes; Robert V. Murton, Vice President and Chief Operating Officer, Commercial Surety and Insurance Corporation, which leased $4.7 million in fraudulent Ginnie Maes; attorney Robert H. Wyshak, Custodian Trustee of certain alleged Ginnie Mae securities; and George Eggleston, paralegal to Mr. Wyshak.

Testimony revealed that regulators and even federal law enforcement agencies have found it virtually impossible to determine the identity of the true owners of a given Ginnie Mae security. Given financial secrecy laws and the trading of securities in street names; neither law enforcement agencies, regulatory officials, Subcommittee staff, nor private insurance counsel were able to determine the actual ownership of the Ginnie Mae securities in question.

Although the Subcommittee is currently continuing its investigation of the U.S. insurance and reinsurance industry, the Subcommittee is issuing this second interim report to set forth its initial findings and recommendations concerning current regulatory efforts to combat fraud and abuse in the insurance industry. This report is based upon the investigation, exhibits and testimony from the April 24, June 26, July 19, and October 17, 1991, Subcommittee hearings. The Subcommittee intends to issue subsequent reports which will deal with other issues raised during the course of the Subcommittees ongoing inquiry.

In addition, since the Subcommittee uncovered evidence that suggests possible criminal activity, the Subcommittee has referred this evidence to the Department of Justice and other law enforcement and regulatory bodies. This access was provided pursuant to Senate Resolution 179, which was considered and agreed to on September 12, 1991.

These hearings and investigations were conducted by the Subcommittees Majority Staff under the direction of Senator Sam Nunn, Chairman, with the concurrence and support of Senator William V. Roth, Jr., Ranking Minority Member. They were authorized pursuant to Senate Resolution 66, adopted February 28, 1989, and Senate Resolution 62, adopted February 28, 1991. These resolutions authorize the Subcommittee to investigate, "all other aspects of crime and lawlessness within the United States which have an impact upon or affect the national health, welfare, and safety; including but not limited to investment fraud schemes, commodity and security fraud, computer fraud, and the use of offshore banking and corporate facilities to carry out criminal objectives."

II. BACKGROUND

A. The Industry

Insurance, as most people understand it, is a system of protection against loss or catastrophe in which a number of individuals agree to pay certain sums (premiums) periodically for a guarantee that they will be compensated under stipulated conditions for any specified loss. While the business of insurance refers to providing the means to share the risk of economic or personal loss, the impact of insurance and reinsurance goes far beyond insuring events, property, and income.

As previously mentioned, the insurance industry, as a whole, has assets of almost $2 trillion. In 1990, the nations insurance companies wrote over $390 billion worth of insurance. This industry is divided into two broad categories life/health insurance and property/casualty insurance. For purposes of this investigation, the Subcommittee looked at the operation and regulation of both types of insurance companies as well as the important concept of reinsurance which is used for both types of insurance.

Reinsurance is a form of insurance for insurance companies. It is the process whereby one insurance company, transfers or "cedes" to the reinsurer all or a portion of the risk they accepted through selling or writing direct insurance policies. In return, the reinsurance company receives a premium from the original insurance company and agrees to reimburse them, according to set agreements, for any losses the insurance company pays on the ceded risk. Reinsurance functions as a way to spread the risk of losses and thereby increase the amount of coverage an insurer can provide.

Although reinsurance is relatively unknown to the average citizen, it is not a new phenomena. According to the June 26 testimony of Franklin W. Nutter, President of the Reinsurance Association of America (RAA), reinsurance treaties can be traced as far back as the 14th Century. Then, just as now, it was intended to spread risk in marine and fire insurance lines. It is estimated by RAA that in 1990, approximately $23 billion in net reinsurance premiums were written in the United States. This is approximately 10 percent of all property-casualty premiums written during that time period.

The chain of reinsurance does not end once a primary insurer cedes business to a reinsurer. Reinsurers may also transfer some of the risk they assumed under a reinsurance contract essentially "reinsuring reinsurance". This is called "retrocession". The primary reinsurer who participates in this arrangement is said to "retrocede" the risk to another reinsurer who is known as the "retrocessionaire".

In most cases the individual policyholder is not party to or even aware of any of the reinsurance agreements. Although transferring the risk on policies does not relieve the original insurer of its responsibility to the policyholder, a company that sells insurance to a policyholder may rely on the services and ultimate solvency of a reinsurance company to pay the claims. In fact, the reinsurer generally has no direct relationship or legal obligation to the original policyholder.

During the April 24 hearing, Senator Nunn expressed his concern that the financial strength of many reinsurers was crucial not only to the financial stability of the insurer but, ultimately, to the policyholder who probably lacked any knowledge of reinsurance in general, let alone the specific company that may have a portion of the reinsurance risk underwriting his insurance policy. Senator Nunn explained that:

Unfortunately, our investigation to date has shown that regulators, as well as consumers, rarely have the means to accurately assess the financial strength of these offshore companies. Moreover, regulators have testified as to the difficulties they face in tracking the flow of U.S. premium dollars . . . . to a vast array of reinsurers in such countries as Belgium, Ireland, the Netherlands, and the Turks & Caicos Islands.

This regulatory dilemma, as will be explained later, became one of the key areas of the Subcommittee investigation.

B. The Regulatory Framework

Regulation of the multi-billion dollar insurance business rests almost entirely in the hands of the States. Unlike other major sectors of our National economy, there is no significant federal regulatory presence in the insurance industry. The states have primary responsibility for the regulation and control of insurance firms in their jurisdiction as well as for the control of the estimated $64 billion dollar reinsurance industry.

James E. Long, Commissioner of Insurance for the State of North Carolina and President of the National Association of Insurance Commissioners (NAIC), noted in his testimony that before 1850, there was no such thing as insurance regulation, even on the state level. It was only after a series of insolvencies occurred in the mid-19th century that states began to impose any kind of regulation on the industry. In 1868, the U.S. Supreme Court upheld the constitutionality of a state statute regulating insurance agents on the grounds that insurance business was not "commerce" under the Constitution and subject to federal regulation. See: Paul v. Virginia, 75 U.S. 168 (1868).

This was the law of the land until 1944, when the Court abandoned this principal and upheld federal regulation of the industry in the case of U.S. v. South-Eastern Underwriters, 322 U.S. 533 (1944). A year later, in 1945, however, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. Secs. 1011-1014 (P.L. 79-15), which reestablished the supremacy of state regulation over insurance issues by strictly limiting federal jurisdiction in this arena.

Since 1945, the primacy of the states in regulating this important industry has been largely preserved. In general, state legislatures set the rules under which insurance companies must operate within their states. While regulatory approaches vary, state insurance departments tend to use similar methods to regulate the industry and to assess the financial strengths of the insurance and reinsurance companies under their jurisdiction. The primary method employed to regulate insurance companies rests upon the state issuance of a license upon meeting certain minimum financial requirements for capital and surplus levels as well as for the quality of their investments. These standards are routinely verified by annual financial statements filed with each insurance department and during periodic site examinations which vary from 3 to 5 years in frequency.

Although the States appear to have jealously guarded their regulatory prerogative, it appears that early on many recognized the need for coordinating their efforts, especially as the industry grew beyond the boundaries of individual states. This awareness led to the creation of the National Association of Insurance Commissioners in 1871 which now includes the heads of the insurance departments of each of the 50 states, the District of Columbia and the 4 U.S. territories. NAIC President Long testified that:

In the 120 years since the NAIC was formed, it has served as the primary vehicle for the coordination of interstate insurance regulatory activities and as the catalyst for the development of a national program of insurance regulation, primarily in the area of solvency. The NAIC has furthered the uniform regulation of insurance through the uniform valuation of securities held by insurers, consistent financial examination processes, a standard financial report form for insurance companies, and Model Laws and Regulations.

It should be noted, however, that the NAIC is a private, voluntary association. It is not a governmental body and therefore has no direct regulatory authority itself. Moreover, the Subcommittee noted that it cannot enforce its own standards even upon its membership which is comprised of the various state insurance commissioners. It can merely suggest regulatory or legislative changes. It cannot compel those states to accept and implement these standards. Therefore, most of the significant reforms it recommends have to await the passage of enabling legislation in each of the states before it has its intended effect.

C. The Loopholes

Further complicating the regulatory patchwork of the state insurance departments are three significant areas which to a considerable extent are largely exempt from state regulation offshore reinsurance, Risk Purchasing Groups and surplus lines.

Reinsurance can be purchased from three distinct sources: professional domestic reinsurers (i.e., reinsurance companies located in the United States whose principal business is the assumption of reinsurance from insurers); the reinsurance departments of primary U.S. insurance companies; and alien reinsurers located outside the United States and not licensed anywhere in the United States.

Domestic reinsurance companies licensed in the United States, including subsidiaries of foreign-owned companies are subject to the same financial filings, licensing procedures and regulatory supervision as are primary insurance companies. Such companies are estimated by the RAA to account for approximately 50 percent of the U.S. domestic reinsurance market. For the most part, the Subcommittees investigation did not uncover any systemic problems of fraud or financial irregularities in these companies.

Likewise, the reinsurance departments of primary U.S. insurance companies have also been essentially free from allegations of significant financial problems or fraud. These departments fall under the same state regulatory scheme as do their parent firms. The RAA in their presentation before the Subcommittee explained that approximately two-thirds of the direct or primary insurance companies in the U.S. also write reinsurance policies and account for approximately 10 percent of the domestic reinsurance market.

By contrast, approximately 40% of the domestic reinsurance market is serviced by offshore reinsurers. These reinsurers do not have to obtain a license or otherwise be subject to regulation in any state to do business with our domestic insurers and reinsurers. As Franklin Nutter, President of the RAA, testified, "This segment of the market, because of its susceptibility to abuse, has seen its reputation damaged over the past few years."

One of the benefits of ceding insurance to a reinsurer is the ability to claim reserve credit. In other words, the ceding company may, if the reinsurer satisfies certain regulatory requirements intended to assure the security of the reinsurance arrangement, count as an "asset" reinsurance payments owed to it on claims it has paid, thus expanding its surplus and "profits". The ceding company can also reduce liabilities and associated loss reserves in an amount equal to the estimated liability for the business ceded to the reinsurer.

Since a reinsurer does not have to be licensed in the state in which it does business, state regulators have attempted to control this market by regulating the "credit" for reinsurance that the ceding company, which is within the states jurisdiction, can take. Many states have accomplished this by prohibiting their ceding companies from taking credit on their annual financial statements for the amount of reinsurance ceded unless certain conditions are met.

In general, most states allow a ceding insurer to take credit for reinsurance if:

a. The reinsurer is licensed in the same state as the ceding insurer;

b. The reinsurer is licensed in another state with similar solvency standards;

c. The reinsurer is listed on the "white list" of accredited reinsurers by the particular state. Generally to be on the list, the reinsurer must agree to standards set by the state; or

d. If the reinsurer is an alien company, the ceding company must ask the reinsurer to secure their obligations by means of a letter of credit or by establishing a trust fund with a financial institution accessible by the ceding company.

Reinsurance should not be confused with surplus lines insurance or with risk retention group insurance. Both surplus lines and risk retention insurers provide direct coverage to insurance consumers. Their function is to supplement the standard insurance markets by providing an insurance product that is normally not available within that state and which, at times, can be exempt from normal state regulation. Neither reinsures nor indemnifies another insurance company as reinsurance does. Both surplus lines insurers and risk retention insurers, however, can be purchasers in their own right of reinsurance.

The surplus lines market exists as an alternative market within the insurance industry. Its purpose is to take care of those risks that cannot be handled within a particular state by that states admitted licensed carriers. Although the requirements for writing policies on a surplus lines basis varies from state to state, there appear to be three basic ways in which states deal with these insurers.

In some states, an out-of-state insurer cannot write policies on a surplus lines basis unless that insurer is on the states "white list" of authorized surplus lines carriers. To appear on this list, an insurer must go through a process in many ways similar to that of applying for a license.

Other states do not require a surplus lines carrier to be authorized, but do maintain a "black list" of certain carriers which would be prohibited from writing policies within their state. In those states, as long as an insurer is not on the "black list" it can write policies within the state without meeting any special requirements.

A third method used by some states is a sort of middle ground approach. In these states, a surplus lines carrier must meet certain reporting requirements, but it is not required to go through a formal application process or to be authorized by the state.

As the Subcommittee has learned from insurance regulators and representatives of the National Association of Insurance Commissioners, determining exactly which states surplus lines rules apply to the issuance of a given policy can be a very complicated undertaking. In essence, the determining factor appears to be where the transaction took place.

The Liability Risk Retention Act of 1986, hereinafter, the "Act", was passed to facilitate the purchase of liability insurance by groups of firms or individuals engaged in a similar business. Like surplus lines insurance, this federal initiative was enacted in response to concerns that certain types of insurance were no longer available within certain states. The Act permitted these groups of individuals to join together as "Risk Purchasing Groups" for the purpose of acquiring insurance even from insurers not licensed within their state. The Act preempts much of the states customary insurance regulations with respect to the Risk Purchasing Groups and their insurers. As long as the insurance company is licensed somewhere in the United States to sell insurance, it can sell to these groups no matter where they are located.

Because of their impact upon state regulation, all three of these sectors of the American insurance market became key elements of the Subcommittee inquiry.

III. VICTORIA INSURANCE

The case study for the Subcommittees hearing of April 24, 1991, was the Victoria Insurance Company, Ltd., a Georgia licensed property and casualty insurer, which was placed in receivership by Georgia authorities. The circumstances surrounding the rise and fall of Victoria are illustrative of many of the difficulties of the current regulatory structure.

Victoria highlights the significant problems that state regulators face in detecting, investigating and ultimately prosecuting insurance fraud, especially when a company operates on an interstate and international level. The facts of the Victoria case clearly show how a company is able to take an insurance license granted by a single state and turn it into a "license" to engage in insurance sales throughout the United States and, indeed, throughout the world.

After having been denied a license by the State of Delaware, Victoria was successfully licensed by Georgia as a property and casualty insurer on May 1, 1987. The original Directors were Paul Yorke-Wade, President; Alan Teale, Executive Vice President; Charlotte Rentz, Treasurer; James Bentley, Jr. and James Bentley III, Directors (a former Georgia Insurance Commissioner and his son, respectively).

At this point, on paper everything about Victoria looked good. Its financial statements looked strong for a new company and it appeared to be fully reinsured. As it turned out, however, there was much that Georgia did not know about Victoria. It was only after Victoria had been placed in receivership that Georgia authorities learned that certain assets listed in Victorias financial statement were non-existent, its ownership had changed hands and that Victoria had been virtually insolvent from the beginning of its operations.

A. Victoria Immediately Removed Its Assets

Under Georgia law, Victoria had to maintain, within Georgia, capital and surplus accounts of at least $1.2 million. In fact, the Subcommittee found that almost immediately after Victoria began writing insurance, an international wire transfer was made from Trust Company Bank of Georgia to Paul Yorke-Wade Associates, Ltd. at Lloyds Bank, London transferring the required $1.2 million. In other words, as explained by the Georgia officials, from its first day of lawful operations, Victoria was an insolvent insurer in terms of required assets within the jurisdiction of Georgia regulatory authorities.

In November of 1988, Victoria was placed in receivership and as of the time of the hearing, Victoria had approximately $20 million in unpaid claims pending. According to Georgia authorities the total of Victorias assets in the hands of the receivers is $691,000.

What should be emphasized about this scenario, is that Victorias insolvency was not caused by economic factors, poor investments or other outside factors. Rather, it was clearly caused by the conscious, deliberate actions of Victorias principals in transferring its money off-shore.

B. Victoria Changed Ownership Without Knowledge of Georgia Officials

Georgia insurance authorities admitted at the hearing that they were also deceived by other actions of Victorias principals. In 1987, Alan Teale, who was listed as Victorias Vice President, sought the Insurance Commissions approval for a management agreement between Victoria and Fenmar International Insurance Services, Ltd., under which Victorias operations would be controlled by Fenmar. Fenmar was a company controlled by Teale. Although the Insurance Commission withheld approval of this arrangement, Teale nevertheless exercised effective control of Victoria through Fenmar throughout much of 1987 and beyond.

In addition, in late 1987, control of Victoria apparently changed hands. Individuals representing an entity known as the Arab American Trust Fund (AATF), working out of Amsterdam, the Netherlands, effectively ousted Paul Yorke-Wade and Alan Teale and installed their own associates as executives of Victoria. Under Georgia law such a takeover of a domiciled insurer must have the prior approval of the Insurance Commissioner. Not only was such approval apparently never sought from the Insurance Commission by the AATF, but the Commission apparently was never even notified of the fact of the takeover. It did not learn of it until after the collapse of Victoria.

Moreover, as the Subcommittee learned, this entire "takeover" may have been a total sham. It was uncovered that the British citizen who operated AATF was convicted of fraud in the United Kingdom regarding his involvement in the AATF/Victoria fraud. None of the alleged owners and officers of AATF have ever been identified as even existing. Therefore a number of law enforcement experts have indicated to the staff of the Subcommittee that this entire scenario may have been fabricated solely to facilitate the flow of premium out of the United States to unknown individuals, and to provide a cover for the actual fraud that had taken place.

C. Victorias Use of Federal Risk Retention Act

In only 18 months Victoria, a property/casualty insurer licensed only in the state of Georgia, wrote liability policies covering attorneys, nurses, certified public accountants, asbestos removal contractors, child care centers, insurance agents, limousine companies, and even police departments throughout the entire country. In addition, it wrote casualty policies on race horses and disability policies on professional and college athletes and sports teams both in this country and in Europe. According to Victorias financial statement for the year ended December 31, 1987, it did business in all fifty states as well as Guam and Grand Turk.

Tim Ryles, the newly elected Georgia Insurance Commissioner, noted in his testimony that Victoria was able to do this by marketing its programs through risk purchasing groups ostensibly established under the Liability Risk Retention Act. Most of the purchasing groups were established by the Federation of Business and Professional Associations International, an organization controlled by Alan Teale and/or Charlotte Rentz. Commissioner Ryles noted that not only did this scheme "circumvent various state licensing requirements" but it also created a significant cash flow which was, for the most part, "wired to London and eventually disappeared when it was withdrawn from Swiss bank accounts."

Victoria apparently took advantage of the Act to expand its base of operations well beyond Georgia. As of September 1988, The Risk Retention Reporter listed Victoria as the insurer of 27 different risk purchasing groups operating in states as diverse as Alabama, California, Nebraska, Delaware, Tennessee, Vermont, Illinois and Florida.

D. Victorias Use of Surplus Lines Status

One of the major lines of insurance offered by Victoria was "sportsman disability". The Subcommittee subpoenaed extensive records from Victoria and other entities which revealed that Victoria issued over 200 policies to individual college and professional athletes, as well as over 40 different teams, in at least five different sports on two continents.

In addition to the athletes from whom the Subcommittee heard testimony on April 24, others who were purportedly insured by Victoria included football players Joe Montana, Bo Jackson, and Dexter Manley; baseball players Orel Hershiser, Ron Guidry, and Dwight Evans; and basketball players Ralph Sampson, Scottie Pippen, and Phil Hubbard.

From what the Subcommittee has been able to determine, the only way in which Victoria legally could have sold sports disability insurance would have been on a surplus lines basis. Victorias Georgia licensing application indicated that the company planned "to write some commercial and personal line in Georgia" and "to operate in several states on surplus lines status."

However, to the extent that Victoria was utilizing the surplus lines exemption to issue policies in Kansas or Texas, the states in which the three largest producing brokers of Sportsmen Disability policies on behalf of Victoria were located, they were probably doing so illegally. Both of these states require a surplus lines carrier to appear on a list of approved carriers before issuing policies. Victoria was not listed in either Kansas or Texas until August 1988, just two months before it was place in receivership. Both states removed Victoria from their lists after learning that it had been placed in receivership. Nevertheless, it appears that Victoria continued to write policies after that date.

E. How Victorias Premiums Were Skimmed

The Subcommittee attempted to find out what happened to the almost $16 million in premiums paid to Victoria in the course of its brief existence. This task was extremely difficult since much of the money went overseas. In the process, the Subcommittee uncovered a myriad of corporate entities that syphoned off a good portion of every premium check.

Approximately 41 percent of the premiums were being skimmed off the top to cover commissions and fees. Moreover, this figure may have even been higher. At least three different Teale-controlled companies were performing services for Victoria. If one assumes a 6 percent fee for each of these companies, as most of Teales companies received, then more than half of all premiums collected was taken off the top before reaching Victoria. It is not surprising then that when Georgia authorities conducted an examination of Victoria in the summer of 1988, they found few assets in Victorias accounts in the United States.

F. Victoria Exemplifies Loopholes With State Regulation

Victoria exemplifies how individuals can abuse loopholes in the current regulatory structure. In this case, it appears that Victoria utilized the time between the initial licensing and the subsequent annual audit to deplete their assets and change ownership. Victoria also seems to have maximized their "surplus lines" and "Risk Retention" exemptions from state regulation to their benefit.

Nevertheless, Victoria also stands for mistakes and laxness on behalf of the Georgia regulators. Tim Ryles, the Insurance Commissioner for the State of Georgia, was quite candid in admitting that there had been problems with his predecessors handling of the Victoria case. He stated:

In hindsight, the approval of Victoria seems to be a state regulatory laxity. Paul Yorke-Wade, the President of Victoria, was a British citizen; and no adequate background or financial checks on him were done. Alan Teale, also a British citizen, had been involved with a Florida insurance exchange which experienced difficulties due to the financial failure of several of its underwriting syndicates. Again, it appears no adequate background check was done.

James Bentley, Jr. was a former Georgia Insurance Commissioner who left office in 1971. Mr. Bentley was an officer of another Georgia domestic insurer, Stone Mountain Insurance Company, which was also placed in receivership in 1988.

Victorias assets were made up principally of cash, placed in an unrestricted checking account. There was, very clearly, a set of questionable circumstances in this case, which should have, at the very least, slowed the approval process.

G. Trademarks of the Fringe Operator

Commissioner Ryles concluded his testimony by presenting the methods and operations (M.O.) of the typical fraudster operating on the fringe of the legitimate insurance industry. They include:

1. Using overseas individuals and companies to stretch the limits of state resources. Few, if any, states have the resources to do adequate overseas background investigations in an efficient manner.

2. Having an office location in a state where little if any business is done. This is simply a boiler room technique intended to skirt state jurisdiction.

3. Taking advantage of gaps or overlaps in Federal and State jurisdiction, such as the Risk Retention Act and ERISA.

4. Creating the appearance of legitimacy. Quite simply if the package looks good enough, it doesnt much matter whats inside the wrapper, somebody will buy it. A good "resume", membership in the industry-related organizations, civic club association, political and educational contacts all help to establish a good cover for white collar crime.

IV. WORLD LIFE AND HEALTH

Concerns raised at the first hearing about unlicensed offshore reinsurance were confirmed during the next stage of the Subcommittees investigation and culminated in hearings on June 26, and July 19, 1991.

As its next case study, the Subcommittee reviewed the circumstances surrounding the 1990 failure of World Life and Health Insurance Company of Pennsylvania. The Subcommittee was interested in the role that offshore reinsurance supplied by the Teale organization played in the ultimate demise of World Life a company which had been successfully providing life, accident and health coverage since 1957. Of particular interest was the fact that two of the reinsurance companies involved with the ill-fated Pennsylvania insurer had listed "Sovereign Cherokee Nation-Tejas" treasury bills as their principal assets.

A. History of World Life and Health

Pennsylvania regulators first became concerned with World Life and Health because of its poor financial condition after they reviewed its 1988 annual statement. Pennsylvania law requires a life and health insurance company, such as World Life and Health, to maintain capital of $1,100,000 and a surplus of $550,000 in order to conduct business writing life, annuity and accident and health insurance.

In 1990 the Pennsylvania Insurance Department completed a thorough examination of World Life and Health to verify that the required amount of capital and surplus existed. The Department found that World Life and Health had overvalued a number of their assets in their 1990 annual statement. Regulators were also concerned about World Lifes relationship with unlicensed, offshore reinsurers, particularly the fact that the assets in its reinsurance trust fund account were substantially less than the amount needed to cover ceded liabilities.

The end result of this, as Pennsylvania Deputy Insurance Commissioner Ronald E. Chronister explained, was "that World Lifes surplus is negative and the company is insolvent and in a hazardous financial condition."

B. Trust Funds Were Inadequate

The Subcommittee found that the most significant adjustment in the 1990 World Life financial statement related to their reinsurance arrangements with unlicensed offshore reinsurers. In its 1990 Annual Statement, World Life and Health reported premium income of approximately, $49 million. Of that $49 million, the company ceded over $19 million, or 38 percent, to reinsurance companies.

Of particular note, however, is the appearance in 1990, for the first time on World Life and Healths financial statement, of five unlicensed, offshore reinsurers, four of which were located in Belgium, and one in Ireland. These unauthorized, offshore reinsurers received a total of $12.5 million, the bulk of World Life and Healths $19 million in reinsurance. This offshore reinsurance was arranged by the Teale/Rentz organization through the auspices of a company called World Re, Inc., which was located at 4 Executive Park Drive in Atlanta, Georgia.

Under Pennsylvania law, World Life would be permitted to reduce its liabilities by virtue of the reinsurance with these companies only if there were securities or cash of these assuming companies in an escrow account under the control of World Life in the full amount of the reinsurance credit taken. World Lifes 1990 Annual Statement reflects reinsurance credit in the amount of $6,163,155. They claimed to have set up an escrow account in that amount.

However, according to bank records subpoenaed by the Pennsylvania officials, the maximum amount on deposit at the end of 1990, giving World Life the benefit of every doubt, was only $1,247,975.51 in cash and stocks. Thus, contrary to the sworn statements in World Lifes Annual Statement, the year-end balance in the escrow account was $4,693,024.49 less than the amount which was required to be held in the escrow account if World Life was to be eligible for the full reinsurance credit.

The Pennsylvania Insurance Department also found that the securities deposited in the escrow account were of such dubious value that it was doubtful that they would ever provide for the payment of policyholders claims. They also found that other claimed assets were not even owned by World Life but were merely leased. In addition to these difficulties, Deputy Commissioner Chronister explained that his Staff uncovered a more basic problem with the reinsurance procured on behalf of World Life by the Teale operation, namely, there was no conclusive evidence that World Life entered into any valid reinsurance contracts through World Re.

C. World Life "Fronted" for Unlicensed Foreign Reinsurers

The Subcommittee investigation showed that World Life agreed to issue policies for several lines of insurance business, including some with particularly high loss ratios, on the condition that 100 percent of the risk would be ceded to reinsurance companies provided by World Re. This procedure is commonly referred to as "fronting".

Like any ceding arrangement, the front company remains liable for paying any claims before seeking reimbursement from the reinsurer. Thus, despite the fact that 100 percent of the risk had been reinsured, World Life and Health was still liable to its policy holders on the claims. It could only turn to its reinsurers for 100 percent reimbursement, not for 100 percent "up-front" liability.

In fact World Re refused to honor its reinsurance treaties with World Life on the grounds that World Life was insolvent. According to the Reinsurance Association of America, the possibility of insolvency is one of the principal reasons that insurers obtain reinsurance. Despite that fact, the World Re treaties, inexplicably, include a clause which terminates the agreement in the event of insolvency.

D. Reinsurance Intermediaries Skimmed the Premiums

The Subcommittee determined that, aside from the use of its name and the receipt of a 6 to 8 percent commission, the role of World Life and Health in this operation was minimal to non-existent. Instead, the Subcommittee found the hub of activity to be the same Atlanta offices which had previously been involved in the demise of the Victoria Insurance Company. The Subcommittee found the Atlanta offices to be a web of insurance-related companies and brokers, most, if not all, directly or indirectly associated with Alan Teale and his wife, Charlotte Rentz.

The Subcommittee determined that approximately $12.5 million for offshore reinsurance was forwarded to World Re, on behalf of World Life and Health. The Staff attempted to determine where this premium money went and how much, if any, reinsurance coverage was purchased with it on behalf of World Life. In doing so, they confronted what can only be viewed as a regulators nightmare: a massive web of brokers, financial intermediaries and companies, many of whom were located offshore and far beyond the jurisdiction of state regulators. The Subcommittee found that the premium income from World Life flowed through this network to fund a host of commissions and fees to these intermediaries, inexplicably leaving only thirty-five cents on the dollar to protect policyholders. Moreover, the money was channeled to a vast array of accounts, both domestic and foreign, making it nearly impossible for regulators to accurately determine the amount or whereabouts of the funds.

E. Teales Reinsurance Network Avoided State Regulation

The Subcommittee interviewed a number of Alan Teales former employees. One made a most telling remark about the reinsurance web that was spun from the Atlanta office at 4 Executive Park Drive:

The reinsurance is a joke. If the treaties with the reinsurance carriers dont make the figures correct, rather than make offsetting entries or corrections, the treaties are changed or the dates of the treaties are changed to make the numbers work right.

Former employees also advised that these companies changed names frequently and often contained the word "International" or "Network" or "World". According to them, Teale displayed an array of corporate seals in his office and although there were many corporate names, there was "only one company", and it was "run by Alan Teale."

Even though Teale and his wife operate a network of companies, 13 that the Staff could confirm, making them overwhelmingly involved in the insurance business, none are currently regulated. Under Georgia law, which is where they are domiciled, they are not, as brokers and intermediaries, technically involved in the business of insurance and therefore not subject to regulation. Such an interpretation is not unique to Georgia. At the June hearings, representatives for both the Florida and Pennsylvania Insurance Commissions agreed that they could likewise interpret their laws this way.

As the investigation of World Life clearly showed, the offshore reinsurance industry is grossly unregulated. For example, World Re, a reinsurance broker, answered to no one, yet handled tens of millions of dollars of policyholders hard-earned premium money. The numerous reinsurance companies, all alien, all unauthorized, also answered to no one and also handled untold amounts of money. Among all of the companies mentioned in this part of the investigation, only one, World Life, was regulated even though they did nothing except allow their name to be used on the policies in return for a 6-8 percent commission.

F. Teale Involved in Other Reinsurance Scandals

The reinsurance activities of Mr. Teale were found to go beyond this one transaction in Pennsylvania. Given the number of companies operating out of the Atlanta offices, his activities touched almost every state.

One state in particular that was highlighted in the June hearings was Florida. Thomas Gallagher, Commissioner of Insurance for the State of Florida clearly implicated Teale and one of his companies, World Re, in at least two reinsurance fiascos in that state.

The first involved the Insurance Exchange of the Americas, Inc. This was an ambitious proposal to build an international insurance and reinsurance market in Florida along the lines of Lloyds of London. Its investor-owned syndicates appointed underwriters to negotiate contracts with brokers. It operated, like Lloyds, as a self-regulated entity.

Alan Teale was recruited in 1981 to be its chief executive officer. Commissioner Gallagher testified that the self-regulatory nature of the exchange was abused by some investors and has resulted in millions of dollars of unpaid reinsurance claims.

Teale left there to become a key figure in another ill-fated Florida reinsurance venture the International Forum of Florida, Inc. (IFF). This entity was a multiple employer welfare arrangement (MEWA) licensed to sell health care benefits. Gallagher, however, criticized it as being nothing other than a pretense to make money for its principals.

He testified that for months IFF lied to the State of Florida concerning solvency. IFF pretended to be solvent, using $2 million in bogus securities that Teale helped to secure. Ultimately, when Florida officials shut IFF down, they found $400,000 in assets and at least $16 billion in unpaid health claims. Commissioner Gallagher explained that:

Our department believes that Mr. Teale was deeply involved in that series of relationships. Our investigations have produced evidence such as the letter, (exhibit 57 of the affidavit,) which shows that Mr. Teale helped IFF to obtain bogus securities which IFF then used to lie to us about its assets.

That fraud ultimately allowed IFF to continue operation months longer than it would have been permitted, causing unnecessary financial loss and anguish to thousands of Floridians.

The ultimate irony of this scandal as described to the Subcommittee was that Teale had arranged reinsurance through World Re for the IFF. When the State of Florida, as receiver for IFF, attempted to collect on the reinsurance, World Re refused to pay "on grounds that IFF listed bogus securities among its assets \* \* \* the very securities Mr. Teale helped IFF to obtain".

V. THE TEALE INSURANCE EMPIRE

The Subcommittee inquiry identified a massive unregulated insurance-related operation being run out of the Atlanta offices of Alan Teale and his wife, Charlotte Rentz. At least twelve management and/or underwriting agencies were utilized and at least 19 offshore insurance or reinsurance companies were being used for the placement of insurance risk.

In examining the claimed financial stability of these companies, the Subcommittee found problems with many of their audited financial statements and the CPAs who supposedly prepared them. Several of the CPAs named on the statements were purportedly licensed to practice in New York. These accountants, however, were not registered CPAs in the state of New York. Nor was the Staff able to contact them from the phone numbers printed on their letterhead or locate telephone listings for them in the New York telephone directories.

Three of the CPAs listed on the financial statements of these companies allegedly shared the same Hollywood, Florida address. The Staff visited that office and found only one of the accountants listed. He submitted an affidavit to the Subcommittee disclaiming any knowledge of the four reinsurance companies which allegedly bear his signature as auditor. He also had no knowledge of the other two accountants and stated that neither of them practiced out of his office. Likewise, the Florida Department of Professional Regulation had no record of these accountants ever having been licensed in the State.

A. Teale Masterminded Dallas Reinsurance Companies

In the course of reviewing the Teale operations the Subcommittee focused on four of the offshore reinsurance companies American Indemnity Assurance Group, Ltd., Turks and Caicos Islands, B.W.I., (AIAG); Euro Reinsurance Company, Ltd., Ireland, (Euro Re); Helensburgh Ltd., Ireland; and Euro Am Re, Netherlands. These four companies are owned and controlled by Dallas Bessant, a British citizen, and Jerry Tidmore, Sr., out of the offices of U.S. Dominion Financial Corporation (USDFC), a financial consulting firm which they own, located in Dallas, Texas. All of the reinsurance companies along with USDFC are subsidiaries of a holding company called Farm Equity, Ltd., incorporated in the Turks and Caicos Islands, and also owned by Bessant and Tidmore.

Both Bessant and Tidmore, the alleged owners of the four reinsurance companies in question, readily admitted that they know very little about reinsurance. It became clear to the Subcommittee that the actual operation of these reinsurance firms was handled by others, specifically Teale and Rentz. Accordingly, neither Bessant nor Tidmore were able to answer some of the most basic though critical questions concerning their insurance companies. They did not know what the potential liability of each of the firms were; what risks had been accepted and placed with their companies; the profits or losses for each firm; nor even if they were being paid the correct proportion of each premium written by the Atlanta intermediaries on their behalf.

B. Questionable Indian Tribe Backed Questionable Reinsurers

The Subcommittee examined an entity calling itself the "Sovereign Cherokee Nation Tejas", hereinafter the SCNT, after discovering that their "Treasury bills" were the principal assets of both the Helensburgh and Euro Am Re reinsurance companies.

Representatives of both the Delaware and Georgia Insurance Commissions had been unsuccessful in attempting to verify the bona fides of these bonds. As testified to in the April hearings, state regulators had called the offices of what they believed to be the SCNT and found themselves talking to an individual calling himself Wise Otter, the treasurer of the "tribe", who spoke with a very distinct British accent. This individual, who the Subcommittee now knows to be Dallas Bessant, the owner of both reinsurance companies, told the Insurance investigators that the bonds were valid and totally secured by the "full faith and credit" of the SCNT.

Unfortunately, the Subcommittee found little "faith" in the "credit" of either Mr. Bessant or the SCNT. The Subcommittee found that the group of individuals who call themselves the Sovereign Cherokee Nation Tejas is neither sovereign, Cherokee, nor a nation. It has no legitimate link to the indigenous Indian population of America, with the exception that one or more of its members may be "Indian" by birth or marriage. Otherwise, it is a sham, run by a group of "white" or "Anglo" Americans for the sole purpose of financial self-enrichment.

The Subcommittee discovered that the SCNT repeatedly claimed that they were associated with the Cherokee Nation located in Oklahoma and the Eastern Band of Cherokee Indians headquartered in North Carolina. Both of these entities are federally recognized Indian tribes and vehemently denounced any association with the SCNT. Statements from both of these legitimate Cherokee Indian tribes were received by the Subcommittee during its July hearing and clearly showed that the SCNT had no legitimate claim to hold itself out as a bona fide Indian nation, tribe or association.

Although the SCNT claimed to have tremendous wealth that it pledged as security for the treasury bills and the industrial development bonds it issued, the Subcommittee could find none of it and therefore believes the SCNT was merely issuing worthless paper.

Some of the assets allegedly claimed by the SCNT included a "life mask" of Marlon Brando, valued at $1.5 million; commercial media titles to movies including "Computer Beach Party", "Distant Drums", and "My Girl Tisa", to name a few, valued at $102,000; certificates of deposit issued by non-existent financial institutions allegedly worth $536,000; and a $25 million note receivable given by one of the SCNT officers. Unfortunately, as with many of the assets of the SCNT, when requested to produce evidence of their existence, SCNT officers admitted in Subcommittee depositions that they could not find them apparently, they had lost them shortly before the Subcommittee began its inquiry.

Mineral leases allegedly valued at close to $100 million that the SCNT did produce for Subcommittee analysis proved to be of equally dubious worth. The Subcommittee discovered that these leases were for gold tailings located under the municipal parking lot of Central City, Colorado. The Subcommittee learned that these leases have for a number of years been used in fraudulent land speculations that have been the subject of regulatory and law enforcement action. Industry experts as well as state and federal regulators advised the Subcommittee that these leases were basically worthless.

Ironically, the Subcommittee discovered that during the time that the Nation was claiming assets of approximately $84 million they had a recurring problem of meeting their payroll. Equally troubling, the Subcommittee found that on June 30, 1989, just 10 days after they issued $40 million in Industrial Development Bonds, they were denied credit to lease two Lincoln Town Cars for "insufficient prior credit history". Again in February 1991, approximately one month after the SCNT issued $50 million in Treasury bills to Helensburgh and Euro Am Re, the SCNT was denied credit approval for direct billing by both the Hampton Inn of Addisson, Texas and the Motel 6 of Dallas, Texas.

The Subcommittee found it extremely difficult to reconcile a financial statement listing a net worth of almost $100 million with this type of credit history. As a result, there apparently were no real assets backing Euro Re, Helensburgh, Euro Am Re, and American Indemnity Assurance Group when they started receiving reinsurance risks and premiums. Although they may have quickly developed a cash flow that might have permitted them to cover their reinsurance obligations, nevertheless, like any other "ponzi" scheme, when started they were undercapitalized and financially insolvent.

C. Reinsurance Companies Were Seriously Underfunded

A review of the financial statements of these four reinsurance companies confirms that they were woefully underfunded. The Subcommittee identified transactions designed to boost the assets of these four reinsurance companies amounting to over $1 billion. However, all of these were "paper" transactions based upon worthless or otherwise overvalued securities. None of the Indian bonds, Treasury bills, debentures, gold certificates, notes, or futures contracts issued by the many entities involved with the Dallas operation were backed by anything of value. A telling fact is that in spite of all of the millions of dollars in notes that passed hands between these individuals and entities, the Subcommittee found no evidence that any cash was ever paid for any of it.

For example, the Subcommittee found that when American Indemnity (AIAG) was created, it had just two main assets $50 million in gold Futures Certificates issued to it by Shell Mining, Inc. and the assignment of "the Strosshof Estate in Austria", valued at $231 million.

In justifying the $231 million valuation that AIAG gave to the "assignment" of the Strasshof estate, Tidmore, one of AIAGs owners, insisted repeatedly in his deposition that its value was "certified by the German Consulate in Cincinnati." However, a review of the "certification" document prepared by the Honorary Consul for the German Republic in Cincinnati, clearly indicates that Mr. Tidmore is wrong. As explained by the Honorary Consul in a letter to Chairman Nunn:

My certification did nothing more than certify the accuracy of the translation. \* \* \*

In answer to your specific question, I have never certified or otherwise verified the valuation of the Strasshof in any capacity whatsoever.

Likewise, the Subcommittee concluded that the Shell Mining certificate was also overvalued if not worthless. Both Tidmore and Bessant told the Subcommittee Staff that AIAG received a major part of its initial funding from a Mr. Shell from Arizona who owned Shell Mining. They explained that Shell Mining operated a gold mine in Alaska and that its net worth was verified by their accountant.

The Subcommittee Staff attempted to verify Shell Minings assets. In doing so, it first found that in 1966, the State of Arizona issued a cease and desist order barring Mr. Shell and Shell Mining from soliciting investors in Shells gold mining operation in Alaska. Coincidently, this is the same operation that is the basis for the certificates that Bessant and Tidmore obtained and listed as assets of their reinsurance companies.

In 1987, Arizona again issued a cease and desist order barring Shell Mining from seeking investors for the Alaska mine. On May 5, 1988, Arizona ordered Mr. Shell to make restitution of $873,000 to 39 defrauded investors. Later that year, Shell was indicted on eight counts of fraud and one count of conducting an illegal enterprise. He pled guilty on April 4, 1990 and was sentenced on September 14, 1990, to four years imprisonment, five years probation and ordered to make restitution in the amount of $398,000 at the rate of $500 per month.

The Subcommittee found that Mr. Shells fraudulent activity overlapped the time during which Bessant and Tidmore utilized his assets for their reinsurance firms. Although the Subcommittee could not conclusively determine that Bessant and Tidmore knew of Shells problems, it appears that with a modicum of due diligence they should have known since all of the information was in the public record and reported widely in the Arizona and trade press.

As with American Indemnity Assurance Group, Euro Re utilized the questionable Shell mining certificates as assets. The opening financial statement that Bessant signed on September 15, 1989, lists total assets of $47,966,252, including the Shell precious metal contracts issued on October 18, 1988, in the amount of $27 million; Allied Indian Tribe "Industrial Development Bonds" in the amount of $20 million; and a debenture issued by an unnamed "publicly traded company" in the amount of $875,000.

The Subcommittee determined that these "indian industrial bonds" came from the same source as the "treasury bills" which were the main assets of two other reinsurance companies, Helensburgh Ltd. and Euro Am Re, owned by Bessant and Tidmore. Both Helensburgh Ltd. and Euro Am Re each listed as their main assets "$25 million in Sovereign Cherokee Nation Tejas (SCNT) treasury bills." As previously explained, these assets were purportedly backed by the "full faith and credit of the Cherokee Nation." However, there is little support for the high valuation placed upon these instruments by Bessant and his accountant.

D. Similar Advance Fee Schemes

The Subcommittee was also able to determine that in addition to their insurance activities, both the SCNT and the Bessant/Tidmore organization were involved in similar advance fee schemes.

Through interviews with former employees as well as a number of their clients, the Subcommittee learned of allegations that Bessant and Tidmore were involved in a fraudulent "advance fee" scheme whereby victims would pay up to $30,000 to them in return for guaranteed financial backing or loans from Bessant/Tidmore at USDFC. The Subcommittee staff contacted a random number of former clients. Fifteen of the seventeen former clients interviewed complained to the Subcommittee Staff about misrepresentations made by USDFC staff and the lack of any assistance in obtaining financial backing.

Like their coworkers down the hall, the SCNT at Quorum Drive appeared to earn most of their day-to-day income from offering alleged financial backing for a set fee. As with Bessant and Tidmore, there is strong evidence that the SCNT activity also constituted an apparent advance fee scheme whereby the SCNT knowingly misrepresented their financial capabilities by promising but never delivering financial assistance to unsuspecting victims.

In sum, the Subcommittee found a striking similarity in the modus operandi of both the SCNT and the Bessant/Tidmore "insurance" portions of the Dallas operations. Not only did they both bolster their financial credibility with bogus and highly inflated paper assets, but the two groups utilized advance fee schemes as their primary income producer. The fact that they did this may tell a great deal about their overall operations. As a former commercial banker told the Subcommittee Staff:

Concerning advance fees, all I can say is that all the crooks operate that way and very few of the honest ones do.

E. Euro Re Sold Surplus Lines in California

Euro Re was one of the most active of the Bessant/Tidmore reinsurance companies. According to the "Gross Insurance Production Summary" through December 31, 1990, provided by the Teale/Rentz Atlanta operation, Euro Re was assigned $8,442,437.98 in direct insurance and reinsurance premiums.

In spite of the fact that Euro Res main assets at the time it started business were bogus "Shell Mining gold certificates" and "Allied Indian Tribe Industrial Development Bonds", in 1990 alone, surplus lines brokers in California wrote and placed over half a million dollars in direct insurance with Euro Re. It should be emphasized that this surplus lines insurance places 100 percent of the risk with Euro Re. During deposition, both Bessant and Tidmore, the owners of Euro Re, clearly did not understand that surplus lines policies were being written on behalf of Euro Re. They repeatedly claimed that no one was permitted to "bind" Euro Re. They were surprised to find out that their own records showed Euro Re had assumed 100 percent of the risk of these insurance policies from California.

The fact that the owners of the reinsurance company did not understand the potential liability of their company until deposed by the Subcommittee is quite significant. It underscores a problem inherent to this unregulated part of the insurance industry namely, that anyone can enter the industry regardless of assets, background or qualifications and operate an offshore reinsurance company that holds 100 percent of the risk on policies issued in the United States.

F. California Insurance Department Confirms Surplus Lines Abuses

Richard D. Baum, Chief Deputy for Operations with the California Department of Insurance and Dennis C. Ward, Chief Investigator for the Department testified at the Subcommittees July 19 hearing. Both confirmed the problem confronting states such as California from alien, offshore reinsurance companies. Although they admitted that not all alien insurance firms were involved in questionable activities, they did testify that a small group of them have abused surplus lines insurance and caused California tremendous problems.

They predicted that over $300 million in premiums will be paid by Californians to alien insurers, almost six times the $54 million paid three years ago. At the same time, they expected that thousands of Californians will suffer losses totalling over $100 million because of fraud by these offshore companies.

G. Insurance Regulators Call for Federal Assistance

All of the State insurance regulators at the July 19 hearing called for some type of additional federal assistance above and beyond making insurance fraud a federal offense. Paul F. Altruda, Assistant Deputy Superintendent of Insurance for the New York Department of Insurance and Counsel to the International Association of Insurance Fraud Agencies, represented the consensus of those insurance regulators who were interviewed by the Subcommittee in the course of this investigation. He saw the federal role in insurance regulation as filling the gaps in current state regulation, not in duplicating what the states already do. Some of those gaps as explained by Mr. Altruda and seconded by Mr. Baum at the hearing included the need for an international data base where data on suspect transactions could be accessed by insurers and federal registration or certification of alien insurance and reinsurance companies.

Sandra A. Autry of the Texas Department of Insurance articulated in more detail the suggestions of her New York and California regulatory associates. In a detailed seven point program for federal assistance she called for:

7f Federal registration/certification of offshore, alien insurance and reinsurance companies;

7f Federal sanctions for violating those new requirements;

7f New cooperative treaties with foreign countries that now are tax, banking and insurance havens;

7f Federal criminal sanctions for insurance fraud;

7f Creation of joint federal and state insurance task forces;

7f Increased use of federal criminal tax laws for insurance fraud; and

7f Reform of ERISA to better control MEWA fraud.

VI. QUESTIONABLE ASSETS NOT LIMITED TO BOGUS INDIAN BONDS, INFLATED REAL ESTATE APPRAISALS OR JUNK BONDS: BOGUS U.S. GOVERNMENT SECURITIES

During the Subcommittees investigation into such fraudulent assets as alleged Indian treasury bills, industrial development bonds and gold mining certificates, the Subcommittee learned of a scheme designed to deter regulators from questioning the value of assets: U.S. government-backed securities claimed as insurance company assets.

The Subcommittee held a hearing on October 17, 1991, to examine the extent to which other fraudulent assets were used as financial backing in the insurance industry. The Subcommittee focused specifically upon the use of assets which insurance companies listed as Government National Mortgage Association (GNMA) bond certificates.

During the hearing, the Subcommittee learned that law enforcement authorities and insurance regulators had found numerous instances of the use of bogus or fraudulent GNMAs in the insurance industry. Witnesses testified that, given the respectability, security, and legitimacy surrounding U.S. government securities, the GNMA bonds were extremely marketable and minimally scrutinized by regulators.

The Subcommittee heard testimony concerning 17 different insurance companies which claimed ownership of GNMA bonds as assets. Investigation revealed that none of these companies actually owned the bonds, but instead had leased the rights to the GNMA bonds from "brokers". When regulators happened to subsequently ask for proof of ownership, the lease agreement was produced. When regulators demanded the GMNA bonds be produced, the fraud was discovered: the GNMAs were not owned by the lessor.

More often than not, witnesses testified, the involved insurance companies had found themselves in financial straits, needing additional surplus to cover projected liabilities. Faced with strict regulatory requirements and little or no liquid assets, insurance company executives found a way to enhance statutory reserves while spending little or no money to do so.

In exchange for a fee and usually a pledge of the insurance companys stock, a purported investor would assign, for a predetermined period of time, his "beneficial interest" in the GNMA bond to the corporate parent of the insurance company. The corporate parent would then pledge the new found assets to the insurance company. The parent company would also issue a debenture to the "investor" for the face amount of the pledged GNMA, so that liability would not be reported by the insurance company.

Through testimony, the Subcommittee determined that the GNMA securities involved in these transactions were not actually owned or controlled by either the insurance company, its parent, or the party leasing the rights to the bonds. The insurance companies merely rented or leased the alleged securities from the investor and received a "Trust Receipt" as proof of ownership of the beneficial interest in those securities. The investors, however, did not own or control the GNMAs, but merely produced extensive bogus documentation to make them appear to be the actual owners. In fact, the investors were apparently using the pool numbers of legitimate, actual GNMA bonds without the knowledge or consent of the true owners.

The Subcommittee found that State regulators often do not ask for any proof of ownership from either the insurance company or the investor/alleged owner of the assets, concentrating on valuation of other assets (real estate, corporate bonds, etc.). Some state insurance departments appear to be overburdened and without the resources to investigate the authenticity of each asset claimed by each insurance company within its jurisdiction.

At its October hearing, the Subcommittee examined in depth the lease of purported GNMA securities by two insurance companies in particular: Integral Insurance Company of Missouri and Commercial Surety and Insurance Corporation of Utah.

Witnesses included Lewis Melahn, Commissioner of Insurance for the State of Missouri; Randall Smart, Deputy Insurance Commissioner for the State of Utah; George Estok, President, Integral Insurance Company; Robert V. Murton, Vice President and Chief Operating Officer, Commercial Surety and Insurance Corporation; Attorney Robert H. Wyshak, Custodian Trustee of certain alleged Ginnie Mae securities; and George Eggleston, paralegal to Robert H. Wyshak.

The Subcommittee learned that Integral Insurance Company leased $10 million in fraudulent GNMA bonds and Commercial Surety and Insurance Corporation leased $4.7 million of the bogus paper. The insurers leased the GNMA bonds from two different, allegedly unrelated entities, yet, unknown to anyone, both insurers leased the same pool of securities at the same time.

When ordered by regulators to produce the actual GNMA certificates, neither insurer was able to do so and both were subsequently placed under State supervision.

Testimony before the Subcommittee at the hearing on October 17 revealed that regulators and even federal law enforcement agencies have found the process for determining the identity of the true owners of a given GNMA bond impractical. Neither law enforcement agencies, regulatory officials, Subcommittee staff, nor private insurance counsel were able, through the use of multiple subpoenas, to determine the actual ownership of the GNMA securities in question.

The reason for this is that many GNMA bonds are held by financial institutions acting on behalf of individuals. The ownership in these cases is recorded in "nominee names", representing the financial institutions. A subpoena for ownership information, therefore, only produces the nominee names and not the names of the beneficial owners of the bonds. Furthermore, bank secrecy laws prohibit the financial institutions from revealing the names of the individuals for whom the financial institution is holding the bonds.

According to GNMA officials, "GNMA and other securities are often recorded in the name of nominees making it harder to track down beneficial owners. Congress enacted strong financial privacy laws to protect privacy and promote the liquidity of these securities. If and when ownership needs to be tracked, it may be accomplished through the proper legal process."

Testimony before the Subcommittee, however, proved otherwise. The Subcommittee found that neither the Federal Bureau of Investigation, the Resolution Trust Corporation, several State Insurance Departments, Subcommittee counsel nor private outside counsel were able to verify the ownership of the Ginnie Mae bonds in question, despite considerable use of the subpoena power.VII. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The ultimate implication of this portion of the Subcommittees inquiry into the soundness of Americas insurance industry is significant. Unless definitive and forceful action is taken by both federal and state governments, the fraud and abuse previously described will only increase. As Chairman Nunn stated: "we are going to be reaping a bitter harvest of people who think their claims are going to be paid out but arent."

Apropos of these predictions, the Subcommittee makes the following factual findings and conclusions:

1. The offshore reinsurance industry is grossly unregulated by the current U.S. regulatory system. For example, World Re, a reinsurance broker, answered to no one, yet handled tens of millions of dollars of policyholders hard-earned premium money. Numerous reinsurance companies, all alien and all unregulated, also answered to no one even though they handled untold amounts of money. Clearly, State attempts at regulation, even to the extent they exist, are inherently inadequate. Even if it had the resources to do so, a State insurance commission lacks the jurisdiction to pursue these alien reinsurers and their unlicensed brokers. Each insurance commission cannot possibly investigate the type of vast interstate and international networking and money flow that the Subcommittee found in its investigation.

2. The Subcommittee also found that current U.S. insurance regulations are replete with a number of significant loopholes that permit underfunded or unscrupulous insurance companies to become licensed in one state and thereby immediately market their product in other states via "Surplus Line" authority or the Risk Retention Act. In either case, serious harm can befall the unsuspecting citizens of states where this unlicensed insurance product is sold. In many instances, insurance regulators have no idea what is happening until the bogus company closes down or refuses to pay claims.

3. Although the Subcommittee wishes to acknowledge the dedicated manner in which many state regulators attempt to combat fraud and abuse in their states insurance market, the Subcommittee found that, overall, they are woefully underfunded and ill-equipped to combat the sophisticated international insurance con artist who frequently changes not only his modus operandi, but also his corporate identity and location to avoid detection and prosecution. In particular, the Subcommittee found that the States lack an effective automated intelligence data base on suspicious companies, individuals and transactions. This problem is particularly acute because of the international aspect of insurance and insurance fraud as exemplified in the Subcommittees hearing record.

4. As the Subcommittee continues to examine fraud and abuse insurance and reinsurance, we have found that many of the same key players are, in one way or another, involved in many of these schemes. The degrees of involvement may differ, the relationship may be once, or twice, or three times removed, but ultimately, a handful of individuals have continued to surface during the course of our investigation. They include Alan Teale and his wife, Charlotte Rentz; Dallas Bessant and his business partner, Jerry Tidmore; Roy Thigpen, the owner of several insurance companies, who was recently convicted of bribing a Wyoming Insurance Commissioner; Ben Kirk, and his list of KLK companies, operating out of Dallas, Texas; and Carlos Miro, who has been indicted by a federal jury for mail fraud and money laundering. The vast network of these individuals and others, bolstered by the many domestic and foreign companies which they create and control, the Subcommittee found, continues to frustrate the efforts of individual state regulators to combat abuse in the industry.

5. Likewise, as the Subcommittee continues its examination of the insurance and reinsurance industry, it has found not only a number of people reappearing time and again, but also similar patterns of fraudulent activity. Like the recent S&L debacle, the reinsurance scams that we found have all utilized insider deals, fraudulent or overvalued assets, dubious appraisals, bogus financial statements, and offshore shell corporations. In addition, the Subcommittee notes the significant role that accountants can play in fostering credibility for these sham deals. The dubious audited statements of the various entities were the sine qua non of the entire Dallas and Atlanta operations. The Subcommittee will further examine the role of such professionals as it continues its ongoing inquiry into the demise of other insurance companies.

6. The Subcommittee also found strong evidence to suggest that many of the insurance frauds that have been identified are global in nature. The Subcommittee has exposed the top of a number of international white-collar criminal syndicates. For example with just the Dallas portion of the scheme, the Subcommittee identified involvement by citizens from England, Brazil, and Canada, the Netherlands, Ireland, Belgium and France to name a few. Based on documents the Subcommittee reviewed as well as from deposition testimony, it appears that one of the near term goals of these syndicates is to take early advantage of the massive free trade zone which will be created by the European Common Market. There is ample evidence to indicate that they and others like them will continue their attempts to establish a foothold in the new European market.

7. Despite assurances made by representatives of the Government National Mortgage Association (GNMA), the Subcommittee found compelling evidence to suggest that current privacy laws are regularly utilized by con artists and other fraud rings to circumvent law enforcement and regulatory authorities. The Subcommittee found that the Federal Bureau of Investigation, the Resolution Trust Corporation, and several insurance departments were unsuccessful in attempts to verify the ownership of GNMA bonds during the course of their criminal investigations. Nor were private outside counsel representing potential fraud victims or even the Subcommittees counsel able to pierce the privacy veil that conceals the beneficial owner of a particular bond. Although such privacy may well promote the liquidity of the legitimate GNMA bond market as opined by GNMA officials, it also appears to equally promote the illegitimate bond market.

It is, therefore, the Subcommittees recommendations that:

1. Congress should, as soon as possible, enact into law, the insurance fraud provisions contained in Conference Report 102-405 that accompanied H.R. 3371, The Violent Crime Control and Law Enforcement Act of 1991. These provisions would establish as federal offenses four types of behavior which, in the experience of state insurance regulators, typifies white-collar insurance fraud. First, it would make it a crime to knowingly file with a state insurance regulator fraudulent financial statements. Second, it would ban embezzlement and theft from an insurance company. Third, it would prohibit the falsification of insurance company records with the intent to defraud. Finally, it would outlaw the criminal obstruction of proceedings before state insurance authorities. This, proposal, if enacted, would be an essential first step to prioritize insurance fraud as a national problem. It should be noted that this recommendation applies to the insurance fraud provisions of H.R. 3371 and is not meant to be an official endorsement of the entire Act by all Subcommittee Members.

2. The Senate and House Commerce Committees should review the operation of the Risk Retention Act as well as the insurance industrys current use of surplus lines authority. In such a review, particular attention should be paid to how these activities are being utilized by unscrupulous individuals to defraud the insurance consumer by avoiding current state regulatory authorities.

3. In the interest of preventing the fraudulent use of GNMA securities as was demonstrated in the hearing, the Subcommittee recommends that the Banking Committee review the financial privacy laws as well as current GNMA recordation procedures as they pertain to law enforcements need for disclosure of beneficial owners of government securities. While understanding the need for privacy laws, the Subcommittee also understands the need for law enforcement and regulatory authorities to have access to this information for legitimate law enforcement purposes.

4. The Department of Justice should devote additional resources to the problem of insurance fraud. In addition to the new Washington headquarters unit and a few ad hoc units created by a number of U.S. Attorneys to combat localized problems with insurance claims fraud rings, the Attorney General should establish joint federal and state task forces in those locations that have become notorious havens for insurance fraud. These task forces should include federal law enforcement agencies such as the Federal Bureau of Investigation, Internal Revenue Service, Postal Service, and U.S. Customs Service since the Subcommittees hearing record shows that the individuals involved in insurance scams were equally willing and able to commit other fraudulent activities involving advance fee schemes, stolen or counterfeit securities, tax evasion, and money laundering. In sum, insurance fraud appears to be just the tip of their criminal iceberg and law enforcement should respond accordingly by coordinating its efforts as it did in creating the very successful Organized Crime Strike Forces in the 1960s.

The new task forces should look at more than just claims fraud which, although serious, has never resulted in the insolvency of an insurance carrier. Rather, the Subcommittee is recommending that the Department devote significant law enforcement resources to combat the internal fraud that has in the past and will in the future continue to bankrupt insurance companies, or otherwise leave thousands of policyholders without insurance coverage.

In recommending the creation of insurance task forces, the Subcommittee is well aware of problems that have hindered former joint federal and state efforts. Accordingly, the Subcommittee strongly encourages the Attorney General to ensure that any Insurance Task Forces include full and equal cooperation between the federal and state agencies. On many occasions, the Subcommittee has received complaints from state agencies that they have been treated as "second-class citizens". Such a perception, whether justified or not, would be the death knell for any successful effort against insurance fraud since state regulatory agencies are clearly now the only repository of information and expertise on the complex subject of insurance fraud.

5. The Department of State, in consultation with state insurance regulators and federal law enforcement agencies, should begin negotiations with other nations concerning the sharing of data and information on insurance fraud. These negotiations should aim for a free and efficient flow of regulatory, financial and investigative information between U.S. insurance regulators and their foreign counterparts. It should be a priority of the U.S. government to aggressively eliminate those insurance havens just as it has been a priority to do so in response to previously documented abuses in various tax and money laundering havens. The need for aggressive action, now, on the part of our government is heightened by growing evidence that insurance con men are increasingly using foreign havens to systematically conceal their illegality.

6. A national intelligence data base should be developed containing information on individuals and businesses that are involved in insurance fraud. Today, no centralized, automated data base exists that would allow the systematic sharing of intelligence data between state regulatory and law enforcement entities, let alone, with relevant federal or international entities. The overall goal of such an intelligence system would be to enhance the ability of state regulatory and law enforcement agencies to identify, target and remove insurance fraud conspiracies before they become the national and international entities that the Subcommittee has identified in this report.

At this time, the Subcommittee is reluctant to recommend that the federal government be responsible for creating or operating such a system. It is still the Subcommittees judgment that the states are inherently better situated to be more responsive to the problems of insurance fraud. Nevertheless, the Subcommittee does recommend that the federal government assist in designing and providing some of the initial funding for such a data collection network. This assistance should be coordinated with state regulators and the insurance industry, both of which should bear the main cost for creating and operating such a network since it is to their advantage that an effective intelligence network is created as soon as possible.

The Subcommittee recommends that in creating this system, the interested parties consider the Department of Justices successful work in the creation and partial funding of the Regional Information Sharing Systems (RISS) project. Since its creation in the 1970s, the RISS project has been an innovative, federally supported program to assist state and local law enforcement efforts to combat interstate organized crime, drug trafficking and white collar crime. Six regional projects provide member law enforcement agencies in all 50 states with a broad range of intelligence and investigative support service. The federal role has been basically limited to partial funding and some program oversight with the actual day-to-day operation and membership remaining a state and local law enforcement function.

The Subcommittee recommends the RISS project as a possible model since it was created in response to a problem similar to the one now confronting the insurance regulator and investigator, namely the absence of intelligence on highly mobile interstate and international criminals. The major premise underlying its formation is that state and local criminal justice agencies in various regions of the country need to communicate and coordinate in order to have any success in combatting this type of criminal. The RISS projects have proven effective and their example should be indicative of what can be done in the insurance field if an effective intelligence system is created.

7. The various states must have a way of identifying and certifying the financial bona-fides of offshore insurance and reinsurance companies accepting risks in the United States. Currently, state regulators are not always aware of an offshore company selling direct insurance in their states via surplus lines authority or the Risk Retention Act until the damage is done. Likewise, regulators have little, if any, information on many of the offshore companies which are not licensed in any state but which still accept millions of dolars of U.S. insurance risk.

The Subcommittee, therefore, recommends that Congress establish federal certification as a prerequisite before an offshore reinsurance or insurance company is allowed to accept direct or reinsurance risk in the United States. In doing so, Congress should mandate that such registration or certification entail that the offshore companies meet minimum capital and surplus requirements, provide access to their books and records, periodic audited financial examinations and relevant background information on their officers, directors and shareholders.

Congress should designate an appropriate federal agency as a central repository for this information which would be readily available to state insurance regulators as well as any interested consumer. Although the Subcommittee does not recommend which agency within the federal government should have this function, it is aware of a number of agencies that have performed similar functions that may be suitable to handle this new responsibility with appropriate increases in funding and staffing.

For example, the Subcommittee is aware that the Department of the Treasury, has since 1947 been responsible for approving insurance companies for government surety work. (See 31 U.S.C. Sec. 9301 et seq.). In performing this function, the Department of Treasurys Fund Management Service compiles and reviews financial data supplied by insurance companies and certifies those deemed to be financially sound for government surety work. This review process includes not only those companies ultimately approved for federal surety work but also those reinsurance companies that have assumed any of the risk of the approved surety company. In conjunction with creating the requirement for federal registration, Congress should enact federal criminal sanctions for those individuals and entities which violate these registration and certification requirements.

It is not the intention of this proposal to preempt state regulation. Rather, the Subcommittee is suggesting that this provision will augment the current state regulatory scheme by filling certain gaps relating to offshore insurance and reinsurance.

The following Senators, who were members of the Permanent Subcommittee on Investigations at the time of the hearings, have approved this report: Sam Nunn, John Glenn, Carl Levin, James R. Sasser, David Pryor, Herbert Kohl, Joseph Lieberman, William V. Roth, Jr., Ted Stevens, William S. Cohen, Warren Rudman, and John Seymour.

Other Senators, who are members of the Committee on Governmental Affairs, approving this report are: Daniel K. Akaka.

The members of the Committee on Governmental Affairs, except those who were members of the Senate Permanent Subcommittee on Investigations at the time of the hearings, did not participate in the hearing on which the above report is based. Accordingly, they have taken no part in the preparation and submission of the report, except to authorize its filing as a report made by the Subcommittee.