DEFINITION OF INSURANCE WORKING GROUP
WHITE PAPER
DEFINITION OF INSURANCE

Definition of Insurance Working Group
National Association of Insurance Commissioners

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I. INTRODUCTION

As we move into the new millennium, state insurance regulators continue to be responsible for insurance regulation in this country. However, with the recent enactment of the Gramm-Leach-Bliley Act (or “GLBA”), emphasis is now placed on state and federal regulators exercising functional regulation together in the areas of insurance, banking and securities. It will therefore be necessary to further define the distinct functions to be regulated by each regulator. The purpose of this White Paper is to provide guidance to state insurance regulators on the commonly recognized elements of an insurance product.

This White Paper will focus on the areas of GLBA which help delineate the boundaries of functional regulation relating to insurance. The White Paper is divided into three areas: (a) Definition of Insurance; (b) Distinguishing the Business of Insurance; and (c) Resolution of Disputes Under Section 304 of GLBA.

II. DEFINITION OF INSURANCE

In considering the scope of state insurance regulation in light of GLBA, one must initially answer the question: “What is insurance? How is it defined?” Historically, this has been an important question because of the rapid evolution of new products and the subsequent debate over which products are insurance and who has the authority to regulate them.

This Section of the White Paper looks at how insurance is defined in GLBA and at the state level. It also includes a brief overview of how the courts have defined insurance. Although discussed in more detail later in this paper, it should be noted here the concept of “insurance product” is just one aspect, albeit an important one, of the broader concept of the “business of insurance.” The issues involved in determining the scope of the “business of insurance” within the meaning of the McCarran-Ferguson Act or ERISA are distinct from the issues involved in determining which contracts are “insurance products” within the meaning of GLBA. The “business of insurance” encompasses all the commercial activities that are part of providing an insurance product, such as claims adjustment, underwriting and marketing. On the other hand, the defining characteristics of an “insurance product” focus more narrowly on the nature of the contractual obligations of the parties to the insurance contract or policy. This Section concludes with guidelines for interpreting the definition of insurance, which include a list of the common characteristics of an insurance product, to provide guidance to state insurance regulators in their role as functional regulators under GLBA.

A. Definition of Insurance in Subsection 302(c) of GLBA

With limited exceptions for “authorized products,” and grandfathered rights for certain banks in connection with title insurance, Section 302 of GLBA (See Appendix A) generally prohibits a national bank and its subsidiaries from acting as insurers. For that purpose, Subsection 302(c) defines the term “insurance” to mean:

(1) Any product demonstrated to be regulated as insurance as of January 1, 1999;
(2) Any product first offered after January 1, 1999 demonstrated to be one that insures, guarantees or indemnifies against liability, loss of life, loss of health or loss through damage to or destruction of property, including but not limited to, surety bonds, life insurance, health insurance, title insurance and property and casualty insurance (such as private passenger or commercial automobile, homeowners, mortgage guaranty,1 commercial multiperil, general liability, professional liability, workers compensation, fire and allied lines, farm owners multiperil, aircraft, fidelity, surety, medical malpractice, ocean marine, inland marine, and boiler and machinery insurance);

(3) A product that includes an insurance component that would be treated as a life insurance contract under Section 7702 of the Internal Revenue Code of 1986;

(4) A product that would qualify for treatment for losses incurred with respect to the product under Section 832(b)(5) of the Internal Revenue Code of 1986, if the issuer is subject to tax as an insurance company under Section 831 of the Code; or

(5) An annuity contract, the income on which is subject to tax treatment under Section 72 of the Internal Revenue Code of 1986.

It is important to note the scope of Subsection 302(c) is specifically limited to defining what products a bank may or may not underwrite under federal banking law. This definition does not by its terms restrict what constitutes “insurance” or the “business of insurance” with regard to any other aspect of functional regulation under GLBA. Indeed, the “NARAB” subtitle of GLBA, which addresses regulation of insurance producers, preserves broad discretion for state regulators: Subsection 336(2) defines “insurance” for those purposes to mean “any product, other than title insurance, defined or regulated as insurance by the appropriate State insurance regulatory authority.” Similarly, GLBA Sections 104(a) and (b), and 301, recognize the States’ continuing jurisdiction to regulate the “business of insurance.”

B. State Statutes and Case Law

The definition of insurance in Subsection 302(c) of GLBA makes reference to products “regulated as insurance.” The listing below provides a sampling of how states define insurance in their statutes, followed by a brief discussion of some of the case law in which courts attempt to define insurance. Generally speaking, one must remember that insurance itself, not particular lines of insurance, is the “thing” which the states regulate pursuant to their police powers. The definitions below set forth the underlying elements of insurance rather than detailing a specific list of products which constitute insurance. These elements allow state insurance regulators the flexibility to apply regulatory practices in an ever changing insurance product environment.

“Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.”
Cal. Ins. Code §22

1 The actual wording in GLBA refers to “mortgage” insurance. The Definition of Insurance Working Group believes the drafters of GLBA used the term to mean “mortgage guaranty” coverage.
“‘Insurance’ means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities.” Colo. Rev. Stat. §10-1-102(7)

“‘Insurance’ means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.” Conn. Gen. Stat. §38a-1(10)

“‘Insurance’ means a contract of insurance or an agreement by which one (1) party, for a consideration, promises to pay money or its equivalent or to do an act valuable to the insured upon the destruction, loss or injury of something in which the other party has a pecuniary interest, or in consideration of a price paid, adequate to the risk, becomes a security to the other against loss by certain specified risks; to grant indemnity or security against loss for a consideration.” Ind. Code §27-1-2-3(a)

“‘Insurance’ is a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils called ‘risks,’ or to pay or grant a specified amount or determinable benefit or annuity in connection with ascertainable risk contingencies, or to act as surety.” Ky. Rev. Stat. Ann. §304.1-030

Insurance “shall mean a contract whereby one party, called the insurer, for a consideration, undertakes to pay money or its equivalent or to do an act valuable to another party, called the insured, or to his or her beneficiary, upon the happening of the hazard or peril insured against whereby the party insured or his or her beneficiary suffers loss or injury.” Neb. Rev. Stat. §44-102

“A contract of insurance is an agreement by which the insurer is bound to pay money or its equivalent or to do some act of value to the insured upon, and as an indemnity or reimbursement for the destruction, loss, or injury of something in which the other party has an interest.” N.C. Gen. Stat. §58-1-10

“‘Insurance’ means a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies[,] . . . includes annuities[, and] . . . includes a contract under which one other than the manufacturer, builder, seller or lessor of the subject property undertakes to perform or provide, for a fixed term and consideration, repair or
replacement service or indemnification therefor for the operational or structural
failure of specified real or personal property or property components. . . .” Or.
Rev. Stat. § 731.102

“Essentially, insurance is a contract by which one party (the insurer), for a
consideration that usually is paid in money, either in a lump sum or at different
times during the continuance of the risk, promises to make a certain payment,
usually of money, upon the destruction or injury of ‘something’ in which the other
party (the insured) has an interest.” Couch on Insurance 3d, 1-11

There are several common terms or concepts in these definitions. First, whatever
conceptual spin may be placed on the term, “insurance,” by definition, is a contract. Second, one
party to the contract -- usually the insured -- promises to pay premiums to the insurer. This
promise secures the third element, the promise by the insurer to pay or indemnify the insured in
case of loss. The second and third concepts make up the bargain that is the basis of the insurance
contract. The fourth concept is risk, the threatened loss that triggers the insurer’s obligation as
specified in the contract. Although the concept of risk is characterized in a number of different
ways, i.e., “contingent event,” “determinable risk contingencies,” “ascertainable risk
contingencies,” or “hazard or peril insured against,” the overall concept remains the same. The
concept of risk is the central theme of the insurance contract. It is the element which
distinguishes insurance from most other contractual relationships.

Where the term “insurance” has been defined judicially, the courts have followed
generally the same formula as the state statutes. One court pronounced: “it appears that
‘insurance’ can be characterized as involving: (1) a contract or agreement between an insurer and
an insured which exists for a specific period of time; (2) an insurable interest (usually property)
possessed by the insured; (3) consideration in the form of a premium paid by the insured to the
insurer; and (4) the assumption of risk by the insurer whereby the insurer agrees to indemnify the
insured for potential pecuniary loss to the insured’s property resulting from certain specified
explained insurance more generally as what “exists when a contractual relationship between the
insurer and the insured shifts to the insurer the risk of the loss transferred.” United States v.
Newton Livestock Action Market, Inc., 336 F.2d 673, 676 (10th Cir. 1964). The courts
acknowledge the contingent risk transfer element as the heart of the insurance contract. It may be
characterized as the element that distinguishes insurance from other contracts, as risk shifting is
crucial to the concept of insurance. “[F]or there to be ‘insurance’ there must be a shifting of risk
of loss or a spreading of the risk.” Stearns-Roger Corp. v. United States, 774 F.2d 414, 415 (10th
Cir. 1985) (citing Helvering v. LeGierse, 312 U.S. 531 (1941)). Therefore, whether looking at
statutes or cases, the concept of insurance as a contract involving the spreading or transfer of risk
remains the same.
C. Definition of Insurance: Interpretative Guidelines

GLBA recognizes state insurance regulators’ authority to make determinations regarding whether particular products will be regulated as insurance. The factors listed below are intended to provide guidance to state insurance regulators as they are called upon to exercise their regulatory authority in the financial products marketplace. Common factors that are consistent with the definition of insurance set forth in GLBA include:

(1) The entry by two or more parties into an agreement, generally in the form of a written contract;

(2) The transfer from one party (usually the insured) to another (the insurer) of all or part of the burden of loss from exposure to one or more identified risks;

(3) Consideration, generally in the form of a cash payment known as a “premium,” payable to the insurer; and

(4) In exchange for receipt of the consideration, an acceptance of the risk by the insurer, accompanied by the obligation to indemnify, defend or provide some other form of benefit intended to offset that risk in whole or part.

The paradigm that is at the core of the definition of insurance is the simplest kind of insurance policy: the insured pays a sum certain to the insurer, in return for which the insurer will reimburse the insured if the specified loss occurs. From the global perspective of an insurance product, that paradigm is based on an insurer that collects relatively small sums of money from many insureds, and subsequently paying relatively large sums of money to the few insureds who suffer covered losses during the policy period. The guidelines above are therefore expressed in considerably more general terms, and it must be emphasized that even in this more general form, they do not provide definitive answers in close cases, but rather serve as a starting point for a more in-depth analysis.

With respect to the first factor, the existence of a contract, enforceability is not an absolute requirement. For example, if an insurance transaction is unenforceable because it is fraudulent as a result of the insured not having an insurable interest in the transaction, or because the risk is deemed uninsurable for public policy reasons, the transaction would still be subject to regulations or laws governing prohibited, and possibly criminal, conduct in the business of insurance.

The second factor, risk or loss transfer, is at the heart of the concept of insurance. The element of chance is often stressed, because if the loss is a certainty, there is nothing to insure against. However, the necessary element of chance may involve the amount (e.g., workers’ compensation insurance for a large employer) or the timing (e.g., whole life insurance) of the loss, even if its occurrence is already known or inevitable. Similarly, a loss is not fortuitous if it is the expected result of an intentional act, but intent must be measured from the point of view of the insured: for example, burglary and employee dishonesty are both insurable risks.
It must also be taken into account there may be certain products regulated as insurance by state law that do not meet a traditional definition of insurance. Conversely, there are products excluded from insurance regulation in many states, such as certain warranties, guarantees and similar products, which would meet the definition of insurance but for a legislature’s determination to enact a law expressly excluding them from that definition of insurance.

Finally, it is necessary to distinguish between the definition of an “insurance product” and the “business of insurance.” The “product” definition is not intended as a comprehensive analysis of the business of insurance, and is only relevant in the broader analysis to the extent the various marketing, administrative and operational activities can only be the business of insurance when associated with or related to the sale, administration and operation of an insurance product. For example, the adjudication and payment of insurance claims is an essential function of the business of insurance. This function can be performed by a third-party administrator (“TPA”), which is not an insurance company. Several states license and regulate TPAs because of the direct impact which the quality of claim adjudication and the timeliness of payment can have on claimants. Thus, they are regulated because they are conducting the business of insurance by providing a service essential to the administration of an insurance product. The “business of insurance” is broader in scope than the issuance of “insurance products,” and defining it involves many issues that are not addressed by these guidelines.

III. DISTINGUISHING THE BUSINESS OF INSURANCE

Apart from the discussion concerning the definition of insurance set forth above, Section 104 of GLBA refers to the operation of state law and reaffirms that McCarran-Ferguson “remains the law of the United States.” For state insurance regulators, whose task it is to regulate the “business of insurance,” this means the whole body of law defining and shaping the concept of the business of insurance will continue to be relevant. Keeping in mind the main focus of this White Paper is to provide guidance on the definition of insurance, this Section of the paper is intended to provide only a summary discussion of federal and state statutes and case law which help interpret the concept known as the “business of insurance” in other contexts.

The debate over the meaning of the phrase “business of insurance” begins with the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq. The Act provides the “business of insurance … shall be subject to the laws of the several States which relate to the regulation or taxation of such business.” 15 U.S.C. §1012(a). The following subsections focus on the efforts by the federal courts to define the phrase as it relates to the areas of antitrust, insurance company insolvency cases, ERISA, and insurance product cases.

A. Antitrust Cases

In the area of antitrust, the U.S. Supreme Court has interpreted the phrase “business of insurance” in §2(b) of the McCarran Ferguson Act (15 U.S.C. §1012(b)) to determine whether the activity in question is exempt from antitrust review under the Sherman Antitrust Act. In Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979), and Union Labor Life Ins.Co. v. Pireno, 458 U.S. 119 (1982), the United States Supreme Court focused its attention on the language of §2(b) of the McCarran-Ferguson Act, 59 Stat. 33 as amended, 15 U.S.C. §§1011-1015, which provides: “[n]o Act of Congress shall be construed to invalidate, impair, or
In determining whether an activity constitutes the “business of insurance,” the Court in Royal Drug and Pireno considered three relevant criteria. First, whether the activity has the effect of transferring or spreading policyholder risk. Second, whether the activity is an integral part of the policy relationship between the insurer and insured. Third, whether the conduct is limited to parties within the insurance industry. As the Court stated in Pireno, none of the criteria is determinative in itself. If the activity is determined to be outside the “business of insurance,” the activity is subject to appropriate antitrust review.

On the other hand, even if the activity is considered to be within the “business of insurance,” it does not fall entirely outside the realm of antitrust scrutiny. Subsection 2(b) also requires the activity in question to be regulated by state law. Additionally, the activity in question must satisfy §3(b) of McCarran-Ferguson, which provides: “[n]othing contained in this Act shall render the ... Sherman Act [antitrust] inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.” Therefore, to determine whether the antitrust exemption applies, the activity in question is reviewed to determine whether it is (1) within the “business of insurance,” giving consideration to the three Pireno criteria, (2) regulated by state law, and (3) not an agreement to or act of “boycott, coercion or intimidation.”

B. Insurance Company Insolvency Cases

McCarran-Ferguson establishes a framework of “reverse preemption,” under which state laws regulating the business of insurance will override conflicting federal laws unless the federal law in question is expressly intended by Congress to apply to the business of insurance and to preempt state law. The analysis generally focuses on three issues: (1) whether the state law in question was “enacted...for the purpose of regulating the business of insurance,” (2) whether the federal law in question would “invalidate, impair, or supersede” the state law, and (3) whether the federal law in question specifically relates to the business of insurance. These issues should be considered in this order, because if the answer to the first issue is in the negative, McCarran-Ferguson will not protect the state law. Likewise, if the answer to the second issue is also in the negative, McCarran-Ferguson will not prevent the application of federal law. Moreover, regardless of the first two issues, if the third issue is answered affirmatively, the federal law will prevail.

These issues have been extensively analyzed by the courts in resolving conflicts between federal bankruptcy law and state insurance insolvency law. Compared to the antitrust cases, the courts appear to take a more expansive view of what is included in the business of insurance in insolvency cases, placing greater emphasis on “regulating the business of insurance.” In this regard, the three “business of insurance” criteria set forth in the Royal Drug and Pireno cases are satisfied where performance of the insurance policy is in issue. More weight is given to protecting the interests of the policyholder. The leading case in this area is U.S. Dept. of Treasury v. Fabe, 508 U.S. 491 (1993). In Fabe, the Court reasoned that since the state law in question dealt with enforcement of policyholder claims and the performance of insurance contracts, there was in fact “risk transfer,” because without contract performance, there could be...
no transfer or spreading of risk. *Id.* at 504. The Court believed that performance of the insurance contract satisfied the other two “business of insurance” factors as well: it is central to the policy relationship between the insured and insurer, and it is confined entirely to entities within the insurance industry. *Id.*

The essence of *Fabe* and its progeny, such as *Bozell v. United States*, 979 F.Supp. 670 (N.D. Ill. 1997), and *Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277 (10th Cir. 1998), is that McCarran-Ferguson “reverses” the doctrine of preemption in cases involving state insurance insolvency laws so that a state law specifically regulating the business of insurance will preempt a conflicting federal law unless the federal law specifically relates to the business of insurance.

C. ERISA Cases

In the major cases involving the Employee Retirement Income Security Act of 1974 (ERISA), the U.S. Supreme Court first looks to see if the state law in question is presumptively preempted by ERISA because it “relates to an employee benefit plan.” If so, the Court then determines whether the state law is “saved” from preemption by the ERISA saving clause because it “regulates insurance.” Rejecting a mode of analysis adopted by a number of lower federal courts, which had focused solely on the three “business of insurance” criteria discussed above, the Supreme Court’s ground-breaking analysis in *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), emphasized the importance of a more expansive “common sense” test, i.e., does the state law in question “regulate insurance” as those words are ordinarily used in the English language? The “common sense” test was derived from two prior cases, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U. S. 724, 740 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U. S. 41, 48 (1987). According to the Court in *UNUM*, the first analysis is whether the state law in question fits a common sense understanding of insurance regulation. Thereafter, the antitrust “business of insurance” criteria are viewed merely as “checking points” or “guideposts,” not as separate essential elements which must be satisfied. The common sense test allows for a more liberal interpretation of whether a state law “regulates insurance.”

D. Insurance Product Cases

In this area, the courts have focused on whether particular products or activities, e.g., underwriting of “Retirement CDs” or selling annuities, should be construed as the business of insurance. For example, in *Blackfeet National Bank v. Nelson*, 171 F3d 1237 (11th Cir.1999), the Eleventh Circuit determined that a bank’s underwriting of “Retirement CDs” was regulated by state insurance law, applying the following three-pronged test under McCarran-Ferguson. First, whether the relevant provisions of the state law were enacted for the purpose of regulating the business of insurance. Second, whether the activity in question involves the business of insurance. Third, whether relevant portions of the federal law specifically relate to the business of insurance. In analyzing the second prong of this test, the Court applied the three business of insurance criteria established in the *Pireno* antitrust case.

On the other hand, the U.S. Supreme Court in *Nationsbank of North Carolina v. Variable Annuity Life Ins. Co.*, 513 U.S. 251 (1995), held the activity in question (sale of annuities by a
national bank), did not involve the business of insurance and was permitted as an incidental power under the National Bank Act. The *Nationsbank* case was one of the key cases in a series of decisions, culminating in the *Barnett Bank* case, which ultimately allow national banks to sell insurance. It is fair to say that these particular cases are ones which should be noted more for the result than for the internal logic. Of course, GLBA allows for the sale of insurance products by financial subsidiaries of banks.

IV. RESOLUTION OF DISPUTES UNDER SECTION 304 OF GLBA

Under Section 304 of GLBA, Congress provides for a dispute resolution process (See Appendix B). The purpose of Section 304 is to provide a mechanism for obtaining a definitive ruling from a U.S. Court of Appeals when “regulatory conflicts” between state insurance regulators and federal regulators arise involving insurance issues that cannot be resolved on a voluntary basis.

Regulatory conflicts may occur when there is disagreement over which regulator has authority to regulate a product or activity. For example, a regulatory conflict may arise where a state insurance commissioner asserts that a particular product is subject to state insurance regulation and a federal regulator takes a conflicting position. With respect to the process for resolving such a dispute, a state insurance regulator or federal regulator may seek an “expedited judicial review” by filing a petition for review in the federal court of appeals with jurisdiction over the state where the controversy arises, or the federal court of appeals for the District of Columbia.

Section 304 also sets forth a deadline for filing a petition for review. A petition for review must be filed no later than: (a) twelve (12) months after the date of the first public notice of the contested order, ruling, determination or other action in its final form or (b) six (6) months after the date such action takes effect, whichever is later. Once a petition for review is filed, the Court of Appeals must complete an “expedited review,” i.e., all of its action on the petition, including rendering a judgment, must be completed no later than sixty (60) days after the date of filing the petition. However, if all the parties agree, the 60-day time period may be extended.

As for the standard of review used by the Court of Appeals, all questions presented under state and federal law will be reviewed on the merits “without unequal deference.” This means the *Chevron* doctrine, under which the courts give deference to regulators’ interpretations of the laws they enforce, will not be applied in a manner that gives federal regulatory interpretations preferred status in the federal courts. The review includes the nature of the product or activity in question, as well as the history and purpose of its regulation under state and federal law. After the Court of Appeals renders a judgment on the petition, a party may request further review by the U.S. Supreme Court. However, whether the Supreme Court decides to review the case is purely discretionary.

The Definition of Insurance Working Group was requested to review the dispute resolution process set forth in Section 304. It was the consensus of this Working Group to suggest to the Coordinating with Federal Regulators Working Group that federal and state regulators work to establish a voluntary dispute resolution process to be utilized before filing a
petition for review with the U.S. Court of Appeals. The suggestion was favorably received and the Coordinating with Federal Regulators Working Group will explore the feasibility of developing such a dispute resolution process.

V. CONCLUSION

With the enactment of the new financial services modernization law, known as GLBA, Congress is requiring the implementation of a regulatory scheme based on the “functional regulation” of financial holding companies. The definition of insurance contained in Subsection 302(c) of GLBA, although it identifies categories of products for purposes of restricting the activities of a national bank and its subsidiaries, does not define the commonly recognized elements which generally constitute an insurance product. This White Paper has been prepared to offer guidance to state insurance regulators on these commonly recognized elements. Of course, where there is any conflict between this White Paper and a state’s law, the state law should control.

The new law also reemphasizes the importance of McCarran-Ferguson and the broader concept of the “business of insurance.” The courts’ analysis of the “business of insurance” has gradually evolved over the years. Initially, the courts in antitrust cases applied a narrow interpretation of the McCarran-Ferguson business of insurance language. However, as evidenced by the recent decisions in Fabe and UNUM, the courts are now applying a broader, more expansive interpretation of what is included in the business of insurance.

Finally, in the new era of functional regulation of financial holding companies, conflicts between state insurance regulators and federal regulators are likely to arise where disputes involving insurance issues cannot be resolved on a voluntary basis. Under GLBA, Congress has provided for a dispute resolution process to address such “regulatory conflicts” through petition for review directly to the U.S. Court of Appeals. The Definition of Insurance Working Group has recommended exploring the establishment of a formal voluntary dispute resolution process before resorting to the judicial process.
APPENDIX A

Subsections 302(a) and (c) of GLBA (15 U.S.C. § 6712) provide as follows:

SEC. 302. INSURANCE UNDERWRITING IN NATIONAL BANKS.

(a) IN GENERAL—Except as provided in section 303 [providing a limited exception for certain grandfathered title insurance activities], a national bank and the subsidiaries of a national bank may not provide insurance in a State as principal except that this prohibition shall not apply to authorized products….

(c) DEFINITION – For purposes of this section, the term ‘insurance’ means--

(1) any product regulated as insurance as of January 1, 1999, in accordance with the relevant State insurance law, in the State in which the product is provided;

(2) any product first offered after January 1, 1999 which—

(A) A State insurance regulator determines shall be regulated as insurance in the State in which the product is provided because the product insures, guarantees, or indemnifies against liability, loss of life, loss of health, or loss through damage to or destruction of property, including, but not limited to, surety bonds, life insurance, health insurance, title insurance, and property and casualty insurance (such as private passenger or commercial automobile, homeowners, mortgage, commercial multiperil, general liability, professional liability, workers’ compensation, fire and allied lines, farm owners multiperil, aircraft, fidelity, surety, medical malpractice, ocean marine, inland marine, and boiler and machinery insurance); and

(B) Is not a product or service of a bank that is—

(i) a deposit product;

(ii) a loan, discount, letter of credit, or other extension of credit;

(iii) a trust or other fiduciary service;

(iv) a qualified financial contract (as defined in or determined pursuant to section 11(e)(8)(D)(I) of the Federal Deposition Insurance Act); or

(v) a financial guaranty, except that this subparagraph (B) shall not apply to a product that includes an insurance component such that if the product is offered or proposed to be offered by the bank as principal—
(I) it would be treated as a life insurance contract under section 7702 of the Internal Revenue Code of 1986; or

(II) in the event that the product is not a letter of credit or other similar extension of credit, a qualified financial contract, or a financial guaranty, it would qualify for treatment for losses incurred with respect to such product under section 832(b)(5) of the Internal Revenue Code of 1986, if the bank were subject to tax as an insurance company under section 831 of that Code; or

(3) Any annuity contract, the income on which is subject to tax treatment under section 72 of the Internal Revenue Code of 1986.
Section 304 of GLBA (15 U.S.C. §6714) provides:

(a) Filing in Court of Appeals. In case of a regulatory conflict between a State insurance regulator and a Federal regulator regarding insurance issues, including whether a State law, rule, regulation, order, or interpretation regarding any insurance sales or solicitation activity is properly treated as preempted under Federal law, the Federal or State regulator may seek expedited judicial review of such determination by the United States Court of Appeals for the circuit in which the State is located or in the United States Court of Appeals for the District of Columbia Circuit by filing a petition for review in such court.

(b) Expedited Review. The United States Court of Appeals in which a petition for review is filed in accordance with subsection (a) shall complete all action on such petition, including rendering a judgment, before the end of the 60-day period beginning on the date on which such petition is filed, unless all parties to such proceeding agree to any extension of such period.

(c) Supreme Court Review. Any request for certiorari to the Supreme Court of the United States of any judgment of a United States Court of Appeals with respect to a petition for review under this section shall be filed with the Supreme Court of the United States as soon as practicable after such judgment is issued.

(d) Statute of Limitation. No petition may be filed under this section challenging an order, ruling, determination, or other action of a Federal regulator or State insurance regulator after the later of –

(1) the end of the 12-month period beginning on the date on which the first public notice is made of such order, ruling, determination or other action in its final form; or

(2) the end of the 6-month period beginning on the date on which such order, ruling, determination, or other action takes effect.

(e) Standard of Review. The court shall decide a petition filed under this section based on its review on the merits of all questions presented under State and Federal law, including the nature of the product or activity and the history and purpose of its regulation under State and Federal law, without unequal deference.