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BY THE COMPTROLLER GENERAL ~~1626~~

Report To The Congress

OF THE UNITED STATES

Issues And Needed Improvements In State Regulation Of The Insurance Business

This report reviews the resources and activities of all State insurance departments in the United States today and evaluates some of them. It is not an all-inclusive evaluation of State insurance regulation because some States perform certain functions better than others; nor does it review the regulation of all lines of insurance. The report covers the following generally applicable issues:

--background and purposes of insurance regulation;

--workload and resources of departments;

--departments' financial examination procedures;

--consumer protection and trade practices regulation;

--automobile insurance price regulation;

--automobile insurance risk classification;

--insurance availability; and

--organization of insurance regulation.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To The President of The Senate and the
Speaker of the House of Representatives

This report assesses the effectiveness of the regulation of insurance by State insurance departments and discusses a number of insurance regulatory issues.

Primarily concentrating on automobile insurance, the report finds a number of regulatory shortcomings in that most insurance departments do not have systematic procedures to determine whether consumers are being treated properly with respect to such matters as claims payments, rate-setting, and protection from unfair discrimination.

This report responds to growing Congressional interest in the effectiveness of the States in regulating the business of insurance pursuant to the McCarran-Ferguson Act. Although we make no specific recommendation with respect to a Federal response to the cited shortcomings, we believe that the information and analysis in this report will prove useful to the Congress in evaluating the alternatives before it.

We are also sending this report today to the Governors and congressional delegations of the States in which we did fieldwork, and the chairmen of cognizant congressional committees.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATION OF THE INSURANCE BUSINESS

D I G E S T

There are serious shortcomings in State laws and regulatory activities with respect to protecting the interests of insurance consumers in the United States. In particular, most State insurance departments do not have systematic procedures to determine whether insurance consumers are being treated properly with respect to such matters as claims payments, rate-setting, and protection from unfair discrimination.

The States have primacy in regulating insurance due to the McCarran-Ferguson Act. The Congress passed the Act in 1944 to reaffirm States' primacy in order to secure adequate regulation of the business of insurance after a Supreme Court decision to the contrary.

Critics in the Congress and elsewhere have since charged that State insurance departments have not adequately protected insurance consumers. GAO examined the resources and activities of the State insurance departments through a questionnaire to all States and fieldwork in a sample of 17 States. Its review covered some regulatory activities with regard to all lines of insurance with the primary focus on regulatory issues involving automobile insurance, particularly price regulation, risk classification, and insurance availability.

Each State has an insurance regulatory agency whose responsibilities include licensing companies and insurance agents, maintaining a system of financial and trade practice regulation, and ensuring that rates are not excessive, inadequate, or unfairly discriminatory.

INSURANCE DEPARTMENT RESOURCES

There is variety in the resources of the various State insurance departments. Some States spend far more than others with about the same population and amount of insurance business. In general, the number of individuals on insurance department staffs with relevant professional training is small, departments spend little to upgrade staff skills, and salary levels are low in relation to the salaries of similar professionals elsewnere. (See ch. 3.)

FINANCIAL AND TRADE PRACTICE REGULATION

Insurance departments are responsible for monitoring the compliance of insurance companies with legal requirements by direct examination and other means. Traditionally, their primary focus was the financial condition of the companies. More recently, there has been increased attention to other consumer protection requirements, and many States now perform market conduct examinations.

An earlier study of financial regulation sponsored by tne National Association of Insurance Commissioners (NAIC) found a number of deficiencies in the process of financial regulation. The NAIC adopted many of the study recommendations, and revised its examination handbook. However, apart from increased use of the NAIC's "early warning system" to detect potential financial problems, most State insurance departments have not instituted the changes recommended by the NAIC-sponsored study 5 years ago. Most States do not have specialized examiners and few States have the capacity to do computerized audits. (See ch. 4.)

State insurance departments are also responsible for receiving and responding to complaints about insurance companies and agents. All departments examined by GAO were responsive to individual complaints, although the authority of departments to order corrective action is very limited. Moreover, most departments do not effectively utilize consumer complaints in other regulatory activities. The most

common use of consumer complaints in enforcement activities is to target companies for special market conduct examinations, but this was done systematically in less than half the States in which GAO did fieldwork. Most States do not maintain a system whereby complaints are coded, analyzed, and used in the examination process.

GAO also reviewed a number of market conduct examination reports and found deficiencies in all of them. The most serious was a lack of explicit standards in evaluating insurance companies. Although all States had unfair trade practices laws, none of the market conduct examinations explained what the minimum standards were or even if such standards were used in assessing company performance. The most common cause of consumer complaints against insurers is the handling of claims. None of the insurance departments GAO examined monitored claims handling performance on a routine basis. Moreover, claims handling was reviewed by departments solely from the perspective of insurance company records, only one State included consumer comments or complaints as part of its review process. (See ch. 4.)

PRICE REGULATION

GAO examined two major issues concerning the regulation of automobile insurance rates.

--How thoroughly do the insurance departments review rate requests?

--Is price regulation of automobile insurance necessary?

GAO found: (See ch. 5.)

--The degree of scrutiny given important premium increase requests varies among the States. Among those GAO examined, only Texas and Massachusetts conducted an original actuarial analysis enabling them to independently recommend the appropriate level of insurance rates.

Viewed retrospectively, the staff recommendations in the two States more accurately reflected actual loss experience than the rates recommended by insurance companies.

--Viewed on a statewide basis, the automobile insurance industry is structured to facilitate competition. However, there are limits to what competition can achieve due to a lack of consumer information, legal impediments, selective underwriting, and other factors.

--There is little difference in the price of automobile insurance (measured by the loss ratio) between States that regulate insurance rates and those that do not.

--Using appropriate statistical analysis, GAO found that what differences exist are primarily accounted for by one State with relatively low insurance costs and, secondarily, by the relative size of the staff and budget of State insurance departments.

Insurance rates in the voluntary private passenger automobile insurance market need not be regulated if there is appropriate regulatory action to lessen the current limitations on competition. Specifically, much greater regulatory action is needed to provide consumers with enough information to enable the automobile insurance market to fulfill its competitive potential. In these circumstances, regulation of base insurance rates would be unnecessary, but regulation to prevent unfair discriminatory pricing would still be appropriate. (See ch. 5.)

AUTOMOBILE RISK CLASSIFICATION

Insurance companies base their automobile insurance premiums on the loss experience of the group to which the policyholder belongs. Since the 1950s, policyholders have been grouped according to age, sex, marital status, and the location where the automobile is garaged. Recently, some States have banned

the use of age, sex, and marital status. Critics have charged that these categories are not as accurate, on an individual basis, as claimed by insurers and yield pricing differences that are inequitable.

Although GAO does not conclude that the classification plans now used either are or are not unfairly discriminatory, there are serious questions which have been properly raised about the propriety of these plans and the resulting price differentials. Similarly, while losses do differ by territory, questions have been raised about whether, in many areas the current territorial boundaries are the optimum way of grouping risks. GAO found: (See ch. 6.)

--Most insurance departments have not analyzed the actuarial basis of personal classification plans.

--Most insurance departments have not determined whether loss experience justifies territorial boundaries.

INSURANCE AVAILABILITY

Community groups and some Government agencies have charged that insurance companies engage in redlining--the arbitrary refusal to insure based on geographic location. Without attempting to reach a conclusion on the merits of these charges, GAO found that only a minority of the urbanized States have conducted studies to determine if redlining was a problem in their States.

Every State has an assigned risk plan or other means of providing insurance for those who are otherwise unable to obtain insurance. Although insurance is available, consumers in many States are affected adversely by being denied coverage in the voluntary market because coverage in assigned risk plans is limited and premiums are considerably higher. Moreover, in some States, many of the people whose

applications for insurance are rejected are not necessarily high risks. The protection of consumer interests in obtaining insurance needs improvement; specifically:

--While consumers are protected against arbitrary cancellation during most of the policy period, most State laws allow a "free look" period of 60 days during which an insurer can cancel coverage for any reason.

--In most States consumers do not have a right to be told why their application for insurance was rejected.

--None of the departments GAO examined routinely determined why individuals are placed in the assigned risk plan, and most did not know the number of clean risks in the plan.

--In some States, so-called substandard companies insure individuals (who otherwise would go to the assigned risk plan) at rates considerably in excess of those charged by the assigned risk plan, a situation that may indicate a serious problem of availability and consumer information. (See ch. 7.)

REGULATORY ORGANIZATION AND INDEPENDENCE

A number of advantages are claimed for State regulation of insurance. These include Federalism, innovation that can be tried on a State-by-State basis, increased effectiveness spurred by the threat of Federal intervention, and more responsiveness to local needs. GAO found evidence that affirms, as well as evidence that contradicts, all of these points. In particular, even though the system emphasizes localism, many insurance problems are national, and there would be economies of scale in performing some functions centrally.

A good deal of uniformity in regulation is provided by the National Association of Insurance Commissioners. None of the insurance company officials interviewed believed that having to comply with different regulations in different States imposed significant costs, and they viewed any problems created by multiple jurisdictions as residing only in a few problem States. (See ch. 8.)

In many regulatory settings, it is important that regulators be impartial and responsive to broad public interests. Nonetheless, a common and longstanding criticism of insurance departments is that they are overly reponsive to the insurance industry at the expense of its consumers.

GAO found that insurance regulation is not characterized by an arms-length relationship between the regulators and the regulated. While the extent of the "revolving door" problem may be overstated by critics of State regulation, about half of the State insurance commissioners were previously employed by the insurance industry and roughly the same proportion joined the industry after leaving office. The meetings of the National Association of Insurance Commissioners are numerically dominated by insurance industry representatives. Its model laws and regulations were drafted with advisory committees composed entirely of insurance company representatives.

Most insurance commissioners commenting on the matter objected to GAO's findings that insurance regulation is not characterized by an arms-length relationship between the regulators and the regulated. GAO did not conclude that most commissioners are "revolving door" appointments or that there is anything necessarily wrong with industry employment before or after department service. However, there is still a substantial imbalance in the meetings of the NAIC.

Several insurance departments partially disagreed with GAO's findings of various shortcomings. Tney stated that although there are

shortcomings, many of the issues GAO raised are new and the insurance departments are responding to problems in a timely fashion. (See ch. 9.)

Although GAO makes no specific recommendation with respect to a Federal response to the cited shortcomings, GAO believes that the information and analysis in this report will prove useful to the Congress in evaluating the alternatives before it.

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ABBREVIATIONS

DLB 02983

NAIC	National Association of Insurance Commissioners
FTC	Federal Trade Commission AGC00059
ICC	Interstate Commerce Commission AGC00072
ISO	Insurance Services Office DLB-02986
FIA	Federal Insurance Administration AGC00751
AIP	Automobile Insurance Plan ID

CHAPTER 1

INTRODUCTION

The primacy of the States to regulate insurance is the result of explicit Federal policy set forth in the McCarran-Ferguson Act of 1945. The Congress passed the act after the U.S. Supreme Court ruled (U.S. v. South-Eastern Underwriters Association (1944)) that the business of insurance is commerce and therefore subject to Federal antitrust laws. The act exempts the business of insurance from coverage by the Sherman, Clayton, Federal Trade Commission, and Robinson-Patman Acts to the extent that the business of insurance is regulated by State law. The Congress declared in the Act that "* * * the continued regulation and taxation by the several States of the business of insurance is in the public interest." Furthermore, in reporting out the bill, the House Committee on the Judiciary stated that enactment of the bill would secure more adequate regulation of the business of insurance. Thus, the current division of responsibility for insurance regulation rests on the assumed adequacy of State regulation. The prerequisites for exemption from the antitrust and Federal Trade Commission laws are fulfilled by the existence of State laws regardless of the quality of those laws or how well they are implemented.

The Congress has also addressed the question of how well the insurance industry and State regulators are serving the needs of the public. In the 95th Congress, the Subcommittee on Citizens and Shareholders Rights and Remedies of the Senate Committee on the Judiciary held hearings on alleged discrimination in insurance underwriting and on the rights of policyholder owners in mutual insurance companies. The Oversight and Investigations Subcommittee of the House Interstate and Foreign Commerce Committee held hearings on life insurance cost disclosure proposals. The Subcommittee on Capital, Investment, and Business Opportunities of the House Committee on Small Business held hearings on the crisis in providing products liability insurance. In the 96th Congress, the House Select Committee on Aging held hearings on alleged abuses in the provision of health insurance to the elderly, and the Senate Antitrust Subcommittee held hearings on life insurance cost disclosure. Several bills have been introduced in the 96th Congress that would repeal or amend the McCarran-Ferguson Act and establish Federal regulation or standards for certain aspects of insurance. Legislation that would substantially repeal the McCarran-Ferguson Act has also been proposed by the National Commission to Review Antitrust Law and Procedures.

Critics of State regulation do not believe that this giant national industry is effectively regulated at the State level. They charge that most State insurance departments do not adequately protect consumers because State insurance regulatory departments have:

--been dominated by "revolving door" commissioners who come from insurance companies and return to the industry,

--been inadequately staffed and funded,

--protected companies and agents rather than the public, and

--failed to address major consumer protection issues.

State regulators, on the other hand, maintain that State regulations do, indeed, serve the public. They argue that State insurance departments already have expert personnel in 50 States, that State regulation is closer to the people than any Federal regulation can be, and that State regulation affords beneficial diversity and innovation. The full contours of this debate are discussed in more detail in chapter 8.

SCOPE

The purpose of this study is to present an overview of the resources and activities of all State insurance departments and to provide an intensive evaluation of a smaller number of States. In this study we did not provide an all-inclusive evaluation of the adequacy of State insurance regulation because some States perform certain functions better than others; nor did we review the regulation of all lines of insurance. We did, however, review the following generally applicable issues:

--The background and purpose of insurance regulation.

--The workload and resources of departments, including overall quantitative measures of workload and the division of resources between regulatory functions, such as budgets, quantity and qualifications of personnel, and the identified needs of departments.

--Departments' financial examination procedures.

--Consumers protection and trade practices regulation, including the extent and thoroughness of the departments' enforcement of trade practice laws, market conduct examinations, complaint handling procedures, and the monitoring of claims handling.

To provide a focus for this study, we concentrated part of our review on the regulatory issues surrounding automobile insurance. We selected this line of insurance for several reasons:

--The way States regulate rates varies considerably, and thus they present a unique opportunity to compare the effects of price regulation.

--Automobile insurance is compulsory in about half the States; in most other States it is the most practical way of complying with financial responsibility laws. For these reasons, questions about the pricing and marketing of automobile insurance are necessarily political issues.

--Automobile insurance has become a highly controversial political issue in many States and there have been calls for Federal legislation to deal with some automobile insurance problems. Apart from no-fault automobile insurance, which we did not review, other automobile insurance problems have not been extensively studied by the Congress or the other support agencies.

Therefore, we reviewed the following interrelated issues pertaining to the regulation of private passenger automobile insurance:

--Price Regulation. States have differing systems of regulating insurance premiums, ranging from no regulation of rates to statemade rates. We assess the procedures by which States monitor insurance rates and review the various effects of different systems of price regulation.

--Risk Classification. The division of risks by territories, and the use of age, sex, and marital status as indicators of risk have become major issues in the debate about State regulation. We review the controversy and assess the extent to which the States have evaluated whether these plans constitute unfair discrimination.

We review State programs designed to address these problems. This issue also includes property as well as automobile insurance.

In general, our criteria in conducting this review are based on the existing regulatory responsibilities of the States. Thus, the report concentrates primarily on the implementation of insurance laws rather than the adequacy of those laws. 1/ Much of the review assesses the extent to which the States are discharging their statutory mandates. There is also a comparative dimension to the review, as we examine the effects of different systems of regulation. Our review applies almost exclusively to the regulation of personal lines insurance, rather than the less regulated commercial lines.

METHODOLOGICAL APPROACH

This review was conducted in two phases. First, a comprehensive questionnaire was sent out to insurance departments in the 50 States and the District of Columbia. (See app. I.) Forty-five of the 51 questionnaires were returned.

Second, staff members from GAO regional offices did fieldwork, ranging from 1 to 4 weeks, in the insurance departments of the following 17 States: Arizona, California, Connecticut, Indiana, Illinois, Kansas, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, South Carolina, Texas, Virginia, Washington, and Wisconsin. The fieldwork supplemented some of the issues covered on the questionnaire. The bulk of the fieldwork, however, focused on the regulation of automobile insurance. Wherever appropriate, we have combined the questionnaire and fieldwork results. Results that originate from the fieldwork are referred to as "fieldwork States" or "fieldwork results."

We have also obtained data from various central sources such as the National Association of Insurance Commissioners (NAIC), insurance trade associations, and research institutions, and we have analyzed that data in relation to the data collected from the questionnaire and the field visits.

1/Statements pertaining to State laws are based on information supplied by the States and on other secondary sources, except for cases and laws directly quoted.

CHAPTER 2

THE BACKGROUND OF INSURANCE REGULATION

HISTORY OF INSURANCE REGULATION

Regulation is thought of as a modern phenomenon, but the regulation of insurance is nearly as old as the business of insurance: both originated during the Renaissance. Insurance policies as we know them were first devised in the 1300s by brokers in the northern city states of Genoa, Florence, and Pisa. The earliest extant insurance policy is dated 1347. Legislation on insurance soon followed these early policies.

In late 14th century the city of Genoa enacted a law to prevent the placing of insurance on foreign ships because such insurance was used frequently as a gambling device.

Most likely the earliest use of a special agency to administer the regulation of insurance was in Florence, where by a statute of 1523, commissioners were appointed by a city magistrate and invested with extensive powers over insurance transactions. 1/

Despite its earlier origins in Europe, insurance and insurance regulation did not begin in the American colonies until the 18th century. Apparently, the earliest fire insurance company was established in 1721, but soon went out of business. The first successful fire insurance association was not established until 1752, in Philadelphia. Until American independence, colonial insurers were necessarily small because Parliament forbade the organization of any stock insurance companies other than corporations based in London and chartered by Parliament. Soon after the adoption of the Constitution, insurance companies began to incorporate, often by enactment of special State legislation. The still-thriving Insurance Company of North American was incorporated in Pennsylvania in 1794.

The regulation of insurance in the United States evolved through several phases during the 19th century. The early

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1/Edwin W. Patterson, The Insurance Commissioner in the United States: A Study in Law and Practice (Cambridge; Harvard University Press, 1927), pp. 514-515. Much of the following historical discussion is based on Patterson.

purposes of regulation were three-fold: (1) to protect policyholders; (2) to protect American companies from once-dominant British insurers; and (3) to raise revenue from license taxes, premium taxes, and similar devices.

During the first phase of the evolution, once a company was put into operation, usually by a legislative charter, the only mandatory regulatory devices were periodic reports to the public on the financial condition of the company. The purposes of these requirements were to provide information for legislative action and judicial enforcement of the law, and to make public the financial condition of the companies so that individuals could determine for themselves the safety of the insurance companies. One leading scholar on the subject noted:

> "That neither of these theories was sufficient in practice to attain the chief end of insurance regulation is evidenced by the fact that in every jurisdiction in which they were tried they have been superseded or at least supplemented, by administrative devices such as licensing, inquisitorial and disapproval powers, which give continuous and effective official control." 1/

Starting with New Hampshire in 1851, the States took the next step in the evolution of regulation--they created boards of insurance commissioners. Although New Hampshire had a special full-time board of commissioners, another common form was a part-time board composed of officials who served ex officio by virtue of their occupying other State offices. Massachusetts created the first of these part-time boards in 1852.

The final phase in the evolution of insurance regulation was the creation of a separate office headed by a single commissioner whose sole function was to enforce insurance legislation. New York was the first State (1859) to create a separate administrative agency headed by a single superintendent vested with broad licensing and inquisitorial powers. By 1919, 36 States had created permanent administrative agencies for insurance regulation.

1/Edwin W. Patterson, op. cit., p. 525.

THE LEGAL BASIS OF STATE REGULATION

Insurance regulation thus developed as a matter under the jurisdiction of the States. State jurisdiction was reaffirmed by the landmark case of Paul v. Virginia (1868) in which the U.S. Supreme Court upheld a Virginia statute requiring the licensing of foreign companies and their local agents. The Court held that "issuing a policy of insurance is not a transaction of commerce," and therefore the insurance business would not come under the commerce clause of the U.S. Constitution. 1/

With Paul as the controlling case, State jurisdiction seemed to be firmly established. In 1945 the House Committee on the Judiciary noted:

> "From its beginning the business of insurance has been regarded as a local matter, to be subject to and regulated by the laws of the several States. This view has been fostered and augmented by decisions of the United States Supreme Court for a period of more than 75 years, leading to the generally accepted doctrine that the business of insurance was not subject to federal law." 2/

That doctrine prevailed until 1944 when the Supreme Court issued its landmark decision in U.S. v. South-Eastern Underwriters Association. 3/ The South-Eastern Underwriters Association was composed of 198 member companies who sold 90 percent of the fire and allied lines insurance in six southern States. The Justice Department obtained an indictment against the Association and its member companies for allegedly fixing premium rates, monopolizing commerce in insurance in the six-State area, and coercing and intimidating nonmember companies. The District Court dismissed the indictment, relying on the Paul doctrine that insurance was not commerce. The Supreme Court, however, overruled the lower court and held against South-Eastern Underwriters Association. Overturning the Paul v. Virginia precedent, the Court held that

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1/8 Wall., 168, 183.

2/U.S. Congress, House Committee on the Judiciary, House Report No. 143, February 13, 1945, pp. 670-671.

3/322 U.S. 533 (1944).

"No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." 1/

The Court's decision threw the industry and State regulators into turmoil. In addition to casting doubt on the legality of private rating bureaus, the decision also cast doubt on the States' power to tax and otherwise regulate the insurance companies. 2/ In response, the Congress passed the McCarran-Ferguson Act in 1945. The act declared that "the continued regulation and taxation by the several States of the business of insurance is in the public interest * * *."

Basically, the act exempted the insurance business from the Federal antitrust laws, the Sherman Act, the Clayton Act, and the Federal Trade Commission Act, as long as insurance was regulated by State law. The antitrust exemption is not complete, however. Still proscribed under the Sherman Act are any acts of or agreements to boycott, coerce, or intimidate.

The courts have held that the McCarran Act exemption applies as long as a State has adopted some comprehensive scheme regulating the business of insurance, but

"* * * there is nothing in the language of the McCarran Act or in its legislative history to support the thesis that the Act does not apply when the state's scheme of regulation has not been effectively enforced." 3/

Although there has been some narrowing of the McCarran exemption, 4/ the States still have primary responsibility for

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1/Ibid., 552-555.

2/H.R. Rep. No. 143, 79th Cong., 1st sess. (1945).

3/Ohio AFL-CIO v. Insurance Rating Board 451 F.2d 1178, 1184 (1971).

4/St. Paul Fire & Marine Insurance Co., et al. v. Barry 98 S. Ct. 2923; Group Life and Health Insurance Co. v. Royal Drug Co., 47 U.S.L.W. 4203 (Supreme Court).

regulating insurance and the States are deemed to be regulating insurance by the existence of relevant laws and by insurance departments to enforce these laws. 1/

Some of the background and legal issues relating to rate regulation are discussed in chapter 5.

RATIONALE FOR INSURANCE REGULATION

When evaluating the effects of regulation, it is useful to examine the justification and purposes of regulation. Although the business of insurance has been regulated for more than five centuries, the justification and assumptions behind that regulation are not always apparent. This section reviews the general rationale for government regulation and insurance regulation within the context of that rationale.

The need for Government regulation

Although the United States is basically a free market economy, the Government intervenes when a particular market does not function efficiently or when the market produces undesirable consequences for society.

Flaws in the marketplace which require regulatory intervention are known as market failures. Examples of market failures are:

--Natural monopolies wherein the production of a commodity is characterized by substantial economies of scale. The largest firm in the industry is the most efficient and has the ability to underprice competing firms and drive them out of business. The surviving firm becomes a monopolist who tends to reduce output, raise prices, and make excess profits.

--Interdependencies in extracting natural resources, which occur when a producer's activities limit the use of the resources by other producers. Unregulated natural resource interdependency results in inefficient use of natural resources. An extreme form of interdependency--natural resource monopoly--would produce the same effects caused by natural monopolies.

1/Ohio AFL CIO v. Insurance Rating Board 451 F.2d 1178. FTC v. National Casualty Co., 357 U.S. 563.

--Destructive competition, which exists when destabilizing price wars render an industry incapable of satisfying consumer demand. Prices and product availability fluctuate widely, sustained losses are incurred by firms and wants go unsatisfied. Both consumers and producers are injured. Destructive competition, however, is rare and is the result of special characteristics of an industry that may be subject to it.

--Externalities, which are costs of production or consumption that fall on third parties rather than on the individual who created them, and therefore cause an inefficient use of resources.

--Inadequate information in the marketplace, which prevents the best functioning of the market and results in poor decisions and wasted resources.

There are also social, political, and other reasons for Government intervention when a market fails to produce desired social consequences. The broad social policy objectives behind regulation include

--consumer health and safety,

--concern over the distribution of income,

--considerations of equity or fair play,

--protection of those deemed worthy of special protection (such as small businesses and family farms), and

--protection of consumers from specific price increases.

The need for regulating the insurance business

The business of insurance is characterized by several market failures requiring Government intervention. The most compelling reason for insurance regulation is that an insurance policy is a contract for future services. Customers pay a small regular, predetermined fee (an insurance premium) for the promise that they will be compensated if certain unpredictable misfortunes occur in the future. The insurance marketplace can function only if there is a reasonable assurance that the company will be able to pay for the future loss--in other words, the company must remain solvent. In most other transactions, the long-term financial viability of the seller is

of no concern to the consumer, but in the business of insurance, future solvency (or provisions for payment in the event of insolvency) is absolutely essential. Theoretically, assurance of solvency is possible through self-regulation. However, the interests of industry, consumers, and society in sharing risks and spreading the costs of loss are so compelling that a Government regulatory system is justified.

The insurance market is also characterized by a lack of adequate consumer knowledge in three main areas. The first is insufficient knowledge of the financial condition of an insurance company. As future solvency is crucial to consumers and consumers cannot be expected to know enough about a company's prospects, Government regulation of the industry's finances is required.

Second, it is difficult for a layman to compare the monetary value of insurance policies. For example, the lack of a meaningful system of price disclosure in life insurance makes it impossible for consumers to compare the value of whole life policies. 1/ When policies offer different types and amounts of coverage, as is the case with supplemental health insurance, it is extremely difficult to judge the value of the policy. Even when the policy forms are more standardized, as with automobile and homeowners insurance, it is hard for consumers to understand what they are buying because the laws of most States permit the policies to be written in obtuse legal language. Even assuming awareness, the consumer would be hard pressed to compare the value of dissimilar policies at different prices because the information necessary to make these comparisons is not available.

Uncertainty about the quality of the service purchased by the policy is the third area of inadequate information. Service quality becomes important when a claim is filed with an insurance company. Companies differ in their claims service and the speed with which they pay claims, and the same company may operate differently at different times. While after-purchase service is a factor that consumers should consider in the purchase of most products, in insurance it is the only factor being purchased. All the consumer is buying from the insurance company is the promise of compensation for specified events. Unlike other products and services, the consumer cannot see or evaluate that service until after the purchase.

1/U.S. Federal Trade Commission, Life Insurance Cost Disclosure, Staff Report to the Federal Trade Commission (July 1979) pp. 70-81.

Without adequate consumer knowledge the market does not provide a system of self regulation that accounts for quality differences. In a competitive market, we would expect price differences to be related to quality differences. Consumer knowledge and demand ensure that those quality differences are fairly valued. Although perfect knowledge is rarely achieved in any market, in many markets consumers have sufficient knowledge to support competition. Although the rise of low cost direct writers is cited by the NAIC as evidence that consumer knowledge is sufficient to support competition, 1/ the apparent awareness of price differences does not imply awareness of quality differences. When sufficient information is not available to compare products and prices, or when the consumer is not able to judge product quality before purchase, consumers are unable to choose the best product for themselves. Not being able to choose limits the consumer impact on the market and reduces the competitive incentive to improve product quality and to lower prices. Lack of knowledge not only leads to a decline in the quality of the products offered, but without adequate knowledge, consumers may also purchase products that are worthless. Thus, regulatory intervention is necessary to produce the effect usually made by knowledgeable consumers.

Another market failure in the insurance market is the existence of externalities. Normally, an externality is an undesirable impact on a third party caused by a transaction between two other parties. In insurance, externalities are caused by the lack of transactions. In most markets, it makes no difference to the consumer if another individual purchases the product. Only in the case of substantial changes in demand for the product is the consumer affected--in in most cases by changes in supply and price. In the case of liability insurance in a fault-finding tort system, it makes a great deal of difference whether other consumers have purchased insurance. If Consumer Jones causes an accident that severely injures Consumer Smith, Smith is harmed again if Jones does not have assets to compensate Smith or liability insurance to furnish those assets. Insurance markets which, for whatever reason, cause availability and affordability problems, do produce externalities in that the majority of consumers who have insurance might be negatively affected by the minority who do not have insurance.

1/National Association of Insurance Commissioners, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business, vol. 1, p. 68.

Social policy reasons for insurance regulation

In one sense, all regulation of insurance is premised on a broad social policy objective--that there be a mechanism whereby losses can be shared so that people can have a greater measure of security in their personal and business lives. A major social policy reason for regulation is that some types of insurance are essential. Insurance is either required by law, as in the case of automobile insurance in most States, or is required as a condition of obtaining mortgages and other necessary forms of credit. Through the years, a number of other social policy objectives have evolved. These include prohibitions on unfair discrimination in insurance, restrictions on unfair trade practices, and procedures for providing necessary insurance coverage to those who would be denied it in a free market.

More recently, some regulators and consumer groups have focused on the relationship between insurance and other social problems such as racial discrimination and urban decay. Regulators have also asserted that the currently used risk classification systems which result in substantial rate differences, which are not only inequitable but interfere with other important social goals such as incentives for preventing losses. 1/

The specific purposes of insurance regulation in the United States are addressed in the following section.

THE PURPOSES OF INSURANCE REGULATION

Although early regulation developed to produce revenue and to protect domestic insurers against competition from out of state and alien insurers, the primary stated purpose of modern insurance regulation is to protect the public. The protection of the public involves three main goals. The first is to assure the solidity and solvency of insurance companies. So that the insurance system can provide security against future loss, the financial health of companies must be monitored and policyholders and third party claimants must be protected against loss due to insolvency. The second goal is that rates be neither excessive nor inadequate. Premiums paid by insurance buyers should not be more than the worth of the coverage, and the rates charged by the company should be

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1/See chapter 6.

enough to keep the company financially solid. There is a subsidiary to this second goal--insurance should not be unfairly discriminatory. Individual insureds with the same risk exposure should be charged the same rate by an individual company. Finally, there should be a market available to those who need insurance and can reasonably qualify for it. 1/ While these goals can be further refined, 2/ these three broad goals are generally cited as encompassing the principal purposes of the States' regulatory law and administration.

Although there are variations in specific laws, resources, and regulatory philosophies among the States, there is considerable consistency in the basic functions of the insurance departments found in every State and the District of Columbia. According to the NAIC, the basic functions undertaken by State insurance departments are as follows: 3/

1. Licensing insurance companies and agents. The licensing function requires that a department enforce State law with regard to the formation of companies, financial standards, qualifications as to character of management, and suspension or revocation of license.

2. Examining the financial condition and claims practices.

3. Implementing statutory standards. This entails making sure that rates are not excessive, inadequate, or unfairly discriminatory and that health policies meet standards requiring benefits to be reasonable in relation to premium.

4. Administering a complaint-handling office.

5. Enforcing unfair trade practices laws.

1/C.A. Kulp and John Hall, Casualty Insurance, 4th ed., (New York: Ronald Press, 1968) p. 959.

2/C.F. Spencer Kimball, "The Purposes of Insurance Regulation: A Preliminary Inquiry Into the Theory of Insurance Law," 45 Minnesota Law Review 471 (1961).

3/Jon Hanson, "An Overview--State Insurance Regulation," 31 CLU Journal, pp. 20-31 (April 1977).

6. Regulating residual market mechanisms designed to provide insurance for risks rejected by the voluntary insurance market.

7. Applying for a court order of liquidation, rehabilitation, or conservation of companies because of insolvency or other reasons.

The States undertake these functions with considerable differences in resources, organization, and regulatory activities as will be seen in the next chapter.

CHAPTER 3

OVERVIEW OF STATE INSURANCE DEPARTMENTS: GREAT VARIATION IN RESOURCES AND ACTIVITIES

Just as the 50 States and the District of Columbia are diverse in size, population, demography and economic characteristics, so too do the State insurance departments vary greatly in size, resources, and regulatory philosophy. This chapter is an overview of the organization and resources of State insurance departments. Where appropriate, comparisons will be made to a 1957 comprehensive survey of State insurance regulation by the Senate Judiciary Committee, widely known as the O'Mahoney Report after Senator Joseph O'Mahoney. The report was authorized in the 86th Congress by S. Res. 238 and in the 87th Congress by S. Res. 52 to study the antitrust laws of the United States, and their administration, interpretation, and effect. The data relevant to this report primarily comes from report 1834, which focuses in part on State regulation of the insurance industry. While our report does not attempt to replicate the O'Mahoney survey, several useful comparisons can be made to see what, if any, changes have occurred in the 20 years since the O'Mahoney data were collected.

Much of the information on the current status of insurance departments comes from voluntary responses provided by the States to our questionnaire, and this data has not been verified by us. In particular, insurance departments' reports of their legal authority may be subject to varying interpretations, but we have reported the interpretation provided by each insurance department. Where we found discrepancies or sought verification which was not provided, we have so indicated.

Every State and the District of Columbia has an insurance regulatory department or bureau. In 33 of the States, the department is a separate administrative entity. In the remaining 18 States, the insurance agency is part of another State department, such as a corporation commission or a department of banking and insurance. Two of the States in which we did fieldwork still maintain multimember commissions, although formal administrative responsibility is vested in a single department head. The head of the insurance department in nearly all States is called the insurance commissioner--presumably a carry over from the time when many States had multimember commissions. Most often, the commissioner is appointed by the governor and serves at the governor's pleasure. The second most frequent type of selection is election for a 4-year term.

The types of appointment and terms of office of commissioners are presented in table 1.

Table 1
Commissioners' Term of Office and Methods of Selection

Length of term (years)	Elected	Appointed		
		By the governor	By other	Total a/
2	0	1	0	1
3	0	0	0	0
4	8	6	2	16
5	0	1	0	1
6	0	3	0	3
At the pleasure of the governor	0	14	2	16
At the pleasure of other State official	0	1	5	6
Other	0	0	1	1
Total	8	26	10	44

a/Totals less than 51 because this table is based on questionnaire responses.

INSURANCE DEPARTMENT WORKLOAD

In other sections of this report, specific department responsibilities are considered in greater detail. This section reviews the numerical indicators of workload in some of the basic functions of insurance departments.

Unlike department budget, some aspects of a department's workload and responsibilities do not vary by size of State. Although the larger States usually have far more domestic

(in-State) insurers than smaller States, the total number of companies licensed to do business in a State does not vary greatly. Approximately 900 property and casualty companies are licensed in nearly all States. Insurance departments have a measure of regulatory responsibility over the conduct of all those insurers--foreign and domestic, but the domicile State has primary responsibility for the regulation of a company.

Workload statistics vary considerably. However, this variation is not related to size of State or size of department. For example, the median number of rate filings (company notices of a change in price) requiring prior approval of a department in 1977 was 2,493, but the range was from 28,000 in Nevada to 1 in Oregon. These great differences in reported workloads are due to differences in States as to which new rates require prior approval and to the probable differences as to what constitutes a "rate filing," i.e., whether States counted identical rate filings (usually pursuant to a rate bureau filing) as separate filings. Nonetheless, we regard the median of 2,493 per year as a reasonable indicator of a substantial workload just in rate approval over several lines of insurance.

Another important workload measurement is the number of policy form filings. This number tends to be more uniform across States due to the greater uniformity in State requirements that the insurance policy documents be approved prior to sale to the public. Because many policies have standardized provisions, and many policies submitted for approval are identical, the number of policies requiring approval is overstated by these figures. Nonetheless, the responses from the States show a substantial quantitative responsibility. The median number of policy form filings is 15,000. The median workload indicators are presented in table 2.

Because State departments use different ways of counting and defining what constitutes a rate filing, an examination, and other activities, it is impossible to evaluate the meaning of these workload indicators based on numbers alone. Moreover, because the bulk of these filings are considered routine, it is difficult to assess whether this workload overtaxes the capacity of insurance departments. The subsequent chapters of this report evaluate the degree to which departments scrutize particular activities: rate filings, complaint monitoring, and market conduct examinations.

Table 2

Insurance Department
Workload Measures

Action	Median number 1977
Company action financial examinations	32
Total number of rate filings	2,493
Number of applications for licensing from domestic insurers	2
Number of applications for licensing from foreign insurers	50
Number of applications for agent licenses	13,030
Number of policy form filings	15,000

STATE INSURANCE DEPARTMENT RESOURCES

Critics frequently assert that State insurance departments are so woefully lacking in resources that the States are incapable of adequately regulating the insurance industry. While we have found that the State insurance departments do lack personnel resources, in most States this is not a crippling lack and the States vary greatly in the quantity and quality of staff regulating the insurance industry.

In this section, we will examine the financial and personnel resources available to State insurance departments.

Financial resources

All State insurance departments receive a budget directly from the State government. The median 1978 budget for State insurance departments was $1,360,000, ranging from a high of $16,806,000 for New York State to a low of $218,051 for South Dakota. Note that this is a substantial increase in spending since 1957 when the O'Mahoney survey found that the median budget was $131,600 or $281,900 in 1977 dollars, but the increase is about the same as that recorded by the median State government budget. Table 3 lists 1978 budgets by State.

Table 3

Total Insurance Department Budget by State 1978

Alabama	$ 1,360,000	Nebraska	1,211,458
Alaska	670,000	Nevada	868,511
Arizona	1,116,000	New Hampshire	966,008
Arkansas	981,175	New Jersey	3,554,434
California	10,497,357	New Mexico	518,000
Colorado	965,000	New York	16,806,000
Connecticut	1,156,926	North Carolina	2,000,000
Delaware	2,674,700	North Dakota	321,258
Florida	9,779,406	Ohio	2,345,337
Georgia	a/ 2,468,100	Oklahoma	a/ 761,200
Hawaii	290,084	Oregon	3,155,357
Idaho	483,300	Pennsylvania	5,317,000
Illinois	4,300,000	Rhode Island	438,538
Indiana	1,437,708	South Carolina	2,758,230
Iowa	1,536,612	South Dakota	218,051
Kansas	1,947,961	Tennessee	1,773,880
Kentucky	a/ 1,850,400	Texas	11,467,643
Louisiana	1,113,258	Utah	837,033
Maine	a/ 510,600	Vermont	236,200
Maryland	1,769,957	Virginia	2,084,525
Massachusetts	4,371,796	Washington	1,978,000
Michigan	4,352,901	West Virginia	463,235
Minnesota	1,258,786	Wisconsin	1,902,220
Mississippi	a/ 937,400	Wyoming	a/ 185,700
Missouri	995,287	District of Columbia	677,300
Montana	382,831		
Total			122,252,663

a/1978 budget figures are based on reported figures for the District of Columbia and 44 States that reported figures to us. For the States that did not respond to our questionnaire: Georgia, Maine, Mississippi, Oklahoma, and Wyoming, and for Kentucky, who responded but did not report budget data, we have estimated budget figures as 0.00122 percent of the State budget. Connecticut also did not complete a questionnaire, but we obtained actual budget figures in our fieldwork. The correlation between State government outlays and insurance department budget is 0.799.

Given the differences in the population and resources among the States, insurance department budgets should be viewed in the context of other factors that allow a more meaningful comparison between the States. Accordingly, we have standardized State insurance department budgets in relation to State population, overall State budget, and insurance business in the State. Not surprisingly, both State population and insurance premium volume correlate highly with the size of State insurance department budgets. The correlations are 0.85 for both. Generally, the larger the population of a State and the larger the amount of premium volume, the bigger the budget of the State insurance department.

Nonetheless, when we look at State insurance department budgets in relation to total State budgets and the amount of insurance business in the States, we do find some great differences in the amount of available resources that the States commit to insurance regulation. Because these figures take into account the size of States, they can be used as a comparative measure of State "effort" in insurance regulation.

Table 4 lists the State insurance budget as a percentage of the total State budget and as a proportion of total insurance premium volume. One cautionary note: Given the relatively small amount of expenditures for insurance regulation, small differences in absolute amounts lead to large differences in percentage amounts. Even with this caveat, however, there are noticeable differences in insurance regulatory expenditures controlling for size of State.

It is impossible to evaluate the adequacy of insurance regulatory expenditures based only on the overall budget figures. Budget figures must be viewed in the context of an overall assessment of State regulation as measured by several criteria--an assessment that constitutes the bulk of this report. Since claims and counterclaims have been made about the adequacy of budget figures, some observations on those State budgets are in order. Of the States reporting directly to us, the total 1978 fiscal year expenditures are $115,529,000. We estimate that the remaining six States come to $6,713,000 for an overall total of $122,253,000. Is this too little, enough, or even too much to spend on regulating the business of insurance?

The total amount spent in 1977 is far more than the $16,906,000 spent in 1957, as reported by the O'Mahoney study. Even accounting for inflation, in 1957 the States spent only

Table 4

State Insurance Department Budget in Relation to State Budget, Premium Volume, and Number of Domestic Companies

State	Dept. budget/State budget	Dept. budget per million dollars premium volume	Dept. budget per number of domestic companies
Alabama	.00642	870	22,667
Alaska	.00078	2,302	134,000
Arizona	.00116	931	2,657
Arkansas	.00144	1,189	25,158
California	.00086	861	67,291
Colorado	.00101	789	14,403
Connecticut	.00060	634	25,151
Delaware	N/A	N/A	N/A
Florida	.00370	2,171	43,848
Georgia	N/A	N/A	N/A
Hawaii	.00034	716	143,815
Idaho	.00170	1,211	30,206
Illinois	.00068	630	10,831
Indiana	.00094	536	13,437
Iowa	.00111	1,033	7,722
Kansas	.00228	1,698	35,417
Kentucky	N/A	N/A	37,763
Louisiana	.00036	539	10,603
Maine	N/A	N/A	N/A
Maryland	.00098	1,038	42,142
Massachusetts	.00114	1,424	66,239
Michigan	.00115	959	41,855
Minnesota	.00039	583	6,489
Mississippi	N/A	N/A	N/A
Missouri	.00069	410	9,758
Montana	.00180	1,052	47,854
Nebraska	.00250	1,429	11,649
Nevada	.00393	2,025	289,504
New Hampshire	.00483	2,509	34,500
New Jersey	.00088	863	72,539
New Mexico	.00108	1,026	37,000
New York	.00148	1,764	60,453
North Carolina	.00093	913	25,316
North Dakota	.00117	1,119	6,835
Ohio	.00055	442	12,609
Oklahoma	N/A	N/A	N/A
Oregon	.00309	2,629	185,609
Pennsylvania	.00103	960	20,294
Rhode Island	.00077	1,039	19,067

Table 4 - Continued

State	Dept. budget/State budget	Dept. budget per million dollars premium volume	Dept. budget per number of domestic companies
South Carolina	.00231	2,355	44,488
South Dakota	.00132	699	3,304
Tennessee	.00059	902	27,290
Texas	.00369	1,729	31,162
Utah	.00313	1,828	49,237
Vermont	.00130	1,079	13,894
Virginia	.00105	943	34,173
Washington	.00076	1,257	49,450
West Virginia	.00055	716	21,056
Wisconsin	.00097	911	7,764
Wyoming	N/A	N/A	N/A
District of Columbia	N/A	1,349	29,110

MEDIAN = .00108

$36,217,338 in 1977 dollars. However, this 202 percent increase in the constant dollar insurance budget is only slightly more than the 186 percent increase in total State government expenditures. While State spending on insurance regulation has increased, it has increased little more than State budgets generally.

Although some regulators claim that if State regulation is less costly than any alternative Federal system would be, the total amount spent on State insurance regulation is a sum that is nearly the combined total of the 1978 budgets of the Securities and Exchange Commission and the Federal Trade Commission (FTC)--the two Federal agencies that are somewhat parallel to State insurance departments in that they have broad jurisdiction over financial and trade practice matters. Comparison can also be made to the Interstate Commerce Commission (ICC), whose regulatory responsibility over the interstate surface transportation industry is similar to that exercised by insurance departments over the insurance industry. The ICC grants operating authority to carriers (licensing), regulates carrier rates, and investigates carrier operations. With regulatory authority over 18,000 carriers, the ICC's 1978 budget was $65 million.

While the mission of these Federal agencies is, of course, different from that of State insurance departments

(the FTC has a far broader range of responsibilities under its purview), enough similarities exist to suggest that expenditures on State regulation are not insignificant.

The problem, of course, is that this aggregate sum of money is not available for regulatory purposes as one lump sum. While in the aggregate the amount spent for insurance regulation is not out of line with the amount spent on other regulatory functions, each State is a separate regulatory jurisdiction responsible for all insurance companies doing business within its boundaries. Viewed in that light, the available resources appear far less ample.

Another reference point for examining regulatory expenditures is to compare them to the resources that are most directly available--in this case revenues produced by the insurance business in the States. In every State, taxes on insurance are a small but significant source of total sales and gross receipts tax revenues. In 1976, insurance taxes came to 4.1 percent of total sales taxes in all the States. While not a large proportion, at $1.96 billion insurance sales taxes are almost as great as alcoholic beverage taxes ($2.1 billion). A very small portion of insurance sales taxes are used to regulate the insurance industry. Of the 41 jurisdictions from which we have complete data, the average (median) percentage of premium taxes spent on regulation is 4.7 percent. For all the States reporting to us, the amount spent on regulation was equivalent to 4.4 percent of the total premium taxes collected. This is very close to the 4.3 percent spent in 1957. Although the percentage of premium taxes used for regulation has been cited by critics of State regulation as showing that the States do not commit sufficient resources to regulation, some insurance commissioners and other advocates of State regulation charge that this is a meaningless figure since the purpose of premium taxes is to raise revenue for the State and not to support regulation. Nonetheless, there is a certain schizophrenia attached to the use of these figures. The Legislative Auditor of the State of Montana observed that:

> "In past years, insurance departments in many states, Montana included, have prided themselves on the low percentage of expenditures used for operation when compared to the revenues taken in through company premium taxes and other fees." 1/

1/State of Montana, Office of the Legislative Auditor, Insurance Department and Insurance Commissioner, Report on the Need for State Regulation of the Insurance Industry, 1978, p. 57.

Although the amounts spent on regulation are sometimes discussed as representing a certain percentage of premium taxes and other revenues collected, such revenues are rarely allocated directly to the insurance department. Rather, these revenues are paid directly to the State treasury and are not earmarked for specific purposes. Only four States reported that any portion of premium taxes was specifically allocated for regulation. Only one of these, Texas, reported any significant amount of allocation--$7.3 million.

The common exception to this lack of direct allocation is the revenue from the examination of insurance companies. Fifteen States reported that all examination revenues were used for regulation; another three States reported that more than 70 percent of examination fees were allocated to regulation.

Other sources of revenue directly related to the operation of an insurance department include company license fees, agents and brokers license fees, and fines and penalties. Among these three categories, the seven States that do allocate the revenues directly to regulation, allocate 90 percent or more. However, so few States directly allocate revenues that the amount allocated is only 13 percent of the amount collected. Including examination assessments, we calculate that 29 percent of the major revenues besides premium taxes are allocated directly to regulation.

Although revenues other than premium taxes constitute only 5 percent of the amount received from premium taxes, if we assume that premium taxes are only for revenue and look at regulatory expenditures as a percentage of all other revenues collected by an insurance department, a much different picture emerges.

The amount spent by the States on insurance regulation is slightly more than the amount received in certain revenues that are directly related to regulation. Among all the States, when premium taxes are excluded, the median regulatory expenditures as a percentage of revenue collected by departments is 100 percent. Thus, for the average State, insurance regulation is, in effect, a self-financed operation, although the revenue and disbursements are generally funneled through State governments. The range is 371 percent to 16 percent, with 20 departments spending less than they receive.

Personnel resources

The total budget and the total number of staff for each State (see table 5) provide only the broad outlines of the

resources available to insurance departments. Of greater importance is the allocation of budget and personnel--how departments spend their time and money. Indeed, budget allocations can only be inferred from the allocation of personnel. Insurance departments typically do not divide budget into program categories, but use instead traditional line categories (salaries, capital expenditures, and so on). Thus, the only way to determine the allocation of budget is to analyze the division of personnel function. Such an analysis will accurately reflect allocations because the bulk of a department's budget is personnel costs. For example, in 1977 these costs constituted 75 percent of the California insurance department budget.

Table 5

Total Staff by State - 1978

Alabama	60	Nebraska	62
Alaska	19	Nevada	37
Arizona	61	New Hampshire	35
Arkansas	52	New Jersey	218
California	384	New Mexico	32
Colorado	56	New York	689
Connecticut	73	North Carolina	130
Delaware	20	North Dakota	16
Florida	456	Ohio	93
Hawaii	16	Oregon	64
Idaho	21	Pennsylvania	232
Illinois	218	Rhode Island	26
Indiana	79	South Carolina	103
Iowa	69	South Dakota	14
Kansas	130	Tennessee	93
Kentucky	N/A	Texas	606
Louisiana	58	Utah	34
Maryland	123	Vermont	15
Massachusetts	235	Virginia	85
Michigan	165	Washington	85
Minnesota	63	West Virginia	28
Missouri	82	Wisconsin	78
Montana	19	District of Columbia	24
		Total	5,258

Our information on the division of labor comes from our 17 State sample. Because different States classify employees in various nonuniform categories, we gathered this information during field visits rather than from the questionnaire. Although sometimes appearing as different labels in various

States, the main functions in insurance departments are rate regulation, financial examination, market conduct examination, policy form review, agent licensing, company licensing, and general administrative. Some States were unable to divide their personnel this way as one person might perform tasks in several categories. Based on a total sample of 1,735 employees in 8 departments for which we have complete information, the division of regulatory function is shown in table 6.

Table 6

Division of Personnel by Function for Eight States

Function	Average percent of staff years
Rate regulation	9
Financial regulation	28
Market conduct regulation (including complaint handling)	19
Policy form review	8
Agency licensing	12
Company licensing and taxing	5
General administrative	13
All other	6
Total	a/100

a/These numbers are the average percent of personnel devoted to each function for 8 States. While the actual percentage for all jurisdictions will vary from these numbers, the rank order will probably be the same for most States. Figures are rounded to the nearest whole percent.

Professional resources

In addition to a minimum number of staff required for certain functions, a variety of professional skills are necessary to adequately regulate insurance. To a considerable

extent, these skills mirror the skills needed in the industry itself. The main technical field that is unique to the business of insurance is actuarial science. Other relevant professional categories are

--attorneys,

--economists,

--certified public accountants,

--certified financial examiners,

--chartered property casualty underwriters, and

--chartered life underwriters.

To quantify the professional qualifications of departments, we requested the number of professional staff having these professional credentials. We then computed the total number of these as a percentage of the total number of professional staff (as opposed to clerical). The resulting percentage provides a rough index of the professionalism of the departments. The median percentage for the 42 departments for which we have adequate data is 26.3 percent. In other words in the typical department, 26 percent of those employees listed as professional have professional or academic training in one of the categories listed above. Taken as a percentage of the total number of employees, however, that percentage is correspondingly smaller, 17.8 percent. The median figure of 26 percent probably overstates the professional composition of insurance departments because a single individual would have been counted more than once if that individual fit into more than one category, such as being both an actuary and a chartered life underwriter.

Actuarial science is perhaps the most relevant professional background for an insurance department. Actuaries are experts in evaluating the cost of insurance coverage. They analyze the probability of loss occurrences and arrive at the price that must be charged to insure against losses--a price that will enable companies to provide coverage and make a reasonable profit. Although an insurance company or an insurance department may classify individuals as actuaries, there is a system of national certification of conformance to high standards of competence provided by the two main professional associations, the Society of Actuaries for life and health insurance and the Casualty Actuarial Society for property and casualty insurance. Certification as an associate

or as a fellow of both societies is by examination. Successful completion or credit for seven examinations is required to be an associate, while the highest category of fellow requires completion or credit for an additional three examinations. Another recognized professional society is the American Academy of Actuaries, which offers membership to members of the other two societies and has recently begun its own certification process.

The questionnaire asked the number of certified actuaries on the staff of each department. Table 7 lists the States, by population, with the number of staff designated by the department as actuaries and the number of staff certified by the professional actuarial societies. The total number of certified actuaries is 112, but 12 States (29 percent of the sample) have no certified actuaries. This overstates the actual number of certified staff because Academy members include those who are in the two actuarial societies, and a few individuals may belong to both societies. Not including the members of the American Academy of Actuaries, insurance departments reported 64 staff members who are fellows or associates of the two professional societies. Even this probably overstates the true number. Although the departments reported a total of 12 fellows of the Casualty Actuarial Society, that society lists only six fellows employed by State insurance departments.

Insurance departments do not rely exclusively on their staffs for professional service. The most frequently used consulting services purchased by departments are actuarial and computer services. In some cases, these services are used instead of department staff. Thus, six of the 12 States with no certified actuaries report contracting for consulting actuarial services.

This is an improvement over the situation in 1957 when the O'Mahoney study reported that 15 States had no staff actuaries, nor used consulting actuaries. Evidence of improvement in this area is stronger when one compares the number of actuaries generally, regardless of certification. Only four States out of 46 reporting do not have staff actuaries or actuarial consultants.

Although consultants are a valuable adjunct, the amount spent on external actuarial consulting is modest. Of the 19 States reporting the amount spent in 1977 on actuarial services, the average was $26,005. Surprisingly, the States that reported no certified actuaries spent a smaller average amount

Table 7

Actuaries and Certified Actuaries Grouped by Size of State

Population*	Actuaries designated by State insurance departments	Society of Actuaries		Casualty Actuary Society		American Academy of Actuaries
		Fellow	Associate	Fellow	Associate	
0 - 999,999 (N=12)	13	1	1	2	3	4
1,000,000 - 2,999,999 (N=11)	15	3	1	2	2	7
3,000,000 - 5,499,999 (N=13)	39	2	2	4	2	11
5,500,000 - 22,000,000 (N=10)	89	16	12	4	7	26
Total	156	22	16	12	14	48

*Estimated as of July 1, 1976.

on consulting. The five States that reported to us spent an average of $14,760 on consulting actuarial services. The States spent far more on external computer services, an average (mean) of $59,631 among the 16 States reporting expenditures for those services.

The need for additional staff

We reviewed the insurance departments' evaluations of their staffing requirements. While, as one commissioner told us, it may be true that bureaucracies always claim that more staff is needed, the reported staffing needs of departments appear to accurately reflect areas where current staffing is seen as inadequate by the organization.

The questionnaire asked whether the insurance department had requested a budget increase in the past 2 years for additional staff or programs. Forty-one out of 45 States reported that they had requested budget increases for staff and programs. The requests are presented in table 8.

Table 8

Items Requested by States for Budget Increase

Items requested	Number of States
Consumer protection/trade practice regulation	21
Rate and policy form regulation	19
Solvency regulation	17
Legal assistance (including hearing officers)	5
Agent or company taxing and licensing	2
Clerical	10
Other administrative	9

In addition, department officials in the 17 fieldwork States were asked if any activities were understaffed. Based on the fieldwork and the questionnaire responses, several

staff needs are perceived in common by State insurance departments. The three areas most frequently mentioned cover most of the State's regulatory activities. They are (1) consumer protection and trade practice regulation (21 States), (2) rate and policy regulation (19 States), and (3) solvency regulation (17 States).

Seven of the 17 fieldwork States said they needed more staff for rate and policy form regulation to perform current responsibilities effectively. Four other States said they would like more staff in this area to carry out new programs. Current work in consumer protection and trade practice regulation has created a need for more staff in six States, and four States want staff for new projects. For solvency regulation three States need people now, and one State wants staff to start new programs in this area. Three States need more legal assistance now, and three others want to start new work in agent or company licensing.

Training and salaries

The hiring and retention of trained staff is one dimension of a department's professionalism. Another is training that will help staff to develop skills. There is an enormous range in the amount of money budgeted for staff training programs. Thirteen States (28 percent) reported no training budget. In only two States was the training budget more than 1 percent of the total budget. More revealing, perhaps, is the amount of training funds per professional (in departments with training budgets) which ranged from $.037 to $965. The median amount was $50.45 (mean $90.51).

The O'Mahoney study measured professional self-improvement by the willingness of insurance departments to allow professional study on department time. Although fewer than half of the 50 States and the District of Columbia allowed any time, of those that did, 12 encouraged the study of insurance, 8 allowed actuarial study, and 4 permitted the study of law.

Salary is another factor to consider in the hiring and retention of high quality personnel. Commissioners' salaries range from $18,000 to $49,700 with a median of $32,350. The median is equivalent to a Federal salary at the GS-14 level. In comparison, the insurance commissioner of the District of Columbia, who is on the Federal general schedule, is a GS-16. Commissioners' salaries are better today than in 1957 when the median salary was $10,180, or $21,800 in 1977 dollars. The current salary of the chief deputy in State departments is usually (but not always) lower than the commissioner's. The top salary of the median chief deputy is $27,150.

Senior and middle level professional staff salaries are such that there is a potential problem in recruiting and retaining them. We obtained the lowest and highest salaries in each State for selected positions. Table 9 shows the range and median highest and lowest salary paid to examiners, actuaries, and attorneys.

Table 9

Salaries of Professional Staff (1978)

Job categories	Lowest		Highest	
	Range	Median	Range	Median
Actuaries	11,200-34,000	19,100	19,000-49,500	31,200
Attorneys	11,200-25,200	16,700	17,800-41,100	25,900
Examiners	9,100-32,000	12,400	13,000-35,000	21,900

While the competitiveness of these salaries depends in part on the local cost of living and the local labor market for those skills, the salaries are somewhat low compared with opportunities in the insurance industry. For example, the average (median) starting salary for actuarial positions advertised in the trade newspaper National Underwriter from January to June 1978, was $23,000 for associates, $35,000 for fellows, and $22,000 for unspecified actuarial positions, compared with medians of $19,100 and $31,200 in the State insurance departments. Because the salaries for the insurance departments are for incumbents who may have been employed with that department for several years, they probably overstate the potential income relative to the starting salaries listed in the advertisements. That the problem of competitive salary levels is more than just a potential one was suggested by an official of the California Insurance Department who told us that an inability to pay competitive salaries had led to problems in recruiting highly qualified staff.

A former insurance regulator, currently associated with the insurance industry, told us that even though the insurance

industry itself was low paying relative to other industries, departments could not compete for the best people in terms of salary.

Length of service of department personnel

Despite the potential problem of low salaries, there is substantial longevity of service among the top staff of insurance departments. Among 40 States, the average length of service of the chief deputy commissioner was a median of 5 years, or a mean of 10.9 years. Sixteen out of 40 States had chief deputies with 10 or more years of service. Perhaps more representative of staff longevity is the chief examiner, who is more likely to be a career employee. In 44 States, the mean length of service for chief examiners was 15.9 years (median = 14.5 years).

The term served by commissioners has declined since 1959. As of July 1978, incumbent commissioners had served a median of 3 years, a reduction from the median of 5 years reported in 1957. The O'Mahoney study noted that consistently shorter incumbency might decrease the quality of regulation, but concluded that the median term in office was almost 5 years which was "* * * sufficiently long to acquaint the average insurance commissioner with his duties and responsibilities, to provide for proper continuity of supervision, and to provide effective regulation." 1/

As our data on the term of office of insurance commissioner represents a point in time, it was necessary to do a static analysis. One can, however, gain an appreciation of the turnover by noting that during the 14-month course of our study, 16 commissioners left office.

CONCLUSIONS

State insurance departments vary greatly in resources and activities, and these differences are not generally related to the amount of insurance business or size of State. For example, although California has a slightly larger population than New York, the budget of the New York Insurance Department is about one and a half times that of California.

1/U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, The Insurance Industry; Aviation, Ocean Marine, and State Regulation, 86th Congress, 2nd sess. (1960), p. 118.

Nationally, the total expenditures on State insurance regulation are not insignificant but are largely matched by nontax insurance revenues to the State.

While States also differ substantially in size and division of staff, it appears that the largest single category of staff activity is financial regulation, followed closely by trade practice enforcement. Most departments indicated a need for more staff.

The professional qualifications of insurance department staff have improved since the earlier congressional study by the O'Mahoney Committee, but there are still few staff members with specialized training relevant to the business of insurance. In particular, there are few certified actuaries. On the other hand, the senior staff of insurance departments, apart from most commissioners, had many years of experience that may be equivalent to more formal training.

The data on budgets, staff size, and professionalism only represent the potential for effective regulatory activity. The effectiveness of State regulation cannot be inferred from that data alone. Therefore, the following chapters provide a more detailed review of selected insurance department activities.

CHAPTER 4

SURVEILLANCE OF COMPANIES: FINANCIAL AND TRADE PRACTICE REGULATION

Insurance departments are responsible for making sure that insurance companies comply with the law. This chapter reviews the surveillance of insurance departments over insurance companies in the areas of financial requirements and trade practices. Our information on financial regulation comes primarily from the questionnaire, while the discussion on trade practice is derived from our fieldwork.

FINANCIAL REGULATION

Traditionally, a major function of insurance regulation has been to monitor and safeguard the financial solvency of insurance companies. Although this function has been supplemented by market conduct examinations, financial examination personnel still comprise about 28 percent of insurance department staff.

The NAIC is heavily involved in providing needed uniformity and coordination in the area of financial regulation. The NAIC develops and provides the form for the annual statement used by insurers in all States in which they do business. These annual statements furnish a major part of the statistical data on the insurance business. For consistency and reliability in estimating the assets held by companies, the NAIC Valuation Office uniformly values the securities held in the portfolios of every insurance company in the United States.

Most companies are domiciled in one State, but do business in many States. To avoid duplicate examinations, the NAIC has divided the country into six zones. An examiner from each zone joins the examiners of the domicile State to examine the companies. The zone chairman (the chairmanship rotates among the commissioners from the States in the zone) picks a State insurance department to represent the zone.

Workload

The median number of domestic companies examined by the State insurance departments was 20, although the number ranged from 1 to 221. More meaningful is the frequency with which companies are examined. A report for the National Association of Insurance Commissioners recommended that the soundest

companies be examined every 3 years, with more frequent examinations for the less sound companies. We compared the number of domestic companies in a State with the number of examinations by taking the number of examinations as a proportion of companies. Thus, if companies were examined an average of once every 3 years, the number of exams in any 1 year should be about equal to 33 percent of the number of domestic companies. In fact there was a very wide range in the number of exams. Some States reported more exams in 1977 than there were companies, which indicates either an expansive definition of the term "examination" or an inaccuracy in the response. The median proportion of domestic insurance companies examined in a single year (1977) was 0.43.

The quality of financial regulation

The most recent study of the quality of financial regulation of insurance companies was a comprehensive report prepared for the NAIC by McKinsey & Company, Inc., in 1974. That study found that there were a number of serious flaws in the surveillance system, such as:

1. Deficiencies in the early detection of problem companies due to varying quality of the analysis of financial statements, infrequent and poorly scheduled examinations, and poor exchange of market conduct and financial condition information among the States.

2. Deficiencies in developing information needed for action, including deficiencies in evaluating internal controls and analyzing reinsurance agreements, auditing computer-based records, and examining holding company relationships.

3. Deficiencies in using manpower effectively, including spending too much time examining companies least likely to have financial problems..

In response to the McKinsey study, the NAIC appointed a task force in 1974 to review the study's findings and recommendations. Over the next 5 years, most of the recommendations were adopted by NAIC. The McKinsey study also led to the revision of the NAIC's Examiners Handbook. According to the responses of our 1978 questionnaire, however, many States have not implemented the recommendations.

Although we did not evaluate the efficacy of the financial regulation process, we did collect data on the quality indicators used by the McKinsey study.

The main purpose of financial surveillance is to detect problems in companies in time to take corrective action to prevent insolvencies. While examinations are only performed triennially, insurance departments can examine the annual statements of companies every year. The NAIC has developed and revised an "early warning system" that calculates the data on the annual statements to identify companies with potential problems. The NAIC study by McKinsey & Company found that only 4 percent of the States used the NAIC system as a primary tool, and 73 percent used it infrequently or never. Only 44 percent of the States systematically analyzed statements. In our questionnaire, we asked what early warning solvency testing program each State used. We found that the use of the NAIC system has increased since 1974 when the McKinsey study was completed. About half the States used the NAIC system, together with their own system while at least 39 percent use the NAIC as their primary warning system.

The NAIC system is not foolproof. A study done by Aetna Life and Casualty found that in the year before insolvency the NAIC system would have picked up only 82 percent of eventually insolvent companies and in the year prior to that only 58 percent. Aetna claimed a much better predictive power for a different technique, the application of multivariate discriminant analysis applied to key financial ratios, and advocated its use for early warning surveillance.

Financial examinations

The resources that go into the examination process are important elements in determining the quality of financial regulation. In terms of the expertise brought to bear on examinations, it is preferable to use examiners who specialize in the major lines of insurance. We asked whether States had examiners who specialized in either life, accident and health, or property-liability. Most States did not have specialists in either line. Thirty-eight percent of the States responding to the questionnaire reported specialists in property-liability, and 39 percent reported specialists in life, accident, and health.

In the past, many States used contract examiners rather than their own staff. Eight States, or 17 percent of those returning questionnaires, used contract examiners for all or nearly all their examinations. There was no difference between the use of contract examiners for domestic 1/ exams or zone exams.

One way to cover more companies and stretch a State's examination staff is to rely more on CPA audits of insurance companies. The McKinsey study recommended greater reliance on CPA audits, but found very little use of these by the States. We also found that nearly all States used neither CPA audits nor participated in such audits. Only Illinois and Wisconsin, reported using an appreciable number of CPA audits.

The increased complexity of financial records and their storage in computers makes it highly advantageous to audit data directly by computer. We asked each insurance department if it used a computer software audit package for examination purposes. Only eight States reported such a capability (17 percent of the sample), while 35 States (76 percent) answered in the negative.

The method of paying for exams also affects quality. The McKinsey study found that about three-fourths of the States cover the cost of examinations by charging companies for each examination. According to the McKinsey study, this method causes a problem of manpower allocation by contributing to the tendency to concentrate examiner staff-days on the companies that are financially strongest and the best able to pay. We found the situation largely unchanged 4 years later. Thirty-five States (76 percent of our sample) still assessed companies for each examination. Other States either assessed companies for the general examination process or paid for it out of the department budget.

The end result of the system of financial regulation is the number of insolvencies. The 45 States returning questionnaires to us reported a total of 102 insolvencies over the past 5 years (the period ending June 1978). Of these, 56 were property-liability companies and 46 were life companies. These figures are consistent with the 230 insolvencies reported by the McKinsey study for the 10 years preceding that study (1974). Compared to the approximately 2,880 property-liability companies and 1,750 life companies, the proportion of insolvencies even over a 10-year period is very small.

1/Domestic, in the insurance business, means an instate company or activity.

However, the record over the past 5 years apparently has not improved over the preceding decade. Moreover, the insurance department in Illinois has expressed concern that property casualty insurers in that State are in some danger because they maintain inadequate loss reserves. This situation is particularly significant because Illinois domiciles more domestic property-casualty companies than any other State.

Companies can be in substantial difficulty short of insolvency, and one function of the insurance departments is to shore up troubled companies until they can become fully solvent. We asked the insurance departments to report the number of mergers, consolidations, or reinsurance arrangements that they had arranged, facilitated, or accepted over the last 5 years in order to avoid insolvency. Approximately 100 such cases of rehabilitative action were reported by the 42 States responding to the question.

In the wake of insolvencies, claims may be paid to policyholders through guarantee funds established by the States. Forty-three of the States responding to the questionnaire reported such funds for property liability insurance. However, only about half the States reported having guarantee funds for life (22) and for accident and health insurance companies (20). Most guarantee funds are actually post-insolvency assessments paid by other insurance companies in the State where the insolvent company is domiciled.

Although our review covered only a few indicators of financial regulation, two tentative conclusions can be drawn. First, improvements are still needed in the resources devoted to financial regulation, particularly in the area of examiner specialization and computer capability. In the comparisons we made with the findings of the 1974 McKinsey study, few changes were apparent. Second, based on the relatively small number of insolvencies, the deficiencies in the process of financial regulation do not appear to exacerbate the insolvency problem.

Although we are not able to offer a first-hand evaluation, an important qualification should be noted in this review of financial examination. Some evidence suggests that the process of State regulation is not closely related to the number of insolvencies. The McKinsey study concluded that capital and surplus requirements were the primary factors related to insolvencies. Other preliminary research we have reviewed also casts doubt on the ability of any examination process to significantly offset the number of insolvencies.

Although insolvency does not appear to be a major problem at this time, we believe that further study by the States and the Federal Government is warranted. When the Government Employees Insurance Company was in severe financial trouble, there was substantial congressional interest in the issue of insurer solvency. Because many insurance companies operate in all States, and insolvencies have potential consequences that spill over State borders, periodic review and study by a body external to the State regulatory community would be appropriate. Particularly since many of the recommendations of the McKinsey study commissioned by the NAIC have not been implemented, further analysis of financial regulation by State insurance departments is warranted.

TRADE PRACTICE REGULATION

In nearly all States the agency responsible for consumer protection affecting insurance is the State insurance department. State consumer protection offices normally do not independently work on insurance questions. Because of the McCarran-Ferguson Act, consumers must look to the insurance departments for regulations and activities protecting their interests in insurance transactions. We reviewed insurance department trade practice regulation, particularly with regard to complaint handling and market conduct examination procedures.

Trade practice authority and enforcement

Legal authority over trade practices resides in a State's statutes and the regulations promulgated by the insurance department. Because practices change over time, it is important that commissioners have flexible authority to use their discretion to stop unfair practices whether or not those practices have been defined in legislation. This type of rulemaking authority is similar to the authority of the Federal Trade Commission. The questionnaire asked the extent of the insurance commissioner's authority to issue rules or regulations describing conduct that is prohibited as an unfair trade practice. Most States responding had the requisite flexibility. Twenty-seven States reported that the commissioner has the authority to specify new categories of unfair practices beyond the trade practice statute. In 13 States, the commissioner lacks the authority to enlarge upon or extend the provisions of the unfair trade practice statute. The remaining States either did not answer the question or indicated some other type of authority.

Most States have similar trade practices statutes. There are, however, great differences in enforcement methods. In our questionnaire State insurance departments were asked to report the number of notices of charges brought or complaints instituted by the department in 1977. The reported practices were misrepresentation and false advertising of policy contracts, false information and advertising generally, boycott, coercion and intimidation, unfair discrimination, rebates, other unfair or deceptive sales practices, unlawful replacement of policy by agents, failure to pay claims, and failure to remit premiums (from agent to insurance company). There were such great differences in the num number of formal actions reported that generalizations are impossible. The median number of formal actions for the 34 States reporting data to us was 85, but the number ranged from 2 to 18,000.

Critics of State regulators suggest that most enforcement activity benefits insurance companies rather than consumers. For example, State laws restricting replacement of ordinary life insurance policies may benefit consumers by protecting them from unscrupulous agents who try to persuade consumers to surrender policies in which they already have substantial investment. Such laws, however, also protect agents from competition. Similarly, when insurance departments act against agents who fail to remit premiums to insurance companies, they not only police unethical agents but act as debt collectors for insurance companies.

Our information suggests that there is some truth to this criticism, but it is not universally valid. While failure to remit premium was the largest category of formal actions (as a percentage of all actions), it was followed in frequency by other unfair or deceptive sales practices and failure to pay claims. In only nine States did actions against unlawful replacement (twisting) account for more than 10 percent of all formal actions.

Formal complaints are not the only means of regulating trade practices. Many regulators preferred to use informal procedures for a variety of reasons, including inadequate resources to pursue formal action and the belief that informal action may be more effective. Slightly more than half the States, 23 out of 44, reported that they frequently used informal rather than formal procedures. Eleven percent reported using informal procedures very frequently, 26 percent occasionally, 7 percent rarely, and one State never used informal procedures. No correlation was found between the number of formal complaints issued and the use of informal procedures.

We did not examine the disposition of formal complaints and charges, but we did ask on the questionnaire how many times a company's license was suspended or revoked. We found that this ultimate penalty was rarely used. For the 3-year period from 1975 through 1977, the median number of revocation and suspension actions in each State was 6 in the 44 States supplying information.

Handling complaints

In large regulated industries, complaints from consumers can constitute a form of participation in regulatory policymaking. The effectiveness of the complaint resolution process also serves as a guide to the probability of favorable claims handling, often a major source of complaints from the consuming public.

The complaint-handling system used by insurance regulators is particularly important because most citizens buy insurance protection, and because the product cannot be seen--it is a promise to pay for losses that may occur in the future. However, unless a complaint-handling system performs effectively, problems may go unrecognized by regulators. For complaint-handling mechanisms to work, consumers must know they exist. And the results of complaint mechanisms must be available to the persons for whom the regulatory body exists--the consuming public.

This portion of our study focuses on (1) a review of the statutory authority provided to State regulators so that they may resolve complaints and claims, (2) an observation of how States currently handle complaints, (3) the availability of consumer information, and (4) the effect of complaints and claims on policy decisions made by State regulators. Our results indicated that:

--Most States do not have direct authority to resolve consumer complaints or claims.

--States have not implemented a national complaint coding system that would provide valuable data to consumers, insurance regulatory agencies, and the insurance industry itself.

--Many States do provide information to consumers about relevant State insurance statutes and regulations, consumer rights, and consumer rights of redress.

--States do not fully use available complaint- and claims-handling data.

--Improvements are needed in consumer input to the regulatory policymaking process.

All State insurance departments we visited considered complaint handling an important function and had special procedures and staff to deal with consumer complaints. The number of complaints received by the departments in 1977 ranged from 243 to 160,000, and the number of complaints is generally proportional to the amount of insurance business in a State. 1/

States often lacked direct authority to resolve consumer issues

Only 6 of the 46 State insurance departments we surveyed reported that they had complete authority to order companies to pay or to increase the payment of claims in disputed cases. Twenty departments had partial authority, while 18 departments had none. Two departments did not respond to this question.

Officials who commented on the matter in nearly all the 17 States we visited said that, for the most part, other statutes and regulations provided the tools necessary to insure fair treatment of consumers. For example, we were told complaints regarding high premium rates or claims disputes could be resolved through the current statutes on fraud or unfair business practices. Similarly, sex or race discrimination charges could be resolved through statutes prohibiting such discrimination.

Despite limited legal authority to order particular insurance company actions, most State insurance departments have a complaint-handling policy that is responsive to consumers. Sixteen out of the 17 fieldwork States regularly follow up on all or nearly all consumer complaints. The States also require a response from the relevant insurance company or agent. While we cannot evaluate, based on our fieldwork sample, how effective the complaint resolution process is nationally, based on the fieldwork sample it appears that consumers in nearly all States are assured of at least getting a response to their complaints and having their complaints pursued to the extent of an insurance department letter or phone call.

1/For the 36 States for which we had data, the correlation between total premium volume and number of complaints was 0.66.

Of course not all complaints are valid. Insurance department officials pointed out that many complaints result from policyholders not understanding their policies and expecting claims payments to which they are not entitled. In our questionnaire, we asked what percentage of complaints were considered valid. Twenty-nine out of 38 States responding to the question considered at least half of the consumer complaints to be valid, and 13 of those considered at least 75 percent to be valid. Thirty-one out of 35 States (88.6 percent) reported that at least half the complaints were settled in the consumer's favor, and 14 States (40 percent) said that at least three-quarters of the complaints were favorably disposed. Favorable disposition can range from clarifying a policy holder's misunderstanding to actually obtaining payment of a valid claim originally denied by a company.

Generally, the insurance departments could not assist consumers who had complaints regarding questions of fact or who misunderstood their insurance policies. For example, in its 1977 report to the Commissioner of Insurance in Massachusetts, the Consumer Services Section (CSS) indicated that it assisted nearly 60 percent of the consumers who filed complaints. Another 10 percent did not have legitimate complaints but, "The remaining 30 percent may have legitimate complaints, but for the most part these cases involve disputes concerning factual issues which must be adjudicated in a court of law." Because Massachusetts has a detailed analysis of complaint resolution, it is useful to examine the outcome of complaints in that State. The complaint disposition breakdown in Massachusetts for calender year 1977 is as follows:

Complaint disposition

Relief	Number	Percent
Additional money received	638	6.3
Cancellation withdrawn	339	3.3
Policy renewal	69	0.7
Premium refunded	543	5.4
Premium problem resolved	489	4.8
Claim paid	2,082	20.5
Coverage extended	205	2.0
Referral to proper agency	506	5.0
Other	962	9.5

No relief

Question of fact	691	6.8
No jurisdiction	113	1.1
Attorney retained	230	2.3
Entered arbitration	131	1.3
Comparative negligence	137	1.4
Cancellation upheld	322	3.2
Nonrenewal upheld	59	0.6
Premium correct	330	3.3
Claims correctly paid	727	7.2
Claim denied properly	1,115	10.9
Other	445	4.4
Total	10,133	100.0

Direct authority to address the no-relief issues may have helped resolve more problems, thus reducing costly litigation for all parties concerned. In fact, the Massachusetts' report stated, "We can safely say that approximately 9 out of every 10 consumers who contact the CSS have a legitimate gripe."

In commenting on our draft report, the Connecticut Insurance Commissioner felt that the Massachusetts chart and our presentation were somewhat misleading. He stated that several categories under "no relief" were in fact not legitimate complaints. These categories consisted of comparative negligence, cancellation upheld, nonrenewal upheld, premium correct, claims correctly paid, and claims denied properly. Counting the complaints in these categories actually yields more than 25 percent of complainants who do not have a "legitimate gripe."

UTILIZATION OF COMPLAINTS

The handling of citizen complaints by insurance departments or any other regulatory agency has an importance that goes beyond the resolution of individual grievances. Since most citizens never participate in formal agency hearings or other proceedings, the pattern of citizen complaints usually is the agency's only direct source of information about insurance problems encountered by consumers. 1/

1/U.S. Senate Committee on Governmental Affairs, Study on Federal Regulation, Vol. III, Public Participation in Regulatory Agency Proceedings, 95th Cong., 1st sess. (1977).

If complaints are to be useful to agencies and the public, they must be handled in systematic ways that include the use of consistent complaint classification procedures, statistical reporting mechanisms, and mechanisms that insure that complaints are fed into regulatory enforcement and decisionmaking. We agree with the criteria set forth in the McKinsey study for the NAIC. The complaint system should be capable of pinpointing:

--companies with a high number of complaints in relation to their size,

--specific lines of business with a high incidence of complaints, and

--the most frequent causes of complaints.

Although the State insurance departments do a good job of responding to individual complaints, improvements are needed to make complaint handling a useful tool of regulatory policy.

The need for a uniform complaint classification system

A uniform complaint data gathering system, with summary results published periodically, would benefit consumers, State regulatory bodies, and the insurance industry. In 1974 the NAIC, recognizing the benefits of such a system, developed a model for coding complaints. However, only 6 of the 46 States responding to our questionnaire adopted it. Two of the 17 States we visited adopted the model, 7 adopted it with variations, but 8 used their own system as shown in table 10.

Officials in the six departments that used a modified coding system generally followed the NAIC format but added information needed for local review purposes. For example, in the category of "Status of Complainant," the NAIC model presented six possible categories: insured, third-party, beneficiary, other, agent, and broker. The Illinois Insurance Department added more than 150 subcategories that included various levels of State government, Federal legislator, news media, producer of record, and public adjuster. Other general categories were similarly subdivided and, overall, the Illinois form appeared to be the most detailed. An Arizona department official said the Illinois form was considered the most complete by people in the field.

On the other hand, officials from six of the nine States that chose to use their own form were not strongly opposed to the NAIC model. One official from the New York State Insur-

Table 10

Use of NAIC Complaint System

Departments visited	Used NAIC model	Used model with variations	Did not use NAIC model
Arizona		x	
California		x	
Connecticut			x
Illinois		x	
Indiana			x
Kansas		x	
Massachusetts			x
Michigan		x	
New Jersey			x
New York			x
North Carolina			x
Ohio			x
South Carolina	x		
Texas		x	
Virginia	x		
Washington			x
Wisconsin			x
Total	2	6	9

ance Department indicated that he is reviewing the possibility of using it in the future. Currently he questions some of the model's categories and is not sure it is better than the new one New York State now uses. He also said that his department would incur the cost of retraining staff if he switched to the NAIC forms.

So that complaints can be easily analyzed, they should be indexed by categories that would be relevant for examination. For example, if complaints are not initially indexed or filed by company name or agent against whom the complaint is lodged, the insurance department cannot know how many similar complaints have been lodged against a company except by tediously reviewing all complaints received. We therefore asked, in our questionnaire, how complaints were filed. The index category and the number of States using each category are presented in table 11.

Table 11

Methods of Indexing Consumer Complaints (note a)

Indexing category	Number of States	Percent of States responding (N=44)
By company name	39	89%
By agent/broker name	30	68
By status of complainant	19	43
By zip code	8	18
By reason for complaint	19	43
By line of insurance	23	52
Other	24	55

a/The question was, "How are consumer complaints indexed in your files? (Check all applicable categories)."

While the insurance departments are able to determine the number of complaints against particular companies, only about half index complaints based on line of insurance and less than half by reason for complaint. Useful information about problems is probably lost in these States because systems of indexing complaints are incomplete.

Indexing complaints is only one step in a good retrieval system. To go beyond subjective judgment, useful information about complaints should be compiled in concise summary form. The easiest way to provide such information is through periodic computer printouts based on a systematic complaint coding procedure. Eleven of the fieldwork States have such a system. Two more are developing a system, and four have no system other than relying on informal subjective judgments.

UTILIZATION OF COMPLAINT INFORMATION

Collecting data is a useful first step toward the full use of complaint information in the regulation of trade practices. Systematic data can serve the purposes of effective regulation in two main ways: providing information to the public and providing information to the insurance department.

Complaint data and public information

Some departments use the number of complaints as a part of the information they provide to consumers about insurance. Since large companies will normally receive many more complaints than small companies, it is necessary to compute some sort of percentage or ratio. The commonly used ratio is the number of complaints to unit of premium volume ($1,000,000, $10,000,000, etc.).

The utility of this kind of information was noted in a press release by Illinois Insurance Director Richard Mathias:

> "Complaint statistics can serve as a guide to both consumers and the insurance industry. By identifying those insurers with the highest ratios, consumers have an additional basis for making a more informed buying decision with the caveat that high numbers alone are not indicative of a poor company. Insurers and producers, on the other hand, can utilize complaint ratios to gauge their ranking among their competitors and to assess potential problems within their own organizations."

The Illinois department published auto complaint ratios in 1976 and 1977 for all companies with 10 or more complaints. The ratios were based on the number of complaints received per $1 million of premium written.

> The same press release also indicated that "* * * although the Illinois Insurance Department has been hampered by budgetary restrictions during the past fiscal year it has strived to maintain an aggressive posture of response to consumer problems and regulatory pursuit of questionable insurer activity."

This department initiated several market conduct examinations based on annual complaint ratios.

The New York State Insurance Department also published a list of complaint ratios for automobile insurers operating in the State in 1976 who had 10 or more complaints or who wrote premiums in excess of $500,000. The department also provided a separate ranking that compared the 25 automobile insurers with the highest complaint ratios with their respective records in 1975 and 1974. The list was also released to the news media, insurance companies, and consumer groups.

According to the New York department, the list is subject to several qualifications:

--Most complaints are settled by compromise.

--Small changes in complaint totals can cause large changes in the relative standings of small companies.

--The list does not distinguish the severity of problems, thus a clerical problem counts just as heavily as a more serious claims problem.

--The premium volume is the necessary denominator in the complaint ratio because it is the available common measure of business transacted. However, this measure tends to penalize companies charging lower premium rates since division by the lower number results in a higher ratio.

Nationally, most States make complaint summaries available to the public in some form. Thirty-four States responding to our questionnaire item reported that complaint summaries or summary data were available to the public. However, based on our fieldwork, very few States publicize complaint ratios or other systematic information on complaints.

Use of complaint data in enforcement activities

Complaints from the public can influence regulatory activity in two ways. First, a small number of individual complaints can sometimes culminate in an enforcement action against companies or agents. Nearly all States in which we did fieldwork followed up on complaints directly if an illegal practice by an insurer or agent was involved. We were not able to evaluate the vigor or effectiveness of such followup, but interviews with officials in the departments indicated that such enforcement activities were at least the formal policy of those departments.

The second way complaints influence regulatory activity is that patterns of complaints identify companies for special market conduct examinations. If complaints are adequately compiled and patterns analyzed, the scarce resources of departments can be channeled toward those companies where abuses are most frequently alleged. This optimum system prevails in fewer than half the States in which we did fieldwork. In only six States were complaints systematically utilized to trigger market conduct examinations. Some other States have an informal way of going from complaints to market conduct examinations in which reliance is placed on the subjective judgment of consumers services personnel or examiners. iners.

Even in some States that have the capacity to use complaint data systematically, such data is not used to full advantage. One southern State, for example, has an excellent system of tracking complaint patterns and identifying problem companies, but it lacks the market conduct examination staff to audit problem companies. In a northern State, with a reputation for aggressive intervention on behalf of consumers, the market conduct staff apparently never consulted the systematic complaint records kept by the complaint-handling staff. Instead, they relied on their own impression of which companies were the subject of complaints. Furthermore, in the market conduct examinations themselves, such complaint data apparently were not used as a way of learning more about the treatment of policyholders.

Based on our fieldwork, most States have the prerequisite for systematic action in that they can identify complaint patterns, but they fail to carry through a procedure that systematically codes, analyzes, and feeds complaints into the examination process.

Another potential use of complaint data is to exchange information among insurance departments to assist in licensing and enforcement activities. This function, however, is not universally realized. Only half of the departments responding reported that they always checked out the complaint records of the domicile State when an out-of-State insurer seeks a license to do business. Seventeen States (39 percent) reported that they undertook such checks only occasionally, rarely, or never. Complaint records are not being fully utilized to compensate for the problems of having 51 jurisdictions regulate interstate companies.

MARKET CONDUCT EXAMINATIONS

Insurance department examinations of consumer affairs matters, such as claims handling, advertising, underwriting, and other trade practices, are known as market conduct examinations. The NAIC report by McKinsey & Company on the surveillance system recommended a specialized market conduct examination process. Thirty out of 43 States responding to a questionnaire item reported that they conducted special market conduct examinations (as contrasted with examining market conduct as part of the financial examinations).

While systematic complaint handling procedures have great utility on a case-by-case basis, an effective market conduct examination process is also needed to guarantee that policyholders and claimants are treated fairly. The primary purpose of market conduct examinations is to identify those insurers engaging in unfair trade or business practices and to develop the basic information needed for appropriate regulatory action. These examinations should distinguish between unintentional errors and specific business policies or procedures that are unfair or that lead to error rates exceeding normal or acceptable levels.

Because of the size and diversity of the insurance industry, market conduct examinations are best performed by trained specialists. The examinations should also be based on a consistent set of quantitative and qualitative standards to insure accurate and consistent regulatory responses. Our review indicates deficiencies in both areas: only about one-third of the State insurance departments employ trained market examiners, and examinations are based on questionable quantitative standards and unstated qualitative standards.

Need for more market conduct specialists

Within the insurance industry, the magnitude and prevalence of unfair practices typically vary by line of business, marketing approach, and geographic area. For example, misleading advertising may be a greater problem in health and life insurance than in automobile insurance; unfair claims practices may reflect the influence of a regional claims manager and, therefore, be a local rather than a company-wide problem. The range and complexity of these market conduct problems require the attention of expert specialists trained to interpret and consistently apply relevant State statutes, rules, and regulations.

According to the questionnaire responses, however, only 16 States employ a separate market conduct examination staff. Other respondents stated that financial examiners, rate and form analysts, consumer representatives, or attorneys performed market conduct examinations.

Specific examiner skills are required to evaluate various aspects of market conduct. Judgment is a key feture in assessing a company's business practices. Reliance on untrained examiners can result in erroneous or ambiguous examination reports.

Absence of consistent quantitative and qualitative standards

The NAIC Examiners Handbook states that market conduct examinations of property, casualty, life, or health insurers could include any of the following business practices: sales and advertising, rating accuracy, underwriting accuracy, claims practices, and licensing. We reviewed 27 sample examination reports from 13 States to determine which business practices were being considered and the quality of the review procedures.

When performed comprehensively, market conduct examinations can be time consuming. To maximize coverage and impact, these examinations can be targeted to specific companies and specific problems within companies. All of the reports we received included reviews of claims practices, and 18 reviewed underwriting accuracy. Other business practices were reviewed in only about one-half of the examination reports (rating accuracy was included in 14 reports; sales and advertising in 13; and licensing in 12). Interestingly, at least 12 of the examinations were not targeted but, rather, were performed routinely as part of a scheduled financial examination. Only half of these, however, considered all the major business practices outlined in the NAIC guidelines.

For some business practices, especially those involving potentially large data bases, such as rating and underwriting accuracy and claims practices, by necessity the examiner must limit his review to a small portion of the available data. When sampling procedures are used, they must be statistically valid so that the resulting information is applicable to the total data base. In all 27 examination reports, some statistical sampling was performed, but only three reports (two from Illinois and one from Massachusetts) explained the sampling criteria. In the other 24 reports, we were unable to project the results of the sample across

the total population or determine whether the identified errors were merely incidental, or whether they indicate pervasive business practices.

Whether statistical samples are selected or total populations are surveyed, all examination results must ultimately be compared to minimum qualitative standards to determine company performance. According to NAIC guidelines, such standards should (1) be developed from a collection of data obtained from the overall State examination program and not from arbitrary judgments, (2) be appropriate for particular business practices, and (3) be determined by the State insurance commissioner.

Any violation of a company's charter, for example, might be considered a serious error, but improper application of rates might be considered an unfair business practice only if the frequency and magnitude of such miscalculations exceed previously determined acceptable standards. Even statistically valid conclusions, such as "at a confidence level of 95 percent, the rating accuracy error falls between 7 percent and 11 percent," offer little useful information about a company's performance until compared to an error rate standard that is applicable to similar companies.

None of the market conduct examination reports we received explained what the minimum qualitative standards were, nor did they state if such standards were used in assessing company performance. During our field work in two States, we were told that final assessment of company performance was based totally on the professional judgment of the onsite examiner, which of course could vary by examiner and by company.

The market conduct examination process is a useful tool for insuring the overall quality of the industry's business practices. For this process to have utility for insurance regulators, the examinations must present the kind of information needed for effective regulatory action. This implies the use of sound procedures by competent examiners and, most importantly, the development of minimum qualitative standards applicable to all insurers. Lacking this, the market conduct examination process will produce inconsistent and possibly insufficient regulatory responses.

Departments do not adequately monitor claims handling

Because the promise to pay a claim is the only thing an insurance consumer purchases, claims handling is an important aspect of company surveillance. Claims are both the most frequent source of complaints from consumers and, as noted above, the most frequently included issue in market conduct examinations. Because of the importance of claims handling, we devoted special attention to departmental surveillance of claims handling in the context of insurance department's consumer protection activities.

Uniform claims handling information, such as speed of compensation and percent of amount claimed that was actually paid, is needed so that insurance departments can compare companies' performance, and so consumers will have another measure of value when shopping for insurance. However, none of the 17 insurance departments we visited maintained such records and only three departments had criteria against which to measure individual company performance. Therefore, neither insurance departments nor consumers were able to utilize a valuable tool with which to measure company performance.

Even though examiners from all 17 States we visited said they review claim files during routine financial examinations and/or during market conduct examinations, only three States had concrete performance guidelines against which to measure performance. In the first State, Wisconsin, the statute stated that all claims must be paid within 30 days after claim's receipt. However, the statute did not define claim receipt date; therefore, examiners accepted whatever definition was used by the company being examined. Michigan also had a statute requiring the company to pay interest at a rate of 12 percent annually if the claim was not paid in 60 days after submission of proof or loss. The Illinois department allowed 40 days to pay claims.

Only one of the 17 State insurance departments we visited included consumer input as a part of their review process. This department, Wisconsin, sent questionnaires to a sample of policyholders as a routine part of their review of claims handling procedures. The sample included policyholders who had past claims and those who never had a claim.

SUMMARY

Our limited review of financial examination revealed that improvements are needed in the resources devoted to financial regulation. In particular, there is a need for greater computer examination capability and for greater specialization among examiners. In reviewing some of the recommendations made 5 years ago by the McKinsey study, we find that very few of that study's recommendations have been adopted.

Most of the States we visited had a very positive philosophy of complaint handling. They generally considered complaint handling an important function and generally followed up on most complaints--at least to the point of getting some response from an insurance company. However, in most States we visited complaint handling was not a systematic part of trade practice surveillance. Although many States have the facility to utilize complaints systematically, few States appear to make complaint data a component of market conduct examinations. The market conduct examination is a particularly weak link in the process of company surveillance. There was no evidence in most States that there are implemented in the examination process itself qualitative standards of what constitutes unacceptable behavior by insurance companies.

In general, we find that State insurance departments, based on the 17 States we visited, do not utilize their personnel resources effectively in a systematic process of company surveillance. This is not to say that insurance companies in States with weak surveillance systems are neglecting consumers. Rather, the problem is that most insurance departments do not have adequate information on the nature and extent of existing problems. Without systematic information these insurance departments cannot regulate as effectively as they should.

CHAPTER 5

PRICE REGULATION OF AUTOMOBILE INSURANCE

THE REASONS FOR INSURANCE RATE REGULATION

Although current controversies over insurance rate regulation focus on the question of equity and affordability for consumers, rate regulation developed in the 1900s in response to the problem of insurer insolvency.

In the late 1800s, before insurance rating bureaus or rate regulation, fire insurance companies competed intensely among themselves. The insurance agents set the rates, often in contradiction of company instructions, and there was little information to guide rate setting even if the companies had been able to enforce prices. Actuarial science was not well developed, and companies tried to set rates based on experience alone. Competition lowered rates, but marketing arrangements and lack of information led to rates that were too low and, hence, to major solvency problems. Following the Chicago fire in 1871 and the Boston fire a year later, scores of companies became insolvent and left policyholders with unpaid claims.

As a result, companies engaged in joint ratesetting, relying on data from many companies, and tried to enforce uniform and noncompetitive rates. In the absence of State action, joint ratesetting as an exercise in self-regulation did not work because of differing interests between agents and companies. Nonetheless, the need for some control over rates became accepted by most companies and regulators.

In 1914, the Merritt Committee in New York State recommended joint ratemaking under State supervision but stopped short of recommending that rates be approved by the States. Three years later, the NAIC recommended a model law for the supervision of fire insurance rates. Many States gave the responsibility for rate control to rating bureaus which collected data from member companies, computed rates, and filed those rates with the insurance department where that was necessary. Prior to 1944, rate regulation by the States was not widespread--only about 10 States required the filing and approval of automobile insurance rates.

With the South-Eastern Underwriters Association case and the consequent passage of the McCarran-Ferguson Act, the situation changed greatly. The States had been relying on concerted ratemaking activity by insurance companies--actions which would have violated Federal antitrust laws had

insurance been deemed subject to those laws. The South-Eastern Underwriters decision held that insurance was indeed reachable by Federal antitrust laws. The McCarran Act removed that threat, but only if the States regulated the business of insurance. In short, joint ratemaking could proceed only under a State rating law. Consequently, the NAIC developed the model Commissioners-All Industry rating laws that provided for uniform joint ratemaking and gave the States the responsibility to insure that rates were neither inadequate, excessive, nor unfairly discriminatory. Where few States supervised rates prior to 1944, most did in the years immediately following.

In summary, price regulation emerged not because prices were too high, but because they were too low. The impetus for uniform ratesetting was solvency not affordability. A second major impetus for direct State involvement in rate setting was the McCarran-Ferguson Act.

All the States, except Illinois, now have rating laws. However, it is not necessary for States to regulate rates directly or to require minimum or maximum rates in order to qualify as regulating insurance under the McCarran-Ferguson Act. Indeed, the Report of the House Judiciary Committee urged:

> "Nothing in this bill is to be so construed as indicating it to be the intent or desire of Congress to require or encourage the several States to enact legislation that would make it compulsory for any insurance company to become a member of rating bureaus or charge uniform rates. It is the opinion of Congress that competitive rates on a sound financial basis are in the public interest."

Even before 1944, numerous States relied on competition as the way to set rates. At that time, 12 States had anticompact laws preventing joint ratemaking, while 33 had laws providing for either rate regulation or State sanctioned joint ratemaking. These two approaches to ratesetting continued after the passage of the McCarran-Ferguson Act: some States adopted price regulation laws that provided for rates set by the State or prior approval of industry rates; other States chose pricing through market forces with competitive rating laws. There are several types of regulatory requirements under price regulation and under competitive rating. For convenience, however, we will refer to all price regulated systems as prior approval and all market systems as competitive rating or open competition.

THE RATE REGULATION PROCESS

Most rate regulatory laws require that rates be neither inadequate, excessive, nor unfairly discriminatory. In the fieldwork States, we examined the processes by which the States determined that rates conform to these requirements. Generally, we assessed how thoroughly the State insurance departments reviewed rates. In prior approval States, the core question is how thoroughly rate filings are scrutinized before they are approved. Competitive rating States do not have to pass on individual rate filings; however, except for Illinois, which has no rating law, they are required to insure the adequacy and nonexcessive rates. In relying on competition as the primary regulator of rates, some competitive rating States endeavor to monitor the vigor of competition among the insurance companies. In these States, we examined how competition is monitored.

Prior approval

Rate regulation in prior approval States has been faulted on two contradictory counts. First, it is thought to be merely a rubber stamp that fails to analyze filings and allow companies to set whatever rates they wish. Second, the insurance industry criticizes the prior approval process as being too restrictive, fraught with delays, and prone to making large cuts in requested rates. Our study found evidence to support both criticisms, depending on which State we reviewed. We also found, however, that review of major rate filings in most States appeared adequate enough to meet the statutory requirement that rates be neither excessive nor inadequate. 1/

Criteria for rate approval

The typical statutory standard for insurance rates is that they be neither inadequate, excessive, nor unfairly discriminatory. The area between "inadequate" and "excessive" is the zone within which insurance rates are judged to be reasonable. While State statutes generally provide no specific guidance, we found that most States had a more specific criterion of rate reasonableness. In the prior approval States (for automobile insurance) in which we did fieldwork, nearly all allowed a projected 5 percent underwriting profit. That is, the ratio of claims plus expenses to premiums should be 0.95. This formula was reported by the States of Arizona, Connecticut, Indiana, Kansas, Michigan,

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1/As discussed in chapter 6, analysis of whether rates are unfairly discriminatory was deficient in most States we visited.

Ohio, South Carolina, and Washington. North Carolina also allows 5 percent, but this includes investment income. New Jersey reported that the actual percentage of underwriting profit allowed varies, but on the average no profit is allowed on liability, while 5 percent is allowed for physical damage premiums. New York reported that the last percentages approved were 3.5 percent for liability and 5 percent for physical damage. The smaller percentages in New Jersey and New York, as well as the criteria in North Carolina, carry the expectation that necessary profits will be earned on investment income rather than underwriting.

The 5 percent underwriting profit used in many States has been in place for many years--one State reported using this criterion since 1921. Higher interest rates in the last few years cast doubt on whether the targeted 5 percent underwriting profit is still appropriate--a point that has been vigorously made by the New Jersey and Massachusetts Insurance Departments. Indeed, recent research suggests that the rule of thumb 5 percent underwriting profit is greater than would occur in a competitive insurance market. 1/ Our questionnaire survey asked if investment income was calculated in the approval of insurance rates. The responding States replied that investment income was usually or always calculated as indicated below in table 12.

Table 12

Calculation of Investment Income of Insurers

Is the investment income of insurers calculated in evaluating the reasonableness of rates?	Number of States	Adjusted frequency
Never calculated	7	16.3%
Rarely	4	9.3
Sometimes	8	18.6
Usually	10	23.3
Always	14	32.6

We suspect that the discrepancy between the questionnaire responses and the findings in our fieldwork States is due to different interpretations of what was meant by the

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1/Raymond D. Hill, "Profit Regulation in Property-Liability Insurance," The Bell Journal of Economics, vol. 10, Spring 1979, pp. 172-191.

term "calculated." The 5 percent underwriting profit allowed by most States indicates that rate approval is not adjusted in most States to take into account the greater return on investment available today as compared to the time when that 5 percent standard was originally used. On the other hand, the great number of States reporting that they do in fact calculate investment income may indicate that company profitability is reviewed but not taken into account in approving rates.

The process of reviewing rates

In the fieldwork States, we critiqued the process by which automobile insurance rates are reviewed. We found no single course of action that typifies the process, either among the States or even within a single State.

The prior approval States all reported that they reviewed all the rate filings they received, but the amount of time devoted to the review of separate rate filings varied considerably. Indeed, the range cited by the States was quite large--from a few minutes to 12 or 14 months. Most States indicated shorter review times, ranging from a few minutes to several days. The amount of time spent on individual rate filings generally depended on the complexity and impact of those filings. Across the board changes proposed by the Insurance Services Office (ISO is a rating bureau), or a large independent filer were given far more time than a single change by a smaller company. Even accounting for these differences, it appears that some States give a cursory review of rate filings, averaging only 1 or 2 hours for each filing.

One step in processing an important rate filing in some States is an administrative hearing which allows the public an opportunity to scrutinize the rate review process. Our questionnaire asked insurance departments how many rate hearings they held in 1977. Of the 35 States responding to questions about the number and disposition of rate filings, 6 had no hearings at all, and the median number of hearings was four.

The rate review procedures used by State insurance departments are basically similar; the differences occur in the thoroughness of the procedures and in the professional resources available to the departments. Two States, New York and Michigan, conduct rather extensive rate reviews. By contrast, the rate review procedures in Ohio are minimal. The methods used by these three States are synopsized below as examples of the rate review process.

Michigan

The Michigan Insurance Bureau's procedures for reviewing automobile insurance rates are extensive for rates that have a great impact, but we did not attempt to determine whether the procedures or criteria are actuarially adequate.

All rates and rate changes must be approved. Most companies obtain prior approval but may use the rates when filed, subject to disapproval.

An analyst reviews every filing and has the assistance of an actuary for the State's largest insurers, the Insurance Services Office, the assigned risk plan, and for any filings that require technical assistance. The largest insurers account for over 78 percent of the State's auto premium volume. The Bureau receives an estimated 150 to 200 filings for automobile insurance as part of the estimated 11,000 to 12,000 total annual filings rate.

The review time for auto filings varies tremendously depending on the potential impact. Minor changes, such as for road trouble rates, may take 10 minutes, while drastic changes with great potential impact may take 40 hours. A review might extend over a 1- or 2-month period because of requests for additional information.

When an auto insurer files a rate change, it submits historical and projected information on a prescribed form. An analyst with appropriate actuarial assistance reviews the information based on the projected premimum volume.

Expenses, such as taxes, commissions, and the like must be justified as reasonable under the projected premium volume. As partial criteria, the Bureau considers that a company's expense ratio should not change significantly from prior years' experience. Additionally, the Bureau has comparable data and ratios from similar companies. As with most other States, a 5 percent underwriting profit is allowed.

New York

According to Insurance Department officials, all rate filings receive a preliminary and a detailed review. The preliminary review entails an examination of all rate changes filed by the company within the previous year and the current filing's relationship to ISO rates. In addition, the volume of business and severity of loss ratios and expense provisions underlying the company's expected loss ratio is verified by

consulting certified annual statements and insurance expense exhibits. For the detailed review, the Department examines the company's method of determining rate levels and the company's experience data for completeness and timeliness.

The time devoted to each rate filing varies with the complexity of the data submitted and the size of the rate increase. For instance, if a small company is requesting an increase based on ISO rates, extensive verification of the data is unnecessary because the Department routinely verifies ISO data. In cases such as these, the Department spends about 2 hours to verify that the company used ISO rates previously and intends to use them in the future. However, if a major company submits a rate filing based on its own data, this data must be verified and compared with Department indices and trends. Such a review may take several weeks. If, however, a company requests an increase that is lower than its data would justify, the New York Department spends less time verifying the data. Finally, if the Department intends to ask the company to reduce the request, more time will be spent verifying the data in anticipation of the company's protest.

The insurance companies are required to submit certified financial statements and certified expense exhibits. The Department stated that it verified rate request data against these documents and also compared the request to data submitted by ISO and the National Association of Independent Insurers. In addition, the State conducts a triannual audit of each company.

According to Department officials, the State does not have the staff to conduct routine independent audits of all data submitted. However, the State does not think there is a need for such audits, since there is no reason to believe that data is systematically falsified. If the actuaries believe something is wrong with the data submitted by a company, an onsite independent check is made by the Department.

In a recent report, the New York State Comptroller's office criticized the Insurance Department's handling of automobile rate requests. 1/ Specifically, the Comptroller found the following deficiencies.

1/Office of the State Comptroller, Operating Practices and Procedures New York State Insurance Department (July 2, 1979).

--The Insurance Department does not verify the data supplied by insurance companies to support their rate requests and does not reconcile data in financial reports with data in rate filings.

--The Department does not have the documentation to support insurers' request for changes in primary and secondary rating factors (i.e., surcharges and factors by which the base rate is multiplied to determine the actual premium charged to an individual).

--Department files do not contain workpapers or documentation for the approval of rates and surcharge plans.

Ohio

A more superficial system of rate review was found in the State of Ohio. 1/ The personnel performing rate reviews are not trained actuaries and do not perform independent actuarial assessments or question the soundness of the methodology used in rate filings. The absence of actuarial analysis and the fact that no recent rate adjustment has been "subsequently disapproved" supports the observation that the Department's rate review efforts do not result in rate adjustments. In fact, both Department officials and representatives of Ohio's insurance industry acknowledge that competition, rather than the Department of Insurance, is the regulator of rates in this State.

Disposition of rate filings

Most rate filings with State insurance departments are approved without modification--about half the States responding to our questionnaire disapproved 10 percent or fewer rate filings in all lines requiring prior approval. Private passenger automobile insurance rates are generally challenged, however, and a large number of these rate filings are modified. Based on the filings of six major companies and ISO in prior approval States, we found that the most recent private passenger automobile rate filings had been cut by an

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1/The Ohio Commissioner of Insurance disagrees with much of this characterization of Ohio rate regulation. See chapter 9.

an average of 3.7 percent. The reductions fell within a range from 0.4 percent to 59 percent of the requested rate increases.

Independent actuarial review: Texas and Massachusetts

In reviewing rate filings, State insurance departments must judge the validity of the actuarial work by insurance companies and the assumptions on which that actuarial work is based. Such judgments are generally based on the department's review of the data and calculations presented by the companies. Rate analysts review the filings, but there is no independent data against which to judge the adequacy of the filings. In most States, the department relies entirely on companies and rating bureaus for loss data and for the actuarial work involved in translating that loss data into rates. In only two States, Texas and Massachusetts, did the department calculate its own version of indicated rates. One of those States, Texas, has State-set rates.

The staff of the Texas State Board of Insurance (SBI) calculates rates, and the three-person Insurance Board makes a final determination after reviewing the staff-developed rates and the rates developed by the industry bureau, the Texas Automobile Insurance Services Office. In Massachusetts the State Rating Bureau, attached to the Insurance Department, computes rates. Thus, the commissioner in Massachusetts also has a choice of rates: those recommended by the State Rating Bureau or the rates suggested by the insurance industry. In Massachusetts, the Commissioner sets rates under the competitive rating law, which provides for State-set rates if the Commissioner determines that competition is not working. The experiences of Massachusetts and Texas indicate that when an insurance department is able to perform its own actuarial work and arrive at recommended rates, the department has a much greater advantage in determining the proper ("reasonable") amount of rate adjustment. Typically, the departmental actuaries recommend greater reductions and smaller increases than do the insurance companies. Table 13 displays this trend for the State of Texas.

However, it should be remembered that reductions of rate increases are not necessarily desirable. When rates are too low, availability becomes a problem. With the benefit of hindsight, it is possible to review the relative judgment of the Texas Automobile Insurance Services Office and the State Board of Insurance. For the 3 years for which we have data, we found that on the average the insurance companies made greater underwriting profit percentages in Texas than

Table 13

Texas Average Statewide Rate Adjustment History

Date	Board of Insurance staff recommendation	Texas Automobile Insurance Services Office recommendation	Actual SBI adjustment
January 16, 1975	+17.8%	18.3%	+7.8%
January 1, 1976	+17.0%	+24.9%	+17.1%
October 1, 1976	19.5%	25.5%	19.5%
July 21, 1977	10.1%	17.4%	
November 1, 1978	3.2%	8.9%	3.2%

for the United States as a whole. For 2 of the 3 years, companies had a lower loss ratio 1/ in Texas, and in the third year, the Texas ratio was only 0.3% higher. In all 3 years, Texas had a substantially higher physical damage loss ratio. Table 14 compares nationwide industry adjusted loss ratios with those for Texas.

Table 14

Insurance Average Adjusted Loss Ratios, Private Passenger Auto Insurance

Year	Liability		Physical damage	
	Texas	U.S.	Texas	U.S.
1975	71.1	70.8	72.2	79.1
1976	65.3	68.4	70.0	72.4

Source: A. M. Best Co., Inc.

A similar exhibit prepared by Massachusetts State Rating Bureau shows that the Bureau's recommendations and the State's ultimate action resulted in a return to the industry greater than the permissible State limits despite a substantial cut in the industry request. In other words, the implementation of the rate bureau recommendations led to rates that were far more reasonable than those set forth by the industry.

1/The loss ratio is the ratio of claims (losses) to premiums and is a commonly used measure of insurer earnings and the cost of insurance. For example, a lower loss ratio indicates greater returns to insurers and lower returns to policyholders for each premium dollar. See pp. 76-77 for further discussion of the analytical use of loss ratio.

While other States can and do cut industry recommendations, in the States we visited, Texas and Massachusetts had the most solid store of information upon which to base their recommendations.

One possible inference from the Texas and Massachusetts situations is that if other States would review rates as thoroughly, insurance rates could be reduced. The matter is not so simple, however. Apparently, insurance rate filing is similar to making budget requests--an organization may ask for more than it thinks it will get in order to get what it really wants. While companies base their rate filings on solid loss data, the requested rate depends on assumptions about loss trends and needed reserves, and these assumptions are very conservative. While most companies claim that they request only what they need, the president of one large company candidly admitted that insurers usually request more than they need or expect in prior approval States because they know their requests will be cut.

This sequence of events suggests the question of whether prior approval does lead to lower insurance costs no matter how thoroughly the States review rates. We examine that on pages 76-80.

Delay

Insurance company executives told us that in some States the real cost of regulation came not from regulatory cutting of rates but from regulatory delay. We found that for six major companies and ISO, prior approval States spent an average of 3-1/2 months to approve major rate filings. In other States, however, the average delay was far greater--almost 1 year in New Jersey and 6 months in South Carolina, for example.

If requested rate increases are justified, such lengthy delays result in inadequate rates for the period of the delay. Insurance commissioners, on the other hand, have pointed out that they have a responsibility to review rate filings carefully, and this sometimes necessitates requesting more data from companies. In some cases, extensive delays were encountered not because of deliberation but because a rate hike had been granted recently (but applied for long before) and the commissioner simply felt that it was too soon to grant another increase.

MONITORING COMPETITION

The mandate that rates be neither excessive nor inadequate applies to open competition States as well as to prior approval

States (with the exception of Illinois which has no rating law). Although competition is presumed to assure the reasonableness of rates, the departments still have administrative responsibilities to monitor rates--or at least to monitor the competition that is regarded as the prerequisite to reasonable rates. In the fieldwork States with open competition--California, Illinois, Virginia, and Wisconsin--we examined the procedures by which the departments monitor the reasonableness of rates.

None of these States perform systematic actuarial analysis of rates, nor would they be expected to do so. All States, however, reported that they monitor some aspects of insurance cost--particularly variations in cost within the State and comparisons with rates in other States. The reasonableness of rates is assumed to be guaranteed by healthy competition, and all four departments reported performing some review of the adequacy of competition. Even the Insurance Department of Illinois, which is not required to do so, has compared prices and reviewed selected economic indices of competition.

Nonetheless, of the four States only Virginia has a documented continuous system of monitoring competition. The Virginia department's staff economist compiles and reviews data on the adequacy of competition, including: underwriting and investment profitability, overall stock company profitability, interindustry profitability comparisons, market share, concentration, availability, and prices. The other States appear to monitor these factors occasionally or impressionistically, and have no documentation system to monitor the adequacy of competition.

Several States have also produced studies of the competitive conditions prevailing within those States and the effects of open competition. Particularly noteworthy are comprehensive studies by New York (which had a competitive rating law from 1970 until 1974), California, and Virginia. 1/

1/State of New York, Insurance Department, Cartels vs. Competition, A Critique of Insurance Price Regulation (1975); State of Virginia, Bureau of Insurance, Competition in the Property and Casualty Insurance Industry: An Evaluation of Alternative Methods of Rate Regulation (1978); State of California Department of Insurance, Competition Under the California Rating Law and Its Effect on Private Passenger Automobile Insurance (1974).

The Illinois Insurance Laws Study Commission supported a more limited study, focusing on cost comparisons. 1/ The National Association of Insurance Commissioners also prepared a comprehensive study of competition as an alternative to rate regulation. 2/ Each of these State studies and the NAIC study have concluded that competition is workable and produces rates at least as low as those produced by price regulation.

Despite the reliance on competition as the regulator of rates, no State had firm criteria for what constitutes adequate competition. As with the prior approval States, the criteria are that rates be neither inadequate, excessive, nor unfairly discriminatory. Even in competitive rating States, this vague statutory mandate is bolstered only by an equally vague reference to the adequacy of competition. The departments we visited, even Virginia with its monitoring system, had not formulated specific criteria, such as permissible market shares or underwriting profits. Thus, whatever data that is collected on competitive conditions can only be used to guide subjective judgments and cannot serve as a means of checking whether competitive conditions conform to previously established standards. In brief, competition is used more as an article of faith rather than as a system of review against objective standards.

THE ECONOMICS OF PRICE REGULATION

Of even greater importance than rate review procedures are the fundamental questions of whether regulation is warranted and the ultimate effects of price regulation. The following sections discuss: (1) whether the private passenger automobile industry is characterized by an economic structure that requires price regulation (2) the price effects of rate regulation and (3) whether market failures justify insurance rate regulation.

Our analysis has followed past practice by defining the industry within the context of automobile insurance, although for some purposes the automobile liability and automobile physical damage insurance are separated. Because automobile

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1/Robert C. Witt, The Competitive Rate Regulatory System In Illinois: A Comparative Study by State," CPCW Journal vol. 31, September 1978, pp. 151-162.

2/National Association of Insurance Commissioners, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business (1974).

insurance policies provide services that are sufficiently similar to be called homogenous, no single company selling auto insurance can exert monopoly power over its customers. There are, however, difficulties in actually comparing policies, which will be discussed later. In the following sections, the structure of competition is measured by size and number of firms and the ease of entry into the market.

Size and number of firms

Viable competition requires that the number of firms in an industry be high enough so that no one firm can unilaterally determine or influence the price that prevails in the marketplace. The number of licensed insurance firms in the United States assures that no one company or group holds a dominant position. In 1978 there were 2,940 property casualty insurance companies, of which 900 were licensed in most States. Once licensed, a company can write policies anywhere in the State. In addition, as will be discussed later in this section, barriers to entry are low and companies can obtain a license in any State if the demand exists.

In some circumstances, however, the number of firms in the market is far less than indicated by State-wide totals. Indeed, critics have alleged that not only are there few firms competing for business in certain urban areas, but no firms will accept business at standard rates in areas that have been subject to redlining. The availability problem is discussed in chapter 7. Even apart from outright refusal to insure, there may be few insurers actually seeking or accepting business in particular submarkets of large States despite the large number of firms licensed to write automobile insurance. Indeed, part of competition in the insurance business is risk selection whereby companies compete to avoid certain customers. Unfortunately, as discussed in chapter 7, few State insurance departments systematically collect and analyze the kind of data necessary to make informed judgments about the State of competition in particular submarkets and the problems of insurance availability.

While there is no single number of firms that define the condition of viable competition, there are attempts to assess the strength of competition by looking at market shares. The market share of any firm is the percentage of the market held by that firm. For the insurance industry, market share is calculated using the percentage of total net premiums written. If a market is highly concentrated--that

is, if the market shares of a few firms are very high--the potential for monopoly power is great. Thus, the existence of a concentrated market can indicate that the industry is not structured to support competition.

In a 1974 article on the property-liability insurance industry, Paul L. Joskow concluded that the national concentration ratio for the industry was low compared to other industries, but increasing. 1/

A major study by the NAIC in 1974, 2/ which reviewed nine previous studies of size and concentration in the property and casualty insurance industry, generally found that concentration was neither high nor a barrier to healthy competition. The NAIC report then reviewed 4-, 8-, and 20 firm concentration ratios for homeowners and automobile insurance and reported that these personal line markets in particular States were or were not concentrated, depending on whose definition of concentration is used. The danger of a concentrated market is that a few sellers will be able to anticipate each other's behavior and engage in discretionary pricing. Dr. Willard Mueller stated that this discretionary pricing power becomes severely limited when the 4-firm ratio is less than 50 percent. On the other hand, in a much more expansive concept of market power, Kaysen and Turner hold that when the 8-firm concentration ratio is greater than 33 percent, there is a structurally oligopolistic market in which the few largest sellers have a sufficient share to make it likely that they will recognize the interaction of their own behavior and their rivals' response. Under the Mueller concept, the market is not concentrated in any State, while under the Kaysen and Turner concept, the market is concentrated in almost every State.

Our analysis of the national concentration ratio shows that it has increased since 1973. Although this data is not directly comparable to the data used by Joskow, the trend is confirmed. (See table 15.)

1/Paul L. Joskow, "Cartels, Competition and Regulation in the Property-Liability Insurance Industry," Bell Journal of Economics, Autumn 1973.

2/National Association of Insurance Commissioners, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business, vol. I, pp. 261-262.

Table 15

Concentration in Private Passenger Auto Insurance Industry, 1973-1977

(Percentage of Total Direct Premiums Written)

Type of coverage	Year	Top group	Top 4 groups	Top 8 groups	Top 20 groups
Liability	1973	13.6	32.1	44.7	62.1
	1974	13.9	32.8	45.3	62.4
	1975	14.2	33.1	45.0	62.5
	1976	14.8	33.7	44.5	62.4
	1977	15.1	34.6	42.6	60.4
Physical damage	1973	13.9	29.7	41.3	58.8
	1974	14.5	30.5	41.5	59.0
	1975	14.7	31.2	42.0	59.0
	1976	15.0	31.9	41.7	57.5
	1977	16.0	33.9	42.7	59.1

Source: A. M. Best Co., Inc.

The continued gradual increase in market concentration is strongly affected by the increasing market share of the direct writers. In 1973 State Farm and Allstate held the top two market positions, and since then they have been slowly expanding their market share. The correlation between the market share of all the direct writers and the 4-firm concentration ratio in each State is strong: 0.86.

Given the general trend toward concentration in American industry, these increases in concentration are not unexpected. Compared to other industries, insurance remains relatively unconcentrated, as seen in table 16.

Entry

Although entry into the property casualty insurance industry is not costless, there is sufficient movement into the industry to absorb excess profits and thus maintain competition. The ability of new firms to enter the market depends on natural and regulatory barriers. If these barriers are prohibitive, the market concentration could increase without the threat of new firms entering, and thus a few large firms could dominate the market.

Table 16

1972 Concentration Ratios for Selected Industries

SIC a/ Code	Industry	4-Firm ratio	8-Firm ratio
(37111)	Passenger cars	99+	b/
(2111)	Cigarettes	84	b/
(3334)	Primary aluminum	79	92
(3011)	Tires and inner tubes	73	90
(2082)	Malt beverages	52	70
(3621)	Motors and generators	47	59
(3241)	Cement, hydraulic	26	46
(2311)	Men's and boys' suits and coats	19	31
(2026)	Fluid milk	18	26
(2086)	Bottled and canned soft drinks	14	21

a/Standard Industrial Classification Code.

b/Cannot be shown without revealing individual company data.

Source: U.S. Bureau of the Census, Census of Manufacturers, 1972, Vol. 1, Subject and Special Statistics SR2-6, 9, 10, 13, 24, 26, 29, 37, 144.

Joskow finds that barriers to entry are low for companies using independent agents, but higher for direct writers. 1/ (Direct writers are companies whose insurance is sold by their own agents, as opposed to independent agents.) He states that barriers are generally low because he found no significant economies of scale in the property casualty insurance industry. Regulation does require that an insurance company be licensed in each State where it sells policies and follow State regulations relating to the amount of capital necessary for reserves. Although Joskow does not think these requirements are important, the NAIC notes that a multiline national firm will have high absolute capital costs that may act as an entry barrier. The Justice Department concurs with the opinion that barriers to entry are generally low and specifically states that any barriers established by the States are not substantial. Data compiled by the NAIC shows entry

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1/Joskow, "Cartels, Competition and Regulation," p. 391.

of new companies in 1976 as a percentage of the firms licensed to sell private passenger auto insurance in prior years. (See table 17.) These data show a net loss in the number of large and small companies writing auto insurance for the United States as a whole. This net loss is indicative of the profits available in the insurance industry and reflects the low profits experienced by the industry in 1975. While there is not much fluidty in the market, more than half the States had new entries equaling 5 percent of the number of the previous year's firms. The movement of major firms is much less, but that is probably because they are already well positioned in nearly all States.

We have no new or independent information relative to the analyses of Joskow and others on the ease of entry of newly formed insurance companies as opposed to the mobility of existing companies. Given the large number of companies nationally, however, the movement of existing companies into new States is probably sufficient to satisfy competitive requirements. Moreover, our interviews with insurance company representatives confirmed that entry and exit patterns support the competitive model. That is, firms sought to expand or enter in States where they saw the potential for profit, and they reported no regulatory or monopolistic barriers to such entry. Indeed, the entry problem may be the reverse of that usually discussed in regard to prerequisites for effective competition. In some States and submarkets within States, there are no barriers to entry but no firms want to enter the market or expand their share because rates are perceived as inadequate or because of other regulatory restrictions. Thus, there may be no structural barriers to entry, but no competition because no firm wants to compete.

Limitations on competition

In terms of such factors as number of firms, degree of concentration, and barriers to entry, the automobile insurance market is competitively structured. However, there are limitations that may affect the degree of competition that is actually present. First is the problem of consumer information. As discussed elsewhere in this report, lack of information about the differences in quality among companies makes it difficult for consumers to compare policies. Second, insurance is compulsory in 25 States, and physical damage insurance is effectively required everywhere so that financing can be obtained for the purchase of an automobile. The necessity for insurance probably makes the demand for the product somewhat inelastic. Third, there are legally sanctioned practices and regulations that may restrict competition. Most States allow an initial 60-day free underwriting

period during which an insurer may cancel coverage for any reason. This means that if a consumer switches policies, he runs a risk of having the new insurer cancel his policy, through no fault of his own, during the first 60 days of the new policy. The only guarantee of continued insurance outside the assigned risk plan is to insure with the new company for the final 2 months of the old policy--a very substantial transaction cost. To the extent that consumers are aware of this problem, the free cancellation period would discourage comparative shopping and decrease competitive pressures.

Finally, unlike other industries, insurance companies compete not only by seeking customers they want, but by rejecting customers they view as high risks (or whose loss expectancy is perceived as being too great for the risks they are permitted to charge). Thus, while companies may solicit business in most areas and for most potential customers, there will be other areas and customers who are shut out of the market by these same competitive forces. These problems are discussed in more detail in the following two chapters.

Consequently, despite a basically competitive structure, there may be limitations on competitive pressures and segments of the market in which there is no competition. 1/ In the next section, we examine whether the competitive potential is realized in practice by analyzing the comparative performance of the insurance market under the situation of price control versus open competition.

EFFECTS OF PRICE REGULATION AND OTHER FACTORS ON AUTOMOBILE INSURANCE COSTS

The most direct measure of the cost of insurance is the premium (the actual amount charged for an insurance policy) or the rate (the amount per given level of coverage). Ideally, we could compare average rates in the various States and relate the differences to type of regulation and to the other factors we seek to examine. Rates, however, are basically determined by the frequency and severity of accidents, and accidents are determined by a great many factors including: degree of urbanization and population density, traffic enforcement, judicial and jury behavior, medical costs, driver licensing requirements, and road conditions. Comparing rates

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1/These market failures and their appropriate remedies are discussed on pp. 94-99.

is further complicated by the fact that rates within States vary depending on driver characteristics and territory. In short, a $200 rate in a low-accident State is more "expensive" than a $200 rate in a high-accident State.

Following a convention used in other analyses, 1/ we have approximated the cost of insurance with a measure of underwriting results--the adjusted loss ratio. The adjusted loss ratio is the ratio of claims incurred to premiums earned, minus any dividends paid to policyholders of mutual companies. This is conceptualized as the proportion of premium returned to policyholders in the form of claims payments. Thus, loss ratios are a relative measure which permit comparisons among States. If one State has a higher loss ratio than another, the cost of insurance is lower and consumers are relatively better off. Of course, if losses are too high, the solvency of companies may be threatened, and if companies were unable to raise rates, they would try to reduce their volume of business in a State, thus causing availability problems. Consequently, consumer welfare can also be reduced by loss ratios that are too high. Within reasonable limits, however, the use of loss ratios can be used to compare cost differences which reflect differences in consumer welfare. Moreover, loss ratios have a high negative correlation with company operating profits and can also be seen as a proxy measure of profitability. 2/ Because liability and physical damage rates are separately justified in rate filings, we have also used data showing the separate loss ratios.

Differences in loss ratios

The first question we sought to answer was whether the rate regulation led to lower insurance costs (as indicated by higher adjusted loss ratios). In order to examine the

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1/Robert C. Witt, "The Competitive Rate Regulatory System in Illinois: A Comparative Study by State," CPCU Journal, vol. 31, Sept. 1978, pp. 151-162; U.S. Department of Justice, The Pricing and Marketing of Insurance, A Report of the Department of Justice to the Task Group on Antitrust Immunities, Jan. 1977, pp. 52-90. (Hereafter referred to as Department of Justice Study.)

2/State of Virginia Bureau of Insurance, Competition in the Property and Casualty Insurance Industry: An Evaluation of Alternative Methods of Rate Regulation, 1978, p. 74.

Table 17

1976 Entries & Exits of Private Passenger
Automobile Insurance Firms as Percentage of Prior Year's Firms

State	Entries		Exits		Entries & Exits	
	Major	Total	Major	Total	Major	Total
Alabama	0.0	2.2	5.4	14.0	5.4	16.1
Alaska	6.7	13.3	6.7	13.3	13.3	26.7
Arizona	2.9	7.1	5.7	14.3	8.6	21.4
Arkansas	4.1	12.2	2.7	9.5	6.8	21.6
California	1.1	13.8	3.4	11.5	4.6	25.3
Colorado	2.4	10.6	5.9	9.4	8.2	20.0
Connecticut	0.0	1.6	0.0	4.8	0.0	6.3
Delaware	3.6	7.1	1.8	5.4	5.4	12.5
District of Columbia	2.0	5.9	0.0	5.9	2.0	11.8
Florida	1.0	4.0	4.0	5.1	5.1	9.1
Georgia	1.9	4.9	2.9	10.7	4.9	15.5
Guam	28.6	28.6	0.0	0.0	28.6	28.6
Hawaii	4.2	4.2	4.2	4.2	8.3	8.3
Idaho	0.0	16.4	3.6	9.1	3.6	25.5
Illinois	1.0	7.8	1.0	2.9	1.9	10.7
Indiana	1.1	4.3	1.1	5.3	2.1	9.6
Iowa	1.3	3.9	2.6	3.9	3.9	6.1
Kansas	6.4	12.8	2.6	7.7	9.0	20.5
Kentucky	3.4	4.6	1.1	4.6	4.6	9.2
Louisiana	3.7	8.6	2.5	4.9	6.2	13.6
Maine	0.0	5.1	0.0	6.8	0.0	11.9
Maryland	0.0	4.9	0.0	1.6	0.0	6.6
Massachusetts	1.4	1.4	5.9	10.3	7.4	11.8
Michigan	0.0	2.3	3.5	9.3	3.5	11.6
Minnesota	1.1	5.6	2.2	6.7	3.3	12.2
Mississippi	4.2	8.3	1.4	5.6	5.6	13.9
Missouri	1.1	7.6	3.3	10.9	4.3	18.5
Montana	5.4	7.1	3.6	12.5	8.9	19.6
Nebraska	0.0	2.9	1.4	4.3	1.4	7.1
Nevada	12.3	15.8	3.5	10.5	15.8	26.3
New Hampshire	3.4	5.2	1.7	8.6	5.2	13.8
New Jersey	0.0	2.6	5.1	10.3	5.1	12.8
New Mexico	2.9	8.6	5.7	10.0	8.6	18.6
New York	1.3	3.9	6.6	11.8	7.9	15.8
North Carolina	0.0	0.0	5.3	5.3	5.3	5.3
North Dakota	1.7	6.8	6.8	8.5	8.5	15.3
Ohio	1.2	2.4	2.4	7.2	3.6	9.6
Oklahoma	1.2	6.0	6.0	9.6	7.2	15.7
Oregon	1.2	4.9	4.9	11.1	6.1	16.0
Pennsylvania	0.0	2.5	1.3	7.5	1.3	10.0
Puerto Rico	3.4	3.4	13.8	13.8	17.2	17.2
Rhode Island	1.7	3.4	3.4	5.1	5.1	8.5
South Carolina	0.0	0.0	4.9	11.1	4.9	11.1
South Dakota	5.9	8.8	4.4	8.8	10.3	17.6
Tennessee	5.2	8.3	2.1	7.3	7.3	15.6
Texas	3.2	5.4	4.3	11.8	7.5	17.2
Utah	4.7	9.4	9.4	14.1	14.1	23.4
Vermont	0.0	1.8	0.0	8.8	0.0	10.5
Virgin Islands	33.3	33.3	11.1	33.3	44.4	66.7
Virginia	0.0	6.7	0.0	1.3	0.0	8.0
Washington	1.4	7.0	4.2	5.6	5.6	12.7
West Virginia	3.3	5.0	0.0	8.3	3.3	13.3
Wisconsin	2.3	2.3	3.5	8.1	5.8	10.5
Wyoming	6.7	8.3	3.3	8.3	10.0	16.7

Key

Major = A firm whose market share rose (or declined) from (1) absolute zero to 0.05 percent or greater or (2) less than 0.05 percent to 0.15 percent or greater. Mergers and insolvencies counted only if they involved firms whose market share was 0.05 percent or greater in the previous year. All such exits are deemed major.

Source: NAIC

difference in costs among States with different forms of regulation, we divided the States into two dichotomous groups--prior approval and competitive rating. While this collapses specific rating laws into one of two categories, it nevertheless captures the essence of the type of regulation and the debate over insurance price regulation. For each of the two groups of States, the average (mean) loss ratio for each year, 1973-1977, was computed together with the mean for all 5 years' experience. Although these averages are based on individual State loss ratios representing greatly different premium volume, we have treated each State equally instead of adjusting for the amount of premium volume. The reason for this is that the States are regulatory entities and the loss ratio represents the cost to consumers in each State, regardless of premium volume.

Of course, one limitation in this analysis is that no adjustment is made for the way laws are implemented. Prior approval States certainly vary in the amount of scrutiny they give to rate filings, and certain kinds of States (e.g., large States, highly urbanized States) may have more intensive review than others. We are, however, concerned with national averages based on the kind of law. Differences that do or do not appear may be due to a variety of factors including different ways of implementing the law.

Table 18 presents the differences in the mean adjusted loss ratios between prior approval and competitive rating States. The differences between the two groups of States are small and inconsistent. The difference in the combined physical damage and liability loss ratios is only 0.8. The loss ratio of liability insurance for rate regulated States is higher than competitive rating States in 1977, the same in 1976, and lower in 1975.

The findings, however, are more consistent for physical damage insurance, which shows a higher loss ratio (lower cost to the consumer) in 4 of the 5 years and is an average of 2.3 percentage points higher in prior approval States. These physical damage ratios are probably more reliable than the liability ratios because the existence of and changes in no-fault laws over this time period may distort the liability ratios and because liability payouts take longer and are less predictable.

In short, the type of regulatory law does not appear to be related to the aggregate cost of insurance, but taking physical damage insurance alone, we find that the physical damage component of insurance cost is slightly less in States

with rate regulation. However, even this relationship is small and not statistically significant, as discussed later in this chapter.

Table 18

Mean Industry Adjusted Loss Ratios

Year and line of loss ratio	Competitive rating	Rate regulated
Combined 5-year industry loss ratio:	65.6	66.4
5-year industry loss ratio - liability	64.9	64.3
5-year industry loss ratio - physical damage	66.2	68.5
Industry liability loss ratio:		
1977	62.1	64.3
1976	67.5	67.5
1975	70.4	68.2
1974	62.7	61.0
1973	62.2	60.3
Industry physical damage loss ratio:		
1977	59.8	63.9
1976	70.5	74.5
1975	76.3	79.5
1974	63.8	64.9
1973	60.7	59.8

Source: Calculations based on data from A. M. Best Co., Inc.

Variation in loss ratios

As noted earlier, some prior approval States are characterized by substantial delays in processing rate filings, and there is considerable variation in regulatory delay among these States. Because an administrative process is involved, we would expect a greater time lag in implementing rate changes in prior approval States than in competitive rating States.

Although there is no approval required in competitive rating States, several companies indicated that some time was necessary to notify the insurance department and receive acknowledgement of the notification. The difference in implementation time between the various types of rate approval systems is shown in table 19.

Table 19

Time Taken to Implement Rate Filings

Rating law	Mean number of days required for decision
State-made rates	N/A
Mandatory bureau rates	N/A
Prior approval	106
Modified prior approval	41
File and use	42
Competitive rating with filing	31
Competitive rating - no filing	10

Largely as a result of the differences in the amount of time required to implement rate changes, we would expect that the lack of restriction on changes in competitive rating States would result in smoother adjustments to market changes because alterations in price can be accomplished frequently and without delay. Therefore, we would expect greater variation in underwriting results in prior approval States than in competitive rating States because in the former States the underwriting cycle is characterized by higher peaks and lower valleys.

The Department of Justice Study found substantially greater variation in prior approval States, but their conclusion was based only on data from three States. Despite its limited sample, the Department's finding is important because the States used, New Jersey, Pennsylvania, and California, are among the "purest" examples of the two regulatory approaches.

A Virginia Bureau of Insurance 1/ study used nationwide data and also found differences in variation measured by the coefficient of variation between the two regulatory approaches

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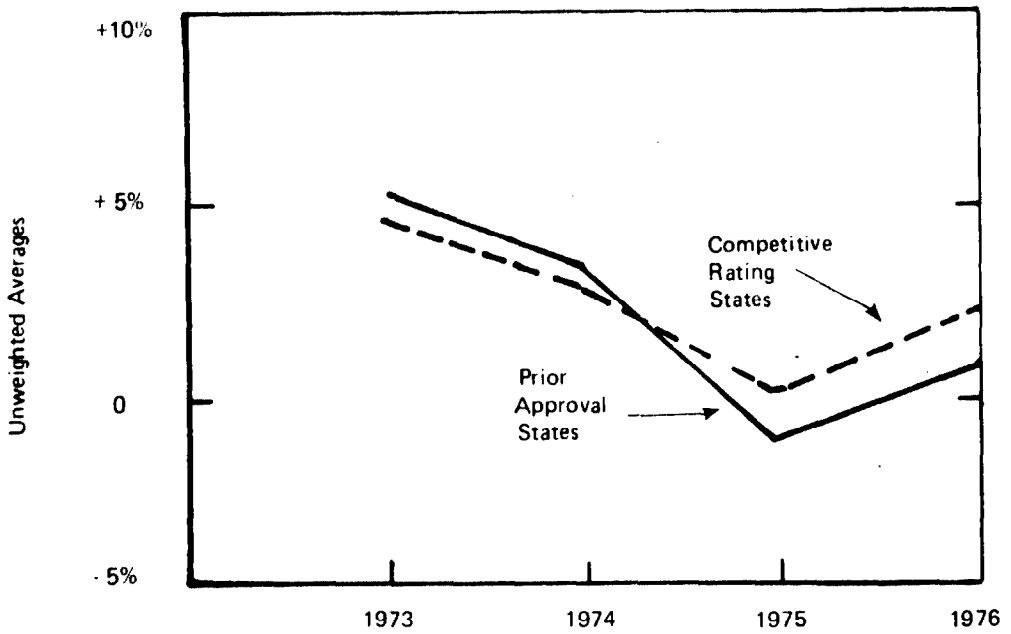
1/Virginia Bureau of Insurance, Competition in the Property and Casualty Insurance Industry.

for 1973 through 1976, but these differences were not of the same magnitude as the limited Justice Department sample. Using operating profit as a measure, the Virginia study found that companies were more profitable in prior approval States in the most profitable year (1973) and realized less profit in the least profitable year (1975). The difference in experience over the underwriting cycle is presented in figure 1.

Figure 1

PRIVATE PASSENGER AUTO INSURANCE

OPERATING PROFIT AS A PERCENT OF EARNED PREMIUM



Source: State of Virginia, Bureau of Insurance, Competition in the Property and Casualty Insurance Industry: An Evaluation of Alternative Methods of Rate Regulation, January 1978, p. 71

Using the measure of underwriting losses and accounting for the additional year of 1977, we did not confirm the theory of greater variation in prior approval States or the findings of the Justice Department and Virginia studies. Our measure of variation is the standard deviation, a statistic that summarizes the variation in a series of numbers. The greater the standard deviation, the greater the variation of the series of numbers around their average (mean). Table 20 shows the mean of the standard deviation in each State for the adjusted loss ratio over the 5 years 1973 to 1977. Although the 5-year average for physical damage

insurance is indeed more variable under rate regulation than open competition, the liability insurance experience is more variable under competitive rating. The difference in our results from the Virginia results may be due to the addition of one more year, the use of the loss ratio as a better proxy for the price of insurance, and the split of auto insurance into its two component sublines.

Table 20

Mean Standard Deviations by State of the Adjusted Loss Ratio Over Time

Companies and type of insurance	Competitive rating (N-16)	Rate regulated (N=35)
Industry liability (1973-1977)	6.1	5.1
Industry physical damage (1973-1977)	8.4	9.3
State Farm liability (1973-1977)	8.2	8.0
Allstate liability (1973-1977)	10.4	11.2

Source: Calculations made from data provided by A. M. Best Co., Inc.

To control for the possible distortion effects in using data based on all insurance companies, we also examined the variation in the experience of the two largest insurance companies in the Nation--State Farm and Allstate. Because these companies are direct writers who generally base rates on their own experience rather than rating bureau filings, we thought that if there were to be differences in year-to-year variation between open competition States and prior approval States, these differences would show up most clearly in these two companies. Even with these companies, however, the differences in variation are small. The mean of the standard deviations for Allstate is somewhat greater in prior approval States, but State Farm shows a slightly greater standard deviation in competitive rating States. In short, despite the theoretical ability of insurers in open competition States to adapt more quickly to changes in loss trends and to thereby "flatten" the underwriting cycle, for the country as a whole the theory does not hold for 1973 through 1977.

This conclusion departs from that of the study of insurance regulation by the Department of Justice, which found substantial differences in the standard deviation of loss experience over the years 1966 through 1975. The Justice Department Study, however, examined 11 companies in only three States, one of which, New Jersey, is generally regarded as among the most turbulent regulatory environments in the Nation. Our study can be reconciled with the Justice Department findings by observing that while there is little overall difference in variation between open competition and prior approval States, there may be substantially greater variation in a few outlying States like New Jersey.

Conclusion: fluctuation of loss ratios

In general, price regulation does not force companies into feast or famine cycles, nor do rates in competitive rating States fluctuate wildly without regulatory control. While individual States may have great variation in loss ratios across time, rate regulated States, on the average, do not have greater variation. We also analyzed whether regulatory lag in prior approval States would lead to greater variation among States in any given year, and we computed the standard deviation of the mean adjusted loss ratio in each of 5 years for prior approval and open competition States. Again, no consistent differences were found, as shown in table 21.

Type of regulation and market structure

As discussed earlier, the insurance industry as a whole is competitively structured and the slowly increasing concentration of the market over time reflects the trend toward increased concentration in almost all industries. However, the market is slightly more concentrated under open competition. In addition, the direct writers' market share is higher under competitive rating.

As seen in table 22, the 4-firm concentration ratios (the percentage of premium volume accounted for by the top four firms) in the competitive rating States have been higher than in the prior approval States for the years 1973 through 1977, and concentration in both groups has been increasing.

The degree of concentration is accounted for by the increased market share of the direct writers. Indeed the 4-firm concentration ratio and the market share of direct writers are highly correlated, with a coefficient of .86.

Table 21

Mean Standard Deviation Across States of the Adjusted Loss Ratio Private Passenger Automobile Insurance

	Type of rating law	
	Competitive rating (N=16)	Rate regulated (N=35)
Industrywide liability		
1977	6.3	6.5
1976	9.3	7.5
1975	9.7	8.7
1974	8.9	6.1
1973	9.4	5.3
Industrywide physical damage		
1977	5.6	7.9
1976	8.2	7.6
1975	6.6	7.3
1974	6.9	6.7
1973	6.5	5.9

Source: Calculations made from data supplied by A. M. Best Co., Inc.

Table 22

Mean 4-Firm Concentration Ratios
Private Passenger Automobile Insurance
States Grouped by Rating Law

	Type of rating law	
Liability insurance	Competitive rating (N=16)	Rate regulation (N=35)
1977	50.7%	46.1%
1976	49.5	45.1
1975	48.6	44.4
1974	48.1	44.1
1973	47.0	43.7
1977	50.5	45.4
1976	48.5	43.2
1975	47.2	42.0
1974	46.0	41.8
1973	45.3	40.5

Source: Calculations made from data supplied by A. M. Best Co., Inc.

As shown in table 23, the market share of direct writers is, in addition, somewhat greater in open competition States. This relationship holds even when we examine the most "extreme" cases of open competition and prior approval--Illinois and New Jersey, respectively. For example, table 24 shows that in 1977 there was somewhat greater market concentration in liability insurance in the open competition State of Illinois than in New Jersey, but the difference was even less than that between the two groups of States in the aggregate.

Traditionally, high concentration ratios have been associated with anticompetitive practices, such as higher prices, because a small number of firms dominate the market. This is not the case with automobile insurance for two reasons.

Table 23

Market Share of Direct Writers

Years and type of insurance		Competitive rating	Rate regulated
Combined 5-year market share of direct writers		59.4	50.8
5-year market share of direct writers - liability		59.1	50.2
5-year market share of direct writers - physical damage		59.7	51.4
Market share direct writers:			
Liability	1977	62.7	53.6
	1976	59.7	51.4
	1975	58.3	50.0
	1974	57.6	48.3
	1973	57.4	47.7
Physical damage	1977	63.7	54.3
	1976	60.7	52.0
	1975	58.9	51.1
	1974	57.7	49.7
	1973	57.6	50.0

Source: Calculations made from data supplied by A. M. Best Co., Inc.

Table 24

4-Firm Concentration Ratios
Illinois and New Jersey - 1977

Type of insurance	Illinois	New Jersey
Liability insurance	46.8%	43.6%
Physical damage	47.4	43.6

Source: Calculations made from data supplied by A. M. Best

First, as noted previously, the industry is not highly concentrated relative to other industries. Second, the direct writers, who account for the increased concentration, usually offer lower prices. Indeed, their increased share of the market is a result of successful competition by a more efficient method of marketing insurance. Thus, the competition stimulated by the presence of this lower cost alternative has benefits for consumers. 1/

ANALYSIS OF INSURANCE COST DIFFERENCES AMONG THE STATES

Having determined that there are no substantial cost differences among the States based on the type of rate regulation law, there still remains the question of what factors are related to observed cost differences. In order to see whether the regulatory system makes any difference in the cost of insurance, we used multiple regression analysis to determine the relationship, if any, among regulatory variables, market structure, and the cost of insurance. We used as the dependent variable our proxy for the price of insurance, the adjusted loss ratio. We used both the loss ratios for 1977 alone and the mean for each State for the years 1973-1977,

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1/ Joskow, "Cartels, Competition and Regulation," p. 382.

for liability and for property damage insurance. 1/ The means for the years 1973-1977 were used as a more permanent measure of the price of insurance, which does not reflect year-to-year fluctuations. We also ran regressions using the loss ratios for 1977 alone, but the findings below are for 5-year averages in order to be more representative of industry experience over time. Complete regression results are presented in appendix III. It should be noted that the loss ratios do not vary widely. The 1973-1977 mean liability loss ratio in the 41 States we used was 64.8, with a standard deviation of 6.3. The corresponding physical damage loss ratio was 67.4, with a standard deviation of 5.0.

As expected from the previous comparison of the means (see table 18), we again found no relationship between regulatory type (prior approval versus open competition) and adjusted loss ratio--either for 1977 or the mean of the 5-year period. We did find that a small amount of the variance was explained by insurance department resources. About 15 percent of the variance in the cost of insurance is accounted for by the size of insurance department staff or budget. But the most striking finding is that one State, New Jersey, accounts for 26 percent of the variance in loss ratios among the States. The low cost of insurance in New Jersey accounted for more of the differences in the cost of insurance among all the States than any other factor we tested. Our methodology in arriving at this finding is described below.

Methodology

In addition to regulatory type, we used as independent variables measures of department resources and market structure. The specific variables were

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1/The analysis was done only for those States for which we had complete data. This eliminated Georgia, Maine, Mississippi, Oklahoma, and Wyoming, who did not return questionnaires. Specific information needed for the analysis was missing also from Delaware, Kentucky, North Dakota, and Tennessee, eliminating those States from the analysis. Additionally, we did not include Illinois because that State has no rating law. It would not be logical to relate regulatory effort to the cost of insurance in a State where the regulator has no authority over price.

--departmental budget, both per capita and scaled by the square root of population;

--number of departmental personnel, both per capita and scaled by the square root of population;

--number of trained professionals as a proportion of total number of staff;

--market share of the direct writers; and

--presence of actuaries.

Both budget and staff size are relatively straightforward measures of departmental resources that can be readily adjusted to account for differences in the size of State populations. Thus, one measure of budget and staff resources is simply to divide these by the number of people in each State. Using this simple division as a measure, however, may be inaccurate. Such a direct measure assumes that a State with a population of 20 million would have an insurance department exactly twice as large as a State with a population of 10 million in order to achieve the same level of regulation. However, there may be economies of scale in many regulatory functions so that a larger State could achieve the same level of regulation as a smaller State and expend proportionately less resources. To test for this economy of scale effect, we have divided State budgets and staff size not only by a direct measure of State population but also by the square root of of population. This standardized measure reduces the differences between the largest and smallest States.

To test the effect of market structure, we used both the four-firm concentration ratio in private passenger automobile insurance and the market share of the direct writers. As might be expected, we found a high correlation between these two measures of market structure, and we chose to use the market share of the direct writers.

We used two measures of the professional quality of the staff--the proportion of trained professionals and whether a department had any certified actuaries. Ideally, it would have been desirable to use the number of certified property-casualty actuaries as an independent variable, but such a a measure would have been misleading unless we could verify the number of such actuaries in each State working primarily on rate filings--information that was not available to us. Therefore, we used a simple dichotomous variable of whether the department reported having any certified actuaries.

On the assumption that whether a commissioner is elected or appointed might have some bearing on the department's handling of automobile insurance rates, we also used the method of appointment (whether elected or not) as an independent variable.

The regressions were run for 41 States for which we had complete information.

Because the use of a single year's loss ratios might not be representative, our findings in this section are presented in terms of a 5-year average (1973-1977) for liability and for physical damage insurance. In fact, we found a stronger relationship between the independent and dependent variables for liability insurance in using the 5-year average. There was little difference in the regression results for physical damage insurance between the single year 1977 and the 5-year average. For the sake of consistency, results reported here are based on the use of the 5-year average for each line of insurance as the dependent variable. Results are reported separately where there were differences in the statistical relationships for liability insurance and for physical damage insurance.

For the 5-year average loss ratio in auto liability insurance, the factors with the strongest relationship to underwriting ratios generally were insurance department resources, followed by the market share of direct writers. However, the standardized measure of staff size had a generally siginificant statistical relationship with the loss ratio. The partial correlation coefficient between the two was 0.15 in Equation 1. Simply put, the scaled measure of staff size explains 15 percent of the variance in liability insurance costs among the States. Adding the market share of the direct writers boosts the relationship to an r^2 of 0.24, although that second variable is not statistically significant.

Different relationships were found for physical damage. The strongest partial correlation was with the market share of the direct writers which yielded an r^2 of 0.18. That relationship, however, was not statistically significant. The pro portion of trained professionals, which is statistically significant, boosts the r^2 to 0.23. No other independent variables were significant.

Variations in departmental staff resources accounted for a small but statistically significant variation in the cost of insurance in the 41 States.

Several independent variables showed no apparent relationship to the loss ratios, either for liability or for property damage. These were method of selection of the insurance and, as noted above, whether a State is open competition or prior approval. We found no relationship between these factors and the cost of insurance in the States in 1977 or for the years 1973 through 1977.

Because the results of multiple regression analysis can be affected by a few cases that are considerably outside the range of values of the other cases, we examined the data for such outlying cases. We found that the State of New Jersey had consistently higher loss ratios than the United States as a whole. Thus, the mean of the industry loss ratios for the years 1973 through 1977 in New Jersey for liability insurance was 85.0 compared to a United States mean of 66.14. There was much less difference in physical damage loss ratios--71.14 for New Jersey compared to 68.26 for the United States as a whole. Because New Jersey was such an outlying case in liability insurance, we analyzed the data again to determine how much the results were affected merely by the experience of this one State. By excluding New Jersey, we found somewhat stronger relationships between loss ratios and the independent variables. Thus, there was a statistically significant relationship between loss ratio and per capita departmental budget. The r^2 (partical correlation) was 0.21 (equation 8). Other relationships still were not statistically significant.

To find out how much of the variance was accounted for by the New Jersey case, we treated New Jersey itself as a categorical variable. This approach produced the strongest relationship. Of all the variables tested as independent variables, New Jersey produced the strongest relationship--the partial correlation between New Jersey and the liability loss ratio was 0.26. Adding the per capita budget increased the r^2 to 0.41 (equation 6). In short, New Jersey alone accounts for 26 percent of the variance in industry loss ratios for liability insurance, while per capita insurance department budgets account for an additional 15 percent.

We performed the same series of analyses for physical damage insurance, but because New Jersey was not an outlying case in that line of insurance, excluding New Jersey or treating the case as a categorical variable added no explanatory power.

Summary: The effects of insurance rate regulation

Despite the time and effort that goes into rate regulation and despite the often heated controversy, there is little difference in the price of insurance, as measured by loss ratios, between States that regulate rates directly and those that have open competition systems. Neither price regulation nor its absence leads to great fluctuations in underwriting ratios--either across time or between States.

However, regulatory factors are somewhat related to differences in loss ratios. The greater the staff or budget resources of a department, the lower was the price of insurance, but the relationship is not strong. There is also a less statistically significant relationship between the cost of insurance and the market share of the direct writers; a higher market share was associated with a lower cost of insurance. Most of the total variation in liability insurance is accounted for by the single case of New Jersey, which can be considered a unique regulatory effect.

We caution that these results are meant to be suggestive rather than definitive. An important limitation on the analysis is that there is a small amount of variance to explain, as noted above. We did not test all possible factors that might relate to differences in loss ratios because of a lack of sufficiently reliable and comprehensive data. Nonetheless, the findings we did develop suggest that it is a few outlying cases more than any systemic differences of regulatory administration that account for cost differences in automobile insurance. This finding, however, does not foreclose the possibility that detailed quantitative measurements of intensity of regulatory scrutiny of rate filings, if available, would have considerable explanatory power.

REGULATION AND MARKET FAILURES IN THE AUTOMOBILE INSURANCE INDUSTRY

Having determined that the cost of insurance is partially explained by the degree of regulatory effort and the market structure, but not by whether insurance rates are regulated, we turn to the question of the justification for regulation. In that the cost of insurance does not depend on whether insurance prices are regulated, is there any reason for the States to regulate those prices?

Is rate regulation an appropriate response to insurance market failures?

Although the automobile insurance industry is competitively structured and the market performs well under open competition, it is nonetheless a market characterized by several market failures requiring some form of regulatory intervention, as discussed in chapter 2. These characteristics include the need for the guarantee of future solvency, the problem of externality and the lack of consumer information. Moreover, insurance is not a luxury or even a discretionary purchase for most consumers. Most States have financial responsibility laws for motorists which, in effect, require insurance, and 25 States explicitly require insurance through compulsory automobile insurance laws. With the government requiring a product, the market is no longer voluntary, and the government has an obligation to assure the availability of the product at a reasonable price.

While some types of regulation of the insurance business are clearly justified, the preceding sections raise serious questions about the continued need for price regulation of automobile insurance. In the first place, most of the States we reviewed do not undertake original actuarial analysis of needed rates. In the second place, the differences among nearly all the States in true insurance costs are not related to whether States directly regulate insurance prices or not.

The fact that price regulation makes no difference in most States does not necessarily mean that it is not justified--only that it is ineffective in terms of obtaining prices that are different from what they would be under open competition systems.

Regulatory action to compensate for market failures

Apart from solvency regulation, rate regulation has been the States' primary response to the various market failures associated with personal lines insurance. Competitive rating States make no systematic effort to deal with market failures. While consumer sensitivity to price is assumed and some States monitor competition, we have found no pattern in open competition States correcting problems of lack of consumer knowledge and externalities any more than price regulated States.

Rate regulation is not a complete substitute for other actions to correct market failures that limit the viability of

competition in the insurance market. In most prior approval States, companies are free to offer rates uniformly below State-mandated maximum rates, and many companies do so. As we have noted, however, the issue is not only price. Inasmuch as the causes of market failures include inadequate consumer knowledge and the externalities of insurance, State remedies should specifically address these problems.

Correcting lack of consumer information

Most State insurance departments do not actively attempt to correct the problem of consumers' lack of information. As discussed in chapter 3, most departments do not compare claims handling procedures of companies, nor do they inform consumers about the comparative complaint records of companies. The most widely available comparison of this nature was done by Consumers Union in the June 1970 and July 1977 issues of Consumer Reports, which did find significant differences in consumers' experiences with various insurance companies. These comparisons are based on national questionnaire responses of subscribers to Consumer Reports and are not really an adequate substitute for more systematic State monitoring of claims handling practices. Future service is the essence of the insurance product, but the consumer cannot now evaluate that aspect at the time of purchase.

Based on our sample of fieldwork States, insurance departments do not do enough to provide consumers with specific information about price differences among companies. Few States, for example, publish consumer guides giving the price of sample policies. Appendix II reproduces a useful guide published by the Virginia Insurance Department as an example of a positive step that could be taken to foster competition.

To increase consumers' understanding of insurance and their ability to compare insurance policies, regulators could adopt several different approaches. One would be a massive educational campaign designed to train laymen to read and understand legal language. Short of that unlikely approach, regulators could provide checklists of coverages so that consumers could at least make some comparison of what is being offered by competing policies.

An approach taken by 11 States 1/ is the use of "readability" laws or regulations requiring insurance policies

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1/As of February 26, 1979, the States were Arizona, Delaware, Massachusetts, Minnesota, New York, Pennsylvania, South Carolina, Virginia, Washington, and Wisconsin.

to be written in conversational English. Some companies have voluntarily adopted the use of readable policies. While consumers might reward these companies in the marketplace by purchasing their policies, market competition will not be fully stimulated until consumers can readily understand all the policies they want to compare.

The most far-reaching approach we encountered in our fieldwork was in Massachusetts, which prescribed the use of a readable policy form developed by the State Insurance Department. Every company is required to use an identical booklet describing compulsory and optional coverages. (See app. V.) Enclosed in the booklet is a form listing the coverages actually selected by the insured and the price for each type of coverage. The comparability problem is resolved because each type of coverage must be offered in identical form by every company. Thus, consumers can both understand the coverage being offered and make a comparison of the policies' prices and services.

There is also a market mechanism for dealing with the externality of coverage for uninsured motorists. Such coverage is available at low cost and compensates the consumer for bodily injuries caused by an uninsured driver. This also is only a partial solution because the amount of compensation through uninsured motorists' coverage is limited and is usually far below the liability limits carried by most drivers.

Price regulation does not solve the availability problem. In fact, it appears to exacerbate the difficulty of getting insurance in the voluntary market. The proportion of drivers consigned to the assigned risk plan or the other automobile insurance plan is markedly greater in prior approval States than in open competition States. Of the 46 States in our questionnaire sample, the average percentage of drivers in the automobile insurance plan in the 31 prior approval States was 6.6 percent, compared to only 2.0 percent in the 11 open competition States. This relationship holds even when we control for whether a State has a compulsory insurance law. That is, open competition States with compulsory insurance have fewer cars in the assigned risk plan than prior approval States with compulsory insurance and the same holds for States without compulsory insurance. Much of the difference is accounted for by a few prior approval States in which insurers believe rates to be inadequate to cover losses in general or for particular classes. In those cases, insurers become far more selective in underwriting new business and the number of applicants rejected consequently becomes higher.

Uninsured motorists constitute an externality in the insurance marketplace. The most direct control of this externality is no-fault insurance whereby a motorist's own insurance company pays for an accident regardless of who is at fault. There are many varieties of no-fault insurance. Some of them provide ample opportunities for fault-finding lawsuits, and critics brand these as not being "true" no-fault systems. In a completely "pure" no-fault system where all damages are paid by one's own insurance company, it is irrelevant whether the other driver is insured or not. In that sense, the externality of the uninsured motorist is removed. We did not study no-fault in sufficient depth to comment on it other than to observe that it does remove this particular externality.

Rate regulation as an indirect regulatory device

Theoretically, rate regulation concerns only the price of insurance; however, some commissioners use their authority over rates as leverage to attain other regulatory ends. For example, the commissioner in Connecticut used his rate approval authority to induce insurance companies to realign their rating territories which he had found to be unfairly discriminatory. In an eastern State, the commissioner withheld approval of one company's rate filing until the company provided information about previous and planned termination of agents.

Some commissioners argue that without the power over rates, State insurance departments would be less able to intercede on behalf of consumers. While this argument is politically accurate, it also admits to insufficient authority to accomplish necessary regulatory ends. If it is desirable for insurance departments to prevent unfair discrimination in territorial rating plans, the States should expressly grant insurance commissioners the authority to implement their decisions. Moreover, the time and effort that goes into automobile insurance rate regulation could be more fruitfully applied to confronting the market failures discussed above or to protecting consumers in noncompetitive insurance markets.

Inadequate rate regulation in noncompetitive markets

Ironically, while most States regulate rates for automobile insurance, a market with robust competition, far fewer States supervise the rates of insurance areas that are noncompetitive or characterized by reverse competition. One

such area is title insurance--the insurance a home buyer purchases to compensate the mortgage holder and himself in the event there is a previous lien on the property. Typically, this insurance is chosen not by the homebuyer but by the broker or attorney handling the settlement. It is a situation characterized by reverse competition, as noted by the Justice Department Task Group on Antitrust Immunities:

> "Competition in the title insurance business is directed at the producer of business rather than at the consumer. A title company wishing to increase its share of the market would not necessarily try to reduce prices or improve coverage in order to attract retail purchasers of title insurance. Rather, the company would seek to influence those brokers, bankers, and attorneys who are in a position to direct title insurance business to the company. The most direct manner of influencing this business is to grant the producer of the business a fee, commission, rebate, or kickback--to the detriment of the title insurance purchaser."

Title loss insurance loss ratios are extremely low. 1/ Eighteen State insurance department annual reports containing complete information on title insurance companies reported an average loss ratio of 7.5 percent. For the title insurance industry as a whole the average percentage of revenue going to losses and loss adjustment expenses was 5.6 percent. This means that out of every $100 paid in premiums, the policyholder received $5.60 in claims. While the title insurance industry argues that it is not unreasonably profitable, with a pretax operating profit of 9.9 percent for the years 1968 to 1976, from the policyholders' view that is scant comfort; a claims payout of about 5 cents for every premium dollar suggests a price considerly in excess of what is required by the degree of risk. Moreover, 43.5 percent of

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1/The title insurance industry argues that loss ratios are not an accurate reflection of the value of their service because companies do more than reimburse loss; they also provide the service of searching the title to make sure that the new property owner will have clear title. However, in some States, including the District of Columbia, consumers pay both for a title search by an attorney and a title company for title insurance. Having paid once for a title search, it is unclear what consumers are paying for a second time, besides pure insurance, if the main function of title insurance is to search the title.

revenue is allocated to an amorphous category of "other expenses," which does not include salaries, payroll taxes,or fringe benefits. With a situation of no consumer information and no price competition, title insurers have little incentive to hold down expenses. It appears that all the incentives work to keep expenses up.

There is very limited State regulation of this insurance line. More than one-fourth of the States responding (12 out of 41) reported that they lacked the authority to disapprove title insurance rates for being excessive. Of the States with authority, only eight reported disapproving any rates during the period 1975 through 1978.

Rate regulation may not be the best solution to the inequitable treatment of consumers in purchasing title insurance. The Justice Department report suggests new direct marketing techniques with greater consumer choice as one possible solution. 1/ Another possibility would be to require the lender to purchase title insurance, thereby using the greater bargaining power and knowledge of banks and savings and loan associations to exert downward pressure on prices. We have no recommendation as to which solution would be more effective. Rather, we simply note that in an area where there is no competitive market, regulatory intervention has not occurred; yet there is extensive but sometimes unnecessary regulatory intervention in the automobile insurance market.

SUMMARY AND CONCLUSIONS

Rate regulation of insurance, which evolved from a fear that insurance rates were too low, is now manifested in the automobile insurance market as an attempt to keep rates lower than they otherwise would be.

We found a wide variety of State practices in the review of insurance rates. Review in the prior approval States ranged from a cursory check to an extensive and independent actuarial analysis. Open competition States also varied greatly in the degree to which they monitored the health of competition in the insurance market. In general, however, prior approval States relied primarily on the calculations of the insurers and did not undertake their own independent

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1/Department of Justice Study, p. 258.

analyses of appropriate rate levels. Most States also used the increasingly questionable standard of allowing a 5 percent underwriting profit, which may not sufficiently account for investment income.

The more important question is not the quality of the rate approval process, but whether the requirement of rate approval is justified by the nature of the automobile insurance market. Our own analysis leads us to concur with earlier studies that found that the automobile insurance industry is competitively structured and that price regulation is not warranted in the voluntary market. Moreover, price regulation does not result in insurance costs that are different from those in States without price regulation.

It should be emphasized that our findings with regard to comparative price apply to statewide averages. In particular, there are two important exceptions to these findings. First, as noted earlier, availability problems in some States lead consumers to the assigned risk plan or the substandard market where rates are considerably higher. Thus, the distribution of rates may be affected by regulation in ways we cannot comment on. Secondly, in States such as North Carolina and Massachusetts, rates for the previously higher charged category of younger drivers very definitely have been reduced, and the use of reinsurance facility with rates equal to those in the voluntary market in those States has also lowered rates for certain drivers.

While the market is competively structured, there still are market failures that may prevent the realization of a fully robust competition that would benefit consumers. Consumer knowledge is still a problem that requires regulatory intervention.

Consumers now have little or no information on which to judge the quality of insurance policies. State intervention should not be in the form of direct regulation, however. Rather, insurance departments can pursue the less intrusive strategy of collecting and disseminating (or requiring the dissemination) of information that would provide consumers with a better basis of knowledge in purchasing insurance. Such information might include annual price comparisons, by territory, for several widely purchased insurance coverages, complaint ratios (e.g., number of complaints per million dollars premium volume or per thousand policies), and requiring readable or standardized policy information <u>prior</u> to purchase so that consumers can compare policies. Additionally, consideration should be given as to whether regulations,

such as permitting an extensive free underwriting period or prohibiting group automobile insurance, serve any purpose that justifies their potentially anticompetitive impact.

In summary, we believe that base insurance rates in the voluntary market need not be regulated if there is much greater regulatory action to inform consumers well enough to make the competitive market work beneficially and effectively. Our conclusion is based on our findings about aggregate rate levels. As we discuss in the next chapter, most insurance departments have not sufficiently analyzed classification and territorial plans. If it appears that rate differentials used by insurers to charge different premium prices to different areas and different categories of drivers are not warranted, then regulation of those differentials would be appropriate.

The concern over solvency that originally gave rise to rate regulation no longer justifies that kind of regulation; independent audits of the health of the industry would be adequate to ensure that insurance companies remain solvent and in a position to meet their claims.

CHAPTER 6

THE REGULATION OF AUTOMOBILE RISK CLASSIFICATION

Consumers purchasing insurance from the same company pay markedly different prices for the same level of coverage. In the case of automobile insurance, price differs according to such factors as the use of the car; the age, sex, and marital status of the principal driver; and where the car is garaged. This is known as risk classification; it is one of the most controversial issues of insurance regulation. While there is little dispute that insurance companies should be able to charge more for demonstrably higher risks (and charge less for demonstrably lower risks), there is great controversy as to where the lines should be drawn between risk classes and, more particularly, whether certain classes of risk should be used at all. This chapter examines the current risk classification system, the arguments advanced by proponents and opponents of that system, and the actions of the States and the NAIC.

DEVELOPMENT OF THE CURRENT CLASSIFICATION SYSTEM

Prior to the 1950s risk classification in the atuo insurance industry was not characterized by classes common to most other types of insurance. Many approaches were tried by various companies. Before World War II most companies based insurance prices on the physical characteristics of the insured car rather than the driver, and during the War, most prices were tied to gasoline coupons. Risk classes began to proliferate after the War. They were based on car use and on driver characteristics. The trend of classification refinement can be illustrated by the case of State Farm Insurance who had just two categories--farm and nonfarm--until 1955 when the company instituted 9 classes, increased them to 108 in 1960, and reduced them to 57 in 1966. Companies filing with rating bureaus had just three classes--business use, pleasure use, and youthful drivers--until 1952 when the Mutual Insurance Rating Bureau adopted six classes in many States. Currently, the plan of the Insurance Services Office (ISO) has 161 classes. 1/

1/In some States, the ISO 217 class plan is still used.

One of the several reasons for refining classes of risk is increased competition in the auto insurance industry. 1/ In the 1950s direct writers (companies selling by mail or using exclusive agents) grew rapidly and became a major competitive force because they charged lower prices as a result of lower selling expenses. The direct writers also chose to select better risks and offer them insurance at lower prices. GEICO, for example, concentrated on Government employees, while State Farm marketed its services to rural populations. Allstate sold insurance directly in its parent company's department stores and was able to offer lower prices to the best risks through what was then a relatively refined 16-class plan. Lower prices not only allowed the direct writers to increase their share of the market but also permitted them to capture a much larger share of the best risks. This caused the bureau-member companies to incur greater costs through having a larger proportion of higher risks and forced them in turn to raise their prices. In response, the bureau companies greatly refined their risk classification plans so that they, too, could offer lower rates to comparatively better risks. Risk classification thus became a tool of competition in the auto insurance market. This competitive process of classification accelerated because of the increased cost of insurance. As premiums became higher, consumers became more price sensitive in an environment in which prices were no longer identical (as the use of mandatory bureau rates declined). The pressure faced by companies to keep prices low led them to attempt to select the best risks for preferred prices.

The trend toward more classes was also due to the growth of the market. After World War II, our increasingly large and heterogeneous population began to purchase more and more cars. Most States enacted financial responsibility laws that also increased the need for insurance. With more and more heterogeneous drivers, insurers tried to distinguish among degrees of risk. While this process of risk classification allowed some drivers to pay less for the same coverage than other drivers, the absolute differences were not of great importance in the 1950s and 1960s when the cost of automobile insurance was less than it is today. As those costs became

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1/Stanford Research Institute, The Role of Risk Classifications in Property and Casualty Insurance: A Study of the Risk Assessment Process. (May 1976) Supplement, p. 62.

victim to general inflationary pressures, issues affecting the price of insurance became more visible and more politically sensitive.

Recently, the differences paid in premiums by individuals on account of personal and territorial classification have increased substantially. In some cases, one person may pay more than 10 times what another person pays for the same coverage--and the absolute dollar spread is correspondingly dramatic. For example, until the situation was changed by regulatory action, a 24-year-old male driver, living in East Boston, would have paid $2,512 for a reasonably complete package of automobile insurance on a 3-year-old Chevrolet Malibu. An elderly resident of rural Deerfield, Massachusetts, with the same car would have paid $160 for the same coverages even if the Deerfield driver had had two accidents the previous year while the Boston youth had none.

This is a common disparity in States with large cities, and it is the result of rates that differ according to territory and age of driver. The classification system leading to such large disparities is being challenged by some regulators, is under review in many States and by the National Association of Insurance Commissioners, and has been banned in at least three States. Critics claim that the classification system based on age, sex, and marital status, used by nearly all insurers, constitutes unfair discrimination because it does not adequately predict actual loss experience and is otherwise socially objectionable. Insurance companies defend the classification system, arguing that it is actuarially justified in that it reasonably reflects loss experience. Companies charge that any flattening of rates would constitute an unfair subsidy from low-risk to high-risk drivers. Both critics and defenders of the system agree that the present system is inherently related to the way insurers compete for business, but the value and implications of that competition are hotly contested. The specific points in this debate are examined below, but first it is useful to examine the actual classification plans used by insurers.

CURRENT CLASSIFICATION PLANS

Classification relativities are expressed as a factor by which the base rate for particular insurance coverage in a specific territory is multiplied. There may also be factors that are added into the multiplying factor based on type of automobile and driving record. For example, in Alexandria, Virginia, a suburb of Washington, the suggested 1978 premium for companies belonging to the Insurance Services Office for liability coverage of 25/50/10, $1,000 medical payments and

25/50/5 uninsured motorists coverage was $123. To determine the premium actually to be paid by an individual, the insurance agent would multiply that base premium by the relevant rating factor. Thus, the rating factor for a car whose principal operator is a male between 25 and 65 years old, who uses the car for pleasure would be 1.00. To this primary classification there is added a secondary classification based on type of car and driving record. For a case where one standard performance car is insured with the company, and the driver has no penalty points for violations, that factor is 0 so the overall rating factor is still 1.00. The actual premium is $123.00, arrived at by multiplying the base of $123 by 1.00. If, however, a middle age male insures a sports car, a factor of 0.15 is added to his primary factor of 1.00. To get the actual premium, the agent multiplies the base rate of $123 by 1.15, for a premium of $141.45.

Young drivers pay higher rates, as illustrated by another example in Alexandria. An unmarried 18-year-old male (for younger drivers there is a distinction between married and unmarried) who is the principal operator of a car used for pleasure has a primary factor of 2.50. Assuming no additional secondary classification factor, his premium will be 2.50 x $123 or $307.50.

In computing coverages for physical damage, i.e., collision and comprehensive, a base rate for each car is determined by make and age of car. This base rate is also multiplied by the classification factor.

It should be noted that the ISO classes are based on national data and the relativities are designed to be applied to all the States. Other insurance companies we interviewed also indicated that the class plans were the same or nearly the same in each State.

The number of classes used varies considerably by insurers, but nearly all companies use similar rating factors based on age, use of car, and driving record 1/ for older drivers. For younger drivers companies apply the additional factors of sex, marital status, and completion of a driver training course. Some companies also give a good student

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1/Some companies use surcharges for violations and chargeable accidents rather than incorporating them as rating factors.

Table 25

ISO Classification Plan a/

PRIMARY CLASSIFICATIONS
RATING FACTORS AND STATISTICAL CODES

NO YOUTHFUL OPERATOR

Age and Sex		Pleasure Use	DRIVE TO OR FROM WORK		Business Use	Farm Use
			Less than 15 Miles	15 or More Miles		
Only Operator in Household is a Female Age 30-64	Factor Code	.90 8131— —	1.15 8132— —	1.35 8133— —	1.35 8138— —	.80 8139— —
Principal Operator is Age 65 or Over	Factor Code	.90 8021— —	1.15 8022— —	1.35 8023— —	1.35 8028— —	.80 8029— —
All Other	Factor Code	1.00 8111— —	1.25 8112— —	1.45 8113— —	1.45 8118— —	.90 8119— —

YOUTHFUL OPERATOR
Not eligible for Good Student Credit

AGE			UNMARRIED FEMALE		MARRIED MALE	
			Pleasure Use or Farm Use	Drive to Work or Business Use	Pleasure Use or Farm Use	Drive to Work or Business Use
WITHOUT DRIVER TRAINING	17 or Less	Factor Code	1.75 8211— —	2.00 8212— —	1.95 8311— —	2.20 8312— —
	18	Factor Code	1.60 8221— —	1.85 8222— —	1.85 8321— —	2.10 8322— —
	19	Factor Code	1.50 8231— —	1.75 8232— —	1.75 8331— —	2.00 8332— —
	20	Factor Code	1.25 8241— —	1.50 8242— —	1.65 8341— —	1.90 8342— —
WITH DRIVER TRAINING	17 or Less	Factor Code	1.60 8261— —	1.85 8262— —	1.70 8361— —	1.95 8362— —
	18	Factor Code	1.50 8271— —	1.75 8272— —	1.65 8371— —	1.90 8372— —
	19	Factor Code	1.40 8281— —	1.65 8282— —	1.60 8381— —	1.85 8382— —
	20	Factor Code	1.20 8291— —	1.45 8292— —	1.55 8391— —	1.80 8392— —
WITH OR WITHOUT DRIVER TRAINING	21 thru 24	Factor Code	1.10 8461— —	1.35 * 8462— —	1.30 8411— —	1.55 8412— —

*If the automobile is classified as "Work 15 or More Miles", the applicable Primary Rating Factor shall be 1.45 (Code 8113——).
If the automobile is classified as "Business Use", the applicable Primary Rating Factor shall be 1.45 (Code 8118——).

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a/ Private Passenger Automobile Manual, Insurance Services Office, 1976.

PRIMARY CLASSIFICATIONS
RATING FACTORS AND STATISTICAL CODES

YOUTHFUL OPERATOR
Not eligible for Good Student Credit

AGE			UNMARRIED MALE			
			Not Owner or Principal Operator		Owner or Principal Operator	
			Pleasure Use or Farm Use	Drive to Work or Business Use	Pleasure Use or Farm Use	Drive to Work or Business Use
WITHOUT DRIVER TRAINING	17 or Less	Factor / Code	2.70 / 8511— —	2.95 / 8512— —	3.50 / 8711— —	3.75 / 8712— —
	18	Factor / Code	2.50 / 8521— —	2.75 / 8522— —	3.30 / 8721— —	3.55 / 8722— —
	19	Factor / Code	2.35 / 8531— —	2.60 / 8532— —	3.10 / 8731— —	3.35 / 8732— —
	20	Factor / Code	2.20 / 8541— —	2.45 / 8542— —	2.85 / 8741— —	3.10 / 8742— —
WITH DRIVER TRAINING	17 or Less	Factor / Code	2.25 / 8561— —	2.50 / 8562— —	3.10 / 8761— —	3.35 / 8762— —
	18	Factor / Code	2.10 / 8571— —	2.35 / 8572— —	2.90 / 8771— —	3.15 / 8772— —
	19	Factor / Code	2.00 / 8581— —	2.25 / 8582— —	2.70 / 8781— —	2.95 / 8782— —
	20	Factor / Code	1.90 / 8591— —	2.15 / 8592— —	2.55 / 8791— —	2.80 / 8792— —
WITH OR WITHOUT DRIVER TRAINING	21 thru 24	Factor / Code	1.50 / 8611— —	1.75 / 8612— —	2.30 / 8811— —	2.55 / 8812— —
WITH OR WITHOUT DRIVER TRAINING	25 thru 29	Factor / Code	CLASSIFY AND RATE AS NO YOUTHFUL OPERATOR		1.65 / 8911— —	1.90 / 8912— —

Table 25 - Continued

PRIMARY CLASSIFICATIONS
RATING FACTORS AND STATISTICAL CODES

YOUTHFUL OPERATOR
GOOD STUDENT CLASSIFICATIONS

AGE			UNMARRIED FEMALE		MARRIED MALE	
			Pleasure Use or Farm Use	Drive to Work or Business Use	Pleasure Use or Farm Use	Drive to Work or Business Use
WITHOUT DRIVER TRAINING	17 or Less	Factor Code	1.50 8214— —	1.75 8215— —	1.60 8314— —	1.85 8315— —
	18	Factor Code	1.35 8224— —	1.60 8225— —	1.50 8324— —	1.75 8325— —
	19	Factor Code	1.25 8234— —	1.50 8235— —	1.40 8334— —	1.65 8335— —
	20	Factor Code	1.10 8244— —	1.35* 8245— —	1.30 8344— —	1.55 8345— —
WITH DRIVER TRAINING	17 or Less	Factor Code	1.35 8264— —	1.60 8265— —	1.35 8364— —	1.60 8365— —
	18	Factor Code	1.25 8274— —	1.50 8275— —	1.30 8374— —	1.55 8375— —
	19	Factor Code	1.15 8284— —	1.40* 8285— —	1.25 8384— —	1.50 8385— —
	20	Factor Code	1.05 8294— —	1.30* 8295— —	1.20 8394— —	1.45 8395— —
WITH OR WITHOUT DRIVER TRAINING	21 thru 24	Factor Code	1.00 8464— —	1.25* 8465— —	1.15 8414— —	1.40* 8415— —

*If the automobile is classified as "Work 15 or More Miles", the applicable Primary Rating Factor shall be 1.45 (Code 8113——).
If the automobile is classified as "Business Use", the applicable Primary Rating Factor shall be 1.45 (Code 8118——).

Table 25 - Continued

PRIMARY CLASSIFICATIONS
RATING FACTORS AND STATISTICAL CODES

YOUTHFUL OPERATOR
GOOD STUDENT CLASSIFICATIONS

AGE			UNMARIED MALE			
			Not Owner or Principal Operator		Owner or Principal Operator	
			Pleasure Use or Farm Use	Drive to Work or Business Use	Pleasure Use or Farm Use	Drive to Work or Business Use
WITHOUT DRIVER TRAINING	17 or Less	Factor Code	2.05 8514— —	2.30 8515— —	2.70 8714— —	2.95 8715— —
	18	Factor Code	1.90 8524— —	2.15 8525— —	2.50 8724— —	2.75 8725— —
	19	Factor Code	1.80 8534— —	2.05 8535— —	2.30 8734— —	2.55 8735— —
	20	Factor Code	1.65 8544— —	1.90 8545— —	2.10 8744— —	2.35 8745— —
WITH DRIVER TRAINING	17 or Less	Factor Code	1.75 8564— —	2.00 8565— —	2.50 8764— —	2.75 8765— —
	18	Factor Code	1.60 8574— —	1.85 8575— —	2.30 8774— —	2.55 8775— —
	19	Factor Code	1.50 8584— —	1.75 8585— —	2.15 8784— —	2.40 8785— —
	20	Factor Code	1.35 8594— —	1.60 8595— —	2.05 8794— —	2.30 8795— —
WITH OR WITHOUT DRIVER TRAINING	21 thru 24	Factor Code	1.20 8614— —	1.45 8615— —	2.00 8814— —	2.25 8815— —

Table 25 - Continued

SECONDARY CLASSIFICATIONS
RATING FACTORS AND STATISTICAL CODES

The Rating Factors applicable to the Vehicle Type, Single or Multi-Car Risks and risks with one or more points assigned under the Safe Driver Insurance Plan shall be determined by the addition, or subtraction, of the appropriate Factor from the applicable table below to the Primary Rating Factor.

Table Applicable to 1971 and Later Model Automobiles

Vehicle Type		Sub-Class 0	1	2	3	4
Single Car						
Standard Performance	Factor	+0.00	+0.40	+0.90	+1.50	+2.20
	Code*	10	11	12	13	14
Intermediate Performance (i)	Factor	+0.15	+0.55	+1.05	+1.65	+2.35
	Code*	30	31	32	33	34
High Performance (h)	Factor	+0.30	+0.70	+1.20	+1.80	+2.50
	Code*	50	51	52	53	54
Sports (s)	Factor	+0.15	+0.55	+1.05	+1.65	+2.35
	Code*	70	71	72	73	74
Multi-Car						
Standard Performance	Factor	−0.15	+0.05	+0.30	+0.60	+0.95
	Code*	20	21	22	23	24
Intermediate Performance (I)	Factor	+0.00	+0.20	+0.45	+0.75	+1.10
	Code*	40	41	42	43	44
High Performance (h)	Factor	+0.15	+0.35	+0.60	+0.90	+1.25
	Code*	60	61	62	63	64
Sports (s)	Factor	+0.00	+0.20	+0.45	+0.75	+1.10
	Code*	80	81	82	83	84

Table Applicable to 1970 and Prior Model Automobiles

		Sub-Class 0	1	2	3	4
Single Car						
	Factor	+0.00	+0.40	+0.90	+1.50	+2.20
Non-High Performance	Code*	10	11	12	13	14
High Performance	Code*	50	51	52	53	54
Multi-Car						
	Factor	−0.15	+0.05	+0.30	+0.60	+0.95
Non-High Performance	Code*	20	21	22	23	24
High Performance	Code*	60	61	62	63	64

*These two digits are to be appended to the four-digit code corresponding to the Primary Rating Factor to which the Factor in this table is added or subtracted.

discount to younger drivers in school. Nonetheless, the degree of refinement in terms of number of actual categories differs markedly among leading companies. ISO's latest class plan has 161 categories, reduced from the 217 in its previous plan. Among the individual companies providing us with information, the categories ranged from a low of 60 for State Farm to a high of 360 for Travelers. This does not mean that the spread between actual multiplying factors is any different or that different underlying factors are taken into account. It only indicates that the underlying factors are divided more finely. For example, ISO has a separate factor for each year of a driver's age from 17 or less to 20, while State Farm groups all drivers under 21 together. In actual practice, the rating factor assigned a particular individual would not vary substantially from one company to another. An example of the magnitude of classification factors is seen in table 25, which presents the rating factors and relativities for ISO. The actual categories used by various companies are listed in table 26. Note that some companies make price adjustments through the class plan, while others use surcharges or discounts. This is common for the factors of multiple car ownership and driving record.

Although most companies use driver age as a major underlying factor, there are a few exceptions. Most notable among these is Commercial Union (CU), a Boston-based company that ranked 21st in private passenger auto liability premiums written nationally in 1977. In 1977 CU announced a plan to be introduced in Virginia and Wisconsin that departs from traditional industry classification plans. Instead of age, sex, and marital status, the CU plan uses the driver characteristics of driving experience, driving record, claims history, and driver training. Like other plans it includes automobile characteristics and vehicle use but uses different specific variables for rating, which CU finds more accurately reflect actual loss experience. Vehicle use is accounted for by territory (including measures of customary traffic density, type of driving (pleasure, business, etc.)) and annual mileage. The general thrust of the CU plan is to conform to the following criteria that the company used in assessing rating factors: causality, homogeneity of the class, incentives for safer driving, social acceptability, practicality, and ability to verify the characteristic.

THE ISSUES OF RISK CLASSIFICATION

The automobile risk classification system has become controversial because it leads to very large differences in the price paid for insurance. The underlying question is whether these differences are appropriate, since unfair discrimination in the pricing of insurance is prohibited.

Table 26

Refinement of Classifications

Underlying Factors

Age	ISO*	State Farm	Travelers'		Liberty Mutual	Allstate
		married:	married males & unmarried females	Unmarried males:	unmarried females:	
(First cut-off includes all prior years)	17	20	18	18	20	20
	18	21-22	19-20	19-20	Married & unmarried male, not owner or principal operator:	21-24
	19	23-24	21-24	21-22		
	20	unmarried:	25-29	23-24	20	
	21-24	20		25-26	21-24	
	25-29	21-24		27-29	Unmarried male, owner or principal operator:	
		25-29			20	
					21-24	
					25-29	
Marital status used until age:	30	30	30		30	49
Sex used until age:	65	30	30		30	49
Car use	Pleasure/farm drive to work or business use less than 15 miles; 15 or more miles	Short annual mileage Long annual mileage Business Non-business Farm	Pleasure Commuting: 6-20 miles/ 20 miles Business Farm Annual mileage: low/high Car pooling		Business Farm Pleasure Drive to work/school 10 miles 10 miles Car pooling	Business Work (Commuting) 20 miles 10-20 miles 3.1-9.9 miles 0-3 miles Pleasure
Car type	Standard Intermediate perform. High perform. Sports		Sports High perform. Damageability Passive restraints		Intermediate perform. High perform. Sports Rear engine Farm	
Driver training (youthful driver)			Yes		Yes	
Good student discount	Yes		No		Yes	No
Merit rating	Yes		Yes		Yes	Yes

The criteria of what is appropriate revolve around the issues of public acceptability, predictability, equity, and competition. This section summarizes these criteria, which have been fully explored in recent major studies.

Two documents in particular have been at the center of the debate. The first is the report of SRI International (formerly called the Stanford Research Institute), which describes and evaluates alternative classification systems and regulations. 1/ Although this study was commissioned by various insurance industry groups, its findings have been cited by critics as well as supporters of current industry practices. The second is the Opinion, Findings and Decision on 1978 Automobile Insurance Rates, issued by James M. Stone, Commissioner of Insurance in Massachusetts. 2/ Stone's decision prohibits the use of age (except for a senior citizen discount), sex, or marital status in classifying risks and articulates the rationale behind that prohibition.

Public acceptability

Our society has been gradually eliminating barriers based on the demographic factors still used in insurance risk classification. Public policy now mandates against sexual discrimination in employment and against mandatory retirement. In the face of these lowered barriers, the question is whether insurance discrimination based on sex, marital status, and particularly upon age is justified. What is at issue here is a question of public acceptability, not a question of fact. There are distinctions between groups of insureds that may be justified actuarially but are not used because such distinctions would not be tolerated by the public. For example, mortality rates vary according to race, but life insurance premiums are not based on these differences. Similarly, there may be significantly different accident rates that are associated with race, but no insurance company includes racial factors in its classification plan.

1/ The Role of Risk Classifications in Property and Casualty Insurance: A Study of the Risk Assessment Process, May 1976.

2/ Commonwealth of Massachusetts, Division of Insurance, Opinion, Findings and Decision on 1978 Automobile Insurance Rates, December 28, 1977. The Division also published Automobile Risk Classification: Equity and Accuracy, which contains the techical papers that supported Commissioner Stone's decision.

Critics of the classification system claim that the continued use of age, sex, and marital status is similarly unsuitable because such use is a socially reprehensible form of discrimination.

Insurers argue that discrimination, defined as differentiating among risks, is basic to insurance. Such discrimination is unfair only when it does not accurately reflect the loss experiences of particular categories of risks. Moreover, they argue that the discrimination argument cuts two ways. Eliminating age as a rating factor would necessarily mean somewhat higher premiums paid by older drivers. In that their premiums would be higher than required by their loss experience, this older group would actually be the one subject to unfair discrimination.

A key point in the debate over the propriety of these rating factors is controllability. Former Commissioner Stone argued in his 1977 decision that the insurance system must provide incentives for better behavior. He asserts, however, that

> "The insurance mechanism in use today provides no constructive incentives. It stands passively by as claim frequencies rise out of control * * *. A fairer system of insurance pricing--one based on individually controllable characteristics--would also be a more effective one." 1/

Stone and other critics of the current system argue that it is inherently unfair to discriminate against individuals because they are young, or male, or live in a city. They argue that such characteristics are not direct causes of of poor driving and are not controllable by individuals. Moreover, and most important, many individuals in the groups designated as high risk are safer drivers than individuals in purportedly low-risk groups. Thus, the issue of whether the classification system is fair in light of current social values is also part of the next two issues--how predictive is the current system and what are the predictive capabilities of merit rating?

1/U.S. Senate Committee on the Judiciary, Rights and Remedies of Insurance Policyholders, Hearings before the Subcommittee on Citizens and Shareholders Rights, 95th Congress, 2nd Sess., p. 95.

Predictability

A major factual issue in the classification controversy is the system's predictability. Obviously, the system is not perfectly predictive, for the insurance industry cannot predict when we will die, whether we will have an auto accident, or whether we will suffer other losses against which we are insured. The rationale for the classification system is to spread the risk of losses that we know will happen to someone, but we do not know to whom or when.

Predictability has a place in the insurance business because different risks have different probabilities of loss. Recall that the classification system developed as insurers competed to locate groups with less loss potential. From the insurers' standpoint, then, the system is clearly based on its proven predictive abilities. On the face of it, loss statistics seem to bear out the division of groups into current classes. In 1977, drivers under 20 constituted 10 percent of all drivers but were involved in 18 percent of all accidents and 17 percent of all fatal accidents. Drivers 29 and younger constituted 34 percent of all drivers but were involved in 52 percent of all accidents and 51 percent of fatal accidents. The accident rates of young males are higher still. But the matter is not so simple, because the statistics show higher losses for groups (and hence higher future loss potential) but not necessarily for all individuals within groups. Indeed, the probability of any individual having an accident in the next 6 to 12 months is very small. So the classification plan relies not on any substantial probability that an individual will have an accident but on the probability that some groups have greater loss potentials than other groups. This leads to the next question: how does the loss potential of the individual relate to that of the group?

There would be no problem if the rating groups were internally homogeneous and different from each other, but such is not the case. The great degree of overlap between the groups is illustrated in figure 1. Based on its sample in California, the SRI study concluded that 28 percent of the male drivers had an accident likelihood lower than the female average, whereas 13 percent of the females have an accident likelihood above the male average. SRI also found that there is

"* * * strong evidence that the expected loss of a policyholder in a high-risk class has a greater (absolute) uncertainty than the expected loss of a policyholder in a low risk class."

Insurers counter this argument by noting that the risk assessment system cannot be perfectly predictive but does measure group tendencies. Thus, the Alliance of American Insurers stated:

"As an industry, we have established a positive record in determining what characteristics influence the hazards we insure. In fact, the competitive nature of the insurance business is based on its ability to make accurate determinations as to which types of risks, on average, are more likely to experience losses than others."

One actuary noted that while there may well be a small number of young male drivers who are much more careful drivers than lower rated groups, as a practical matter they cannot be located. He said that if he could tell an insurance company exactly who are these allegedly low-risk young males, he would make a fortune because the company would be able to offer much lower prices and corner the market on that business. He argued that there is an incentive to get that business, but that no company has been able to determine just who those safe drivers are.

There has been considerable discussion of the overall predictive power of classification plans. The Stanford Research Institute report estimated that 30 percent of the variance in expected loss distribution could be explained by the current risk selection process. This is based upon the use of variance as a statistical measure of uncertainty and includes underwriting as well as the classification system. The breakdown of the estimate is shown in table 27. Note that personal and territorial classification by themselves are estimated to explain 22 percent of the variance.

Table 27

Estimates of Expected Loss Assessment Efficiency

in Automobile Insurance

Classification systems	Fraction of estimated loss variance explained			
ISO 217 class plan	12%	16%	22%	30%
Merit rating	5%			
Territorial relativities	7%			
Underwriting and marketing	8%			

Source: SRI Final Report, 49.

The SRI estimate is cited frequently by critics of the current rating plans. The National Association of Insurance Commissioners Rates and Rating Procedures Task Force in a September 1978 report states:

> "Available statistical evidence also raises questions about the superiority of age, sex, and marital status over alternative rating factors. The SRI report estimated that even the most detailed rating plans now in use account for only about 20 percent of the variations in losses among individuals * * *."

Commissioner Stone noted in his December 1977 decision that the 30 percent figure of SRI "implies that 70 percent of the variance in inherent risk remains unexplained by this combination of rating variables."

In defense of the current system, Aetna Life and Casualty notes that explaining 30 percent of the variance does not mean that only 30 percent of the individuals in a class are at the actual risk level of the class. The company notes that there is nothing to which to compare the system, and it argues that:

"The risk assessment process should not be attacked for being 'only' 30 percent efficient. Those who understand the 30 percent efficient figure are not apt to use it pejoratively. It may be possible to improve the current risk assessment process but, in terms of 'efficiency,' it is the best process now known." 1/

SRI generally holds that its findings have been misinterpreted by critics of current class plans. Noting the overlap between the expected loss distributions of males and females, SRI states that such a simple dichotomy is in fact very powerful compared to more refined classification systems. "The appropriate focus is the degree of separation achieved rather than the overlap." Noting that their estimate of the risk assessment process is 30 percent efficient has been cited in support of the contention that the industry is doing a poor job of risk assessment, SRI later stated:

"SRI did not reach any such evaluative conclusions. More importantly, we feel they are not warranted based on work accomplished to date along these lines."

* * * *

"* * * we have noticed that we are usually quoted as having found current classification systems to be only 30 percent efficient. Only implies a judgment not included or intended by our findings, and appears to reflect people's fundamental sense that 30 percent is relatively (i.e., relative to 100 percent) low and, therefore, "bad" performance."

The problem is that no one knows just what that 30 percent is relative to. Clearly, the practical limits of explaining variance in loss expectancy is considerably short of 100 percent, but we do not know what the upper limit is. Given this uncertainty, SRI suggested the likelihood that some classification variables currently in use could be replaced by new ones without significant loss of precision.

1/Aetna Life and Casualty Co., A Report on Automobile Insurance Affordability, March 1978, p. 78.

The report recommended that data be collected and analyzed for the purposes of identifying substitute rating variables in order to enhance the social acceptability of the risk assessment process.

One problem with the accuracy of current classification systems is that the rate differentials are based on country-wide data. Thus, even if the classification system reasonably reflects loss experience for the country as a whole, it may not reflect substantial differences that occur in various localities. That this is not merely a hypothetical possibility was suggested in a 1976 report of the National Association of Insurance Commissioners task force on private passenger automobile classifications. The report stated that:

> "There appear to be significant differences in the loss cost relativities by type of territory group and sub-group, indicating that the higher rated /i.e., higher priced/ territories require a narrower spread between the base class and the young driver classes. This appears in the voluntary and the assigned risk data." 1/

Given the conflicting arguments and the admitted uncertainty in SRI's estimates, we conclude that the accuracy of the system is an open question that needs further analysis by the industry and by regulators.

Merit rating

A recent national public opinion survey found that 84.1 percent of the people polled agreed with the statement, "Drivers who do not cause accidents or commit traffic violations should pay less for auto insurance than drivers who do." Although this principle cannot be faulted, the assessment of insurance premiums based on driving record is difficult to agree on in specific situations. Most insurance companies penalize drivers who have had recent chargeable accidents. The penalty is either direct through a surcharge or indirect through a discount to those drivers who have had a clean record. In principle, this practice is not at issue. The issue is whether, or to what extent, "merit rating" should replace other factors, particularly age of driver.

1/ NAIC (D1) Subcommittee Task Force on Private Passenger Classifications, Report, June 1976 NAIC Meeting.

Most insurers have stated that while past driving record should be one factor in a rating plan, this factor is not sufficiently predictive to replace age. For example, Allstate Insurance Company stated:

> "[Insurance company] statistics do show that those drivers with recent accidents and violations, as a group, have more accidents the next year than the group which has been accident and violation free. However, the difference is not as dramatic as most people believe, and prior accident and violation histories do not divide drivers into homogeneous classifications to any better degree than other forms of subjective classification systems. Furthermore, most accidents each year are caused by drivers who have been accident free for several years." 1/

Apparently the available data is subject to varying interpretations. Commercial Union Assurance Companies, reviewing other research, stated that:

> "Both accident record and conviction record are useful in predicting future potential for losses and both are currently available on the Statistical Plan records. Driving record is presently a secondary rating factor; however, it appears that it is valid and practical to use driving record as a primary rating factor." 2/

Allstate drew its conclusions by looking only at accidents. In addition to previous accidents, Commercial Union reviewed California data that showed a substantial increase in driver accident rate correlated with the number of traffic convictions.

In general, the insurance industry's research on the relationship between driving record and accident likelihood has been inconclusive. Most exhibits prepared by the industry focus on accidents rather than convictions.

1/Statement of Allstate Insurance Co. before the Joint Senate and Assembly Standing Committee on Insurance, New York City, October 16, 1978.

2/Commercial Union Assurance Companies, Private Passenger Automobile Insurance Rating Plans Research, Auto Classification Plan, p. 21.

In favor of greater reliance on merit rating is the fact that it satisfies the public desire that insurance rates bear a relation to responsibility for accidents. Moreover, it fulfills the criteria of critics of current classification plans that there be a factor for controllability and one as an incentive for safer driving. On the other hand, Allstate's data show that that 80 percent of accidents were caused by drivers who had no accidents in the preceding 5-year period. 1/ The probability of future accidents increases as individuals have two or three accidents or convictions, but very few drivers have so poor a record. With such a small number of higher risk drivers, any shift of a significant portion of insurance premiums would result in impossibly high premiums. As noted previously, a highly predictive system would have far greater price disparities than the present system and such a system would heighten the problem of affordability.

Equity and subsidy

The issue of whether the classification plan and proposed reforms are equitable hinges directly on the concept of subsidy in the insurance system. Of course, the question of whether the system is predictable or socially acceptable are also criteria for equity, but in the debate over classification, the question of fairness is most often stated in terms of who pays for losses. Flattening the relativities would sharply decrease costs for a small group of drivers while moderately increasing costs for a larger group of other drivers.

Defenders of the current classification system argue that it is both fair and economically sound for groups to pay premiums based on the expected losses of their own group. To spread the cost more broadly by eliminating certain classification categories would involve cross subsidies--i.e., lower risk groups would "subsidize" higher risk groups by paying higher premiums than they now pay. Some companies have prepared exhibits showing how the lower priced groups would fare if the classification plan eliminated age, sex, and marital status.

1/Allstate Insurance Co., New York Statement.

The Department of Justice, in its report on the Pricing and Marketing of Insurance, approached the question of classification from an economic perspective. It regarded pricing plans imposed by regulators in which classes were not self-sustaining as involving objectionable cross-subsidies. 1/ The Justice Department report asserted that if subsidies for currently higher priced drivers (primarily young urban drivers) are necessary, they should be paid from public funds. 2/

Critics argue that this notion of subsidy is conceptually wrong in several respects. First, all insurance may be seen as a subsidy--those who have no loss subsidize those who do. The purpose of insurance is to spread loss. Given the fact that all drivers within a class or territory are not at the average loss expectancy for that class, it is not fair for good drivers in a higher risk class to have to share claims costs only with other drivers in that class. Under the current system young males who are skilled and responsible drivers must share the cost of loss only with other younger drivers who, as a group, have a disproportionately high loss rate. Critics of the system argue that there is no inherent reason why these good drivers should have the exclusive burden of bearing the loss cost of other younger drivers. The only thing held in common among them is age--not a controllable attribute. Thus, according to this viewpoint, flattening the rates would not be a subsidy but rather a more equitable way of spreading the cost of losses.

The problem of subsidy and the younger driver was put in this light by a recent study done for the Florida Department of Insurance:

1/There are other aspects of the subsidy question in addition to personal classification. In particular, premiums charged drivers in assigned risk plans may not be adequate to pay for claims in which case insureds in the voluntary market (i.e., not in the assigned risk plan) pay higher premiums to make up the losses in the assigned risk plan. This issue is discussed in chapter 7.

2/U.S. Department of Justice, The Pricing and Marketing of Insurance: A Report of the Department of Justice to the Task Group on Antitrust Immunities, January 1977, p. 368.

"* * * there is seemingly a small minority of youthful males who are incurring much greater than average accident experience. It appears this subgroup has not been identified using traditional class plans and has led to the heterogeneity of this class. Of major concern today is whether the social cost of not identifying this subgroup should be borne only by other youthful males who have no other common characteristic. In effect, the subgroup is being subsidized under the present system and the issue is how broad should be the group which bears the cost of subsidization." 1/

Of particular concern in evaluating the response of State insurance departments is the question of whether current classification plans constitute unfair discrimination of the sort that is proscribed by State laws. Unfair discrimination has traditionally been defined by insurance regulators from an actuarial standpoint. Speaking for the National Association of Insurance Commissioners, Wisconsin Commissioner Harold Wilde stated:

"A rate structure providing for actuarial fairness would require the various insured risks to pay their share of anticipated losses and expenses * * *. [I]nsureds are grouped into classes to reflect essential differences in their actual or probable losses and expenses. An actuarially fair share is determined by reference to loss and expense experience of different classes (or individuals) and by the expected effect of the insured's risk characteristics and underwriting factors upon the insured's costs. It would be unfair discrimnation from a statistical standpoint if the the classes thus identified were not rated accordingly." 2/

1/D.J. Nye, et al., An Evaluation of Risk Classification Systems in Automobile Insurance (Gainesville, Florida Insurance Research Center, 1979) p. 129.

2/U.S. Senate Judiciary Committee, Rights and Remedies of Insurance Policyholders, hearings before the Subcommittee on Citizens and Shareholders Rights, 95th Cong., 2nd Sess. (1978), p. 106.

Commissioner Wilde went on to note that the above definition applies to the concept of statistical fairness. Social fairness depends on public attitudes toward the propriety of the classification categories. Critics regard the system not only as socially unfair but as inadequately supported by statistical evidence. Nonetheless, the traditional concept holds that not only is the use of age, sex, and marital status not unfairly discriminatory, but it would be an exercise of unfair discrimination to discard these categories unless more predictive ones could be found.

Insurers maintain that it would be unfair discrimination not to use age, sex, and marital status because ignoring these factors would involve objectionable cross-subsidies. It is by no means clear, however, who is subsidizing whom under the current system. The notion of cross-subsidies assumes that the rating groups are homogeneous in their loss expectancy, an assumption that is far from proven. Looking beyond the context of the present grouped categories, it is just as accurate to say that the current system has subsidies from the low risk young drivers to both high risk young drivers and all adult drivers.

There is also an important equity question in determining the size of differentials that different categories should be charged. In that the groups are not homogeneous and the higher priced group is even less homogeneous, is it fair to have substantial differences in rates based on imperfect information and categories that are administratively convenient but not controllable by the insured? Critics of the current system argue that even if age or a similar factor, such as years of driving experience, is kept as a category, it is doubly inequitable to the low risk driver who is grouped in the high risk class to be charged substantially higher premiums. In other words, in that certain individuals will inevitably be subject to errors in pricing, should the errors be the type that improperly overcharge a small number of drivers several hundred dollars annually, or should they be the type that overcharge the larger number of drivers 10 to 20 dollars?

Competition and classification

The degree of competition and pricing freedom depends directly on the extent of regulatory control of classification. Just as the classification system was refined in response to competitive pressures in the industry, restrictions in classification freedom decrease competition and require greater State intervention.

In his 1978 decision on "The Operation of Competition Among Motor Vehicle Insurers," Massachusetts Commissioner Stone declared that a disadvantage of competition in automobile insurance is its dependence on "distasteful classification variables." Stone went on to state:

> "Society, as represented by its courts and legislatures, has demonstrated an increasing intolerance of economic distinctions based on group statistics and invasions of privacy. Competition, on the other hand, exhibits an insatiable hunger for information without regard to source. It is not easy to pursue the traditionally cited benefits of competition in automobile insurance and, at the same time, meet our society's evolving standards of fairness and justice."

Regulators and the industry generally agree that a regulatory restriction on the continued use of such factors as age and sex would require further regulatory intervention in the insurance market; otherwise, there would be a severe availability problem for certain groups. If, for example, age is banned, insurers still will act on the belief that young drivers are poorer risks. If the insurers are unable to charge commensurately more for those young drivers, they simply will refuse to insure them and would direct their marketing efforts toward better than average risks. The same is true for any group (or territory) where insurers are prohibited from establishing differential rates high enough to cover higher expected losses. To counter this problem, the States that have abolished age, sex, and marital status have enacted laws requiring insurance companies to insure all applicants. 1/ In order to spread the risk evenly, it has also been necessary to use a reinsurance facility--a pooling arrangement whereby insurers can turn over to a reinsurance pool the insurance policies they do not want to carry (sometimes limited to a percentage of their business). The premiums go to the pool and any losses in excess of the premiums are assessed against the companies by some formula mandated by legislation or regulation. Both proponents and opponents of changing the current classification plans agree that increased regulation

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1/Drivers regarded as being higher risk are placed in a reinsurance facility or joint underwriting association. See chapter 7.

is necessary in States that have eliminated the major rating factors. They only disagree as to whether the resulting situation is desirable or not. Those who favor elimination of age, sex, and marital status as rating factors regard the chain of increased regulatory controls as a desirable wider spread of the risk of individual losses. Others view it as an undesirable exercise of government control. The SRI report asserted:

> "* * * direct control of risk assessment is an unnecessary and undesirable interference with the free market forces. This interference has all the negative effects of rate control. In addition, it requires legislating against the use of knowledge, which is likely to be futile. 1/

REGULATORY RESPONSE TO THE CLASSIFICATION ISSUE

While the criticism of the risk selection process is aimed primarily at insurers, our analysis does not attempt to evaluate the merits and actuarial justification for the classification practices of insurers. In the following sections we review and evaluate the actions of the States in response to the issues discussed in the preceding sections. We also review the consequences of several actual and proposed regulatory responses.

Authority over classification

Authority over classification generally resides in an insurance department's authority over rates. The usual mandate in State law is that rates be neither inadequate, excessive, nor unfairly discriminatory. It is under that last category that all States have some authority over the relative rates in classification plans. Beyond that general grant of authority, the specific authority of departments over the categories used in classification plans is quite limited, as indicated in table 28.

1/SRI, The Role of Risk Classifications, Final Report, p. 107.

Table 28

Authority of 17 States over Classes and Territories

None	Possibility of subsequent disapproval	Prior approval required	Established by State
Illinois	Arizona	Kansas	North Carolina
Virginia	California	Michigan	South Carolina
	Ohio	New Jersey	Texas
	Wisconsin	New York	Massachusetts
	Indiana	Washington	
	Connecticut		

Typically, insurers (or rating bureaus on behalf of insurers) file with an insurance department the classification plan and territories used in establishing rates. The only requirement is that such classifications be statistically justified. Even in States requiring prior approval of classifications, much the same criteria apply.

In all the fieldwork States with authority over classification, the legal criteria require only that established classifications reasonably reflect differences in loss experience and that the data be credible. 1/ For example, New York law stipulates that:

> "Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses."

1/ In actuarial terms, credible means that there be enough cases for the data to be statistically valid in predicting the class average of a primary driver class or territory separately--but not any particular one of the myriad subcells taken individually.

There is no specific requirement in New York law or the law of any other State we reviewed that classification plans confront the objections discussed in the preceding sections. Indeed, most State laws affecting classification were enacted long before the classification plans became so sophisticated and before premiums became so high. That State law in this area may be insufficient to guarantee the rights of citizens was suggested by the Supreme Court of Michigan.

Due process considerations--
the Shavers case

The Michigan Supreme Court suggested possible State criteria for the regulation of classification plans as well as rates, and found that Michigan law and practice had been deficient in meeting the criteria. The case of Shavers v. Kelly 1/ in Michigan tested the constitutionality of Michigan's no-fault automobile insurance law. Although the Michigan Supreme Court upheld the constitutionality of the no-fault law, the Court also found that the mechanisms for implementing the law, including various provisions of the State insurance code, were constitutionally deficient in failing to provide due process. In particular, the Court held:

> "The statutory structure against 'excessive, inadequate or unfairly discriminatory' rates is without the support of clarifying rules established by the Commissioner, without legislatively sufficient definition, and without any history of prior court interpretation. The legislative due process mandate is thus reduced to mere exhortation. When we add that the statute authorizes insurers to utilize any classification scheme which 'may measure any differences among risks that may have a probable effect on losses or expenses', it becomes clear that rates can be established on insubstantial bases which do not satisfy due process." (Emphasis added.)

The Michigan Supreme Court gave the State legislature and/or the Insurance Commissioner 18 months to give substantial meaning to the statutory standards "rates shall not be excessive, inadequate or unfairly discriminatory."

1/404 Mich, 554, 267 N.W. 2d 72 (1978).

Administrative discretion under State law

Traditional legal criteria may provide considerable leeway, however. Thus, in prohibiting the use of age, sex, and marital status as rating factors, Commissioner Stone of Massachusetts asserted that:

> "Were competitive filings being considered at present, [rather than State-made rates] I would be compelled to judge whether any provision of any classification plan was unfairly discriminatory or violative of public policy. Determinations with respect to evolving social mores are necessarily a part of this task." 1/

Regulation of classification plans

In that all States prohibit unfair discrimination, we examined the extent to which States analyzed the actuarial basis for personal and territorial classification plans.

The relativities assigned to classes are based on national data, not on State data. The actual base premiums within a State are based on statewide loss data. Normally, the rate review performed by the insurance departments covers only base rates, adjusted for each territory. So if a particular State had loss data for young drivers that was particularly different than national trends, this difference would not be reflected in data submitted by the industry to the insurance commissioner, nor is it required to be submitted. If, as suggested, by an NAIC task force, the relationship between the losses of younger drivers and adult drivers was significantly different in high rated urban territories than as indicated by national classification relativities, the difference would not be reflected in the data submitted by the insurers to the insurance commissioner, nor is it required to be submitted.

The question is whether, in carrying out the mandate that insurance prices not be unfairly discriminatory, State insurance departments perform actuarial and other evaluations to determine if relativities and classes within a State

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1/Commonwealth of Massachusetts, Division of Insurance, Opinion, Findings and Decision on 1978 Automobile Insurance Rates, December 28, 1977, p. 162.

are justified. In our fieldwork States, we found that no State periodically or routinely performs an independent actuarial analysis of personal classification relativities used by insurance companies. Three States did report, however, that they reviewed changes in classification plans or plans that departed from those used by most insurance companies. Nine States did not review classification plans at all, or reviewed them only incidentally to reviewing rate filings. Only two fieldwork States, Massachusetts and New Jersey, have done comprehensive studies of the actuarial basis of classification plans. The Massachusetts study is discussed above. The New Jersey study is not yet completed but is similarly intensive and covers a wide range of important issues that apparently have not been examined sufficiently by other States. South Carolina, Texas, and Massachusetts have mandated their own classification plans, and so whether they review the plans of the insurance companies is irrelevant to them. Wisconsin periodically reviews the basis of classification plans used by domestic companies when it conducts financial examinations of those companies.

State action of merit rating

Ideally, merit rating should provide incentives for safer driving. The provision of such incentives is not entirely in the hands of insurers, however. States have an important role to play in that most insurance departments must approve (or refrain from disapproving) plans that relate driving and claims records to premiums. In our fieldwork, we sought to determine the extent to which insurance departments were actively involved in programs that promote insurance pricing incentives for safer driving. All the States permitted the use of safe driver incentives. Beyond that, six States had no program of encouraging insurance company use of such incentives. Seven States encouraged but did not require incentives. Only three of the 17 States required companies to use a safe driver incentive plan. South Carolina requires insurers to offer a 15 percent discount to drivers with clean records. The State-established classification plan in Massachusetts includes merit rating. Texas requires premium discounts for drivers who attend driver's training or defensive driving courses.

Based on these findings in the field, most States apparently have only a passive position on merit rating and safe driver incentive plans.

Prohibition of traditional categories--
State action and study

Only three States in the Nation explicitly prohibit the use of any traditionally used rating category. In Hawaii and North Carolina, age, sex, and marital categories are prohibited by statute. In Massachusetts age and sex categories have been prohibited by administrative action of the insurance commissioner. North Carolina and Massachusetts are among our fieldwork States.

The North Carolina Insurance Code, Article 12B, Section 58-124.19 allows the grouping of risks by class for establishment of rates and base premiums, but provides that:

> "No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles in whole or in part, directly or indirectly, upon the age or sex of the persons insured."

That Article of the North Carolina State Code became effective September 1, 1977, and expires September 1, 1980. Although marital status is not explicitly banned, since that category in most rating plans applies only to younger drivers, banning age effectively eliminates the use of marital status.

Massachusetts' ban on the use of age, sex, and marital status as personal rating factors was in the form of an order from the Commissioner of Insurance, pursuant to his authority under Section 113B of Chapter 175 and other sections of the Massachusetts General Laws. The Order was the culmination of hearings spanning 24 days. The previous Massachusetts plan used 11 driver classes, including divisions based on age, sex, and marital status. The alternative plan, developed by the State Rating Bureau and adopted by the Commissioner, contains only three primary classes: business use, drivers with less than 3 years of driving experience, and a standard rate for all other drivers. There are also two subclasses--a discount for standard rate drivers over 65, and a discount for inexperienced drivers who have completed driver training. With the senior citizen discount, age is not completely eliminated as a rating category, but unfair discrimination based on age is reduced. The State Rating Bureau plan contains no classification based on sex or marital status.

Although only two of our fieldwork States have banned the use of age and sex, several others are studying the question. The most extensive efforts have been hearings

and a study conducted for the New Jersey Insurance Department. The staff of the New York Insurance Department reported devoting a substantial amount of time in 1978 to reviewing the issues posed by personal and territorial classification. However, the Department's position is that while it is not wedded to the present system, it cannot develop any meaningful reform without also establishing a more comprehensive residual market plan--i.e., a State-mandated plan to provide for insurance for all those who would be denied insurance if the traditional classification categories were banned. The Department does not now believe the Massachusetts plan is a workable alternative in New York State.

Of our fieldwork States, only Texas had insurance department hearings in 1978, which turned down a proposal to eliminate traditional rating categories.

In two States, Ohio and New York, legislative committees held hearings on classification plans, but no legislation has been enacted.

In conclusion, only one of the fieldwork States has conducted an extensive analysis and held hearings that resulted in overturning the traditional rating classifications. A second State, New Jersey, has held hearings and commissioned a consultant's study. Two other States have considered the issue, and two more States have held legislative hearings.

The National Association of Insurance Commissioners grappled with the classification issued by establishing a special Rates and Rating Procedures Task Force, which was instructed to prepare recommendations for the December 1978 semi-annual meeting of the NAIC. The Task Force issued a preliminary report in September 1978. That report briefly reviewed the statistical issues and public policy considerations involving the use of age, sex, and marital status as rating factors. The Task Force originally concluded that neither age, sex, nor marital status display significant levels of controllability or causality in regard to driver performance and are objectionable on social policy grounds as well. Based on that analysis, the Task Force recommended the adoption of NAIC model laws that would ban these as classification factors in the future. However, when the final draft of the NAIC Task Force report was issued in December 1978, it cautioned that age should be retained as a rating factor until alternatives of greater predictability could be found.

The Task Force's recommendation that sex and marital status be prohibited, but that age be retained, was accepted by the organization's automobile subcommittee and the full Property and Casualty Committee. The NAIC Executive Committee, however, did not adopt the Task Force position and voted to defer action for 6 months. Where the Task Force stated that the current classification factors "lack adequate justification," the NAIC Executive Committee substituted the words "are subject to serious question." The Executive Committee recommended that the NAIC should consider at the next meeting (6 months later) adoption of a public position that the use of sex and marital status as rating factors is contrary to public policy. The NAIC plenary session agreed, but also passed a resolution of exhortation to the automobile insurance industry:

> "NOW THEREFORE BE IT RESOLVED THAT THE NAIC calls on the automobile insurance industry to exhibit concern equal to that demonstrated by the NAIC with respect to more equitable automobile insurance pricing mechanisms; and FINALLY BE IT RESOLVED that the automobile insurance industry demonstrate such concern and provide specific evidence thereof at or before the June 1979 meeting."

In its June 1979 meeting, the NAIC again deferred a recommendation of specific regulatory action on classification. Instead, another resolution was passed:

> "* * * all rating classifications should be subject to minimum regulatory standards which would require that rates and classifications for private passenger automobile insurance be based on a reasonable classification system, sound actuarial principles, and actual and credible loss statistics, relevant external data or in the case of new coverages or classifications, reasonable anticipated loss experience."

TERRITORIAL RATING

Rating territories have been set by insurers to reflect the fact that more accidents occur in some geographic areas than in others. Just as with personal classifications, insurers have sought to reflect those territorial differences in group losses by charging different premiums. Within each rating territory, policyholders with the same characteristics pay the same for a particular level of coverage with an insurance company. Premiums are increased and decreased (usually annually) based on the loss experience in that particular territory.

Territories vary in size and population within States, and larger urban States have many more territories than smaller rural States. In most States, most insurers follow the territories established by the Insurance Services Office. In eight of the 17 fieldwork States, all insurance companies used the same territories. In four of those, Massachusetts, North Carolina, South Carolina, and Texas, all companies are required by law to use uniform territories. In the other nine States, some of the larger companies that do not file rates with ISO had territories that were different from ISO territories.

The origin of particular territories is not altogether clear. Sometimes territories follow legal jurisdiction (counties, cities). The larger cities and suburban counties frequently consist of several territories with the dividing line being listed as a highway, a city street, a river, or other boundaries. Insurance industry officials were unable to explain why particular territorial boundaries were formed, other than an intuition or observation that accident rates were different in certain areas. Once territories are developed, they are rarely changed and are justified by showing differences in loss experience from the statewide average. Territorial rating is an issue primarily in States with large metropolitan areas. Controversies over territorial rating generally range over the issues of racial discrimination and fairness. Closely related to this controversy is the issue of redlining, defined as the arbitrary refusal by the industry to insure certain risks because of their location. Redlining is discussed in the following chapter, "Insurance Availability."

Racial discrimination

Racial discrimination is closely related to redlining, and indeed is the effective result of such underwriting practices. From a legal and social policy standpoint, the problem is differentiating a policy of racial discrimination from the discriminatory results of territorial rating. As noted in the Department of Justice Report: 1/

1/U.S. Department of Justice, "The Pricing and Marketing of Insurance." A report of the Department of Justice to the Task Group on Antitrust Immunities, January 1977, pp. 332-333.

"* * * racial discrimination is most often encountered as a product of a more subtle classification, that of geographic location. Frequently, major U.S. cities are divided into a number of territories, with the inner city, an area most often populated by minorities, classified as a high risk area and thus subject to significantly higher rates. Although the insurer is using the racially neutral geographic classification, the effect is that minority-group citizens (and most often those with the lowest incomes) are paying a great deal more for auto insurance than white citizens."

Insurers argue that the territories do have different loss experiences, with much higher losses in central city areas, and that differential pricing based on those territories is justified. Critics assert, however, that in some areas the racial composition of territories is not accidental but is in fact the basis on which those territories have been established. They further argue that the territories are not as distinctive in loss experience as claimed by insurers but are only presumed to be distinctive because of their distinctive racial/ethnic composition. The controversy on this point has been particularly intense in Los Angeles where it is the subject of a lawsuit.

Equity

One equity issue is present with regard to territories just as with personal classifications--the fairness of various methods of spreading the risk and sharing the cost. This issue is compounded by territorial rating because the central city areas with higher premiums also have lower personal income on the average. Indeed, a Massachusetts study found an almost perfect negative correction between family income and insurance premiums by territory. Commissioner James Stone of Massachusetts argued:

"There is no obvious reason why the poor with good insurance records should have to carry the burden of the poor with bad claims records while the wealthy must share claims only with one another."

Insurance companies can readily document the higher loss costs in most higher rated territories (and are required to do so in States with rate regulation). However, there is disagreement on the question of who is responsible for the

loss costs. Critics of territorial rating and industry officials agree that city accident rates are higher than outlying areas because of urban traffic congestion. The critics part company with the industry in asserting that the congestion is caused by suburban cars coming into the city, and thus the higher insurance rates of innercity residents reflect the costs of the driving habits of suburban residents. 1/ The industry points out that losses are charged to the territory where an automobile is garaged (i.e., the driver's residence), not where the accident occurs. Allstate Insurance Company has argued that because of this

> "* * * the residents of the central city do not pay more for their insurance because suburbanites become involved in accidents there. Rather, the higher price simply reflects the fact that the vast majority of their auto travel takes place in congested traffic areas and thus, their exposure to loss is greater."

However, at least one insurer, Commercial Union, acknowledged that there is an

> "* * * inequity caused by suburban commuters who drive into urban areas and cause increased traffic densities and congestion on city streets (causing) more hazardous driving conditions for city residents who end up paying higher premiums because of it."

CU proposed using a modified version of a Canadian plan of rating commuting vehicles based in part on where the car is going.

In summary, territorial classification presents two issues similar to those manifest in the controversy over personal classifications. First, are the territorial lines actuarially fairly drawn--i.e., are they reasonably distinct units that are relatively homogeneous internally? Second, are the existing territorial lines fair and not contrary to preferred social policy? The second issue, of course, hinges on the values of the critic.

1/Michael Etgar, "Uniform Price Discrimination in P-L Insurance and the Reliance on Loss Ratios," Journal of Risk Insurance, vol. 42 (Dec. 1975) p. 615.

State action on territorial rating

The responsibility, but not necessarily the authority, of States over territorial rating plans is considerably different than over personal classification plans. The major companies use the same personal classifications in most States in which they do business, and the relativities are based on national data. Although the major empirical document on the subject, the SRI study, is based on California data, a study of personal classification could just as well be based on national data, and legislation or regulations could just as readily be national in scope. Territories, on the other hand, are limited to State boundaries, and the relativities between territories affect only the people within a particular State. While it is responsible and efficient for the NAIC to conduct a review of whether particular age groups should be taken as a rating category, only the State in question can determine whether it is equitable for a territorial boundary (and different rates) should stop at one place rather than another.

In those States where territorial rating has become a controversy, there have been allegations of unfair discrimination by insurers. States must be able to collect data on the nature and extent of such problems if they are to respond to allegations of unfair treatment. Because States are responsible for making sure that insureds are fairly treated, we focused our review on what information the States collect on territorial rating practices and how the insurance departments analyze and use that data.

All departments receive for each territory the insurance companies' or rating bureau's loss costs, loss ratio, and loss ratio in relation to the State average. These data indicate whether rates for particular territories should be raised or lowered. We determined that the level of rates for territories as units is monitored. The more fundamental issue is whether the composition of territories was reviewed by departments to see if territorial boundaries were justified by patterns of losses within each territory. In the fieldwork States, we reviewed whether insurance departments determined if loss experience justified the territorial boundaries used in automobile insurance.

There is no standard or authoritative criterion used by State regulators to justify territorial boundaries. Nevertheless, by deduction from the statutory standard that rates shall not be unfairly discriminatory, several criteria can be suggested. The prohibition against unfair discrimination means that persons with the same risk characteristics shall not be charged different rates by an insurer. The question

with regard to territories is whether the residents of a rating territory, who are being charged the same base rates by each insurer, do indeed have the same risk probability. The most basic criterion, therefore, is whether each territory is relatively coherent and homogeneous internally. Indeed, this standard of homogeneity was posed by the Commissioner of Insurance in Connecticut in his decision on territories in his State. A territory can never be entirely homogeneous. If everyone in a territory had an accident and nobody in another territory ever had an accident, there would be no need for or possibility of insurance. However, areas within territories should not deviate substantially from the territorial average, nor should they be more similar to other territories (with other rates) than they are to the areas in their own territory.

In statistical terms, there should be more variance of loss experience among territories than within them. Moreover, the degree of variation within the territories should be similar. If some territories in a State had substantially greater internal variation than other territories, this situation would indicate that many insureds in those higher variation territories had risk probabilities which were significantly different from the average for the territory. Those insureds are therefore being consistently overcharged or undercharged since the rate would be based on the average loss experience for the territory.

There are several ways to analyze the integrity of territories. One way, being tried in California, is to collect data by zip code. Such a method would show if smaller areas within territories were close to the territorial mean for accident frequency and severity. Alternatively, rating could be done directly by zip code since it is a smaller (and probably a more homogeneous) unit. As territories get smaller, however, the magnitude of overcharge or undercharge for the risks that are further from the average would probably increase. Thus, there are limits, in terms of equity as well as statistical validity, to how small or large a territory should be.

Another way would be to use insurance company claim records and determine whether there is less variance within territories than between them or to compare variation within territories. In reviewing State action on territorial rating, we did not impose any particular criterion or methodology as a standard against which to assess State insurance department actions. Rather, we reviewed whether the States were using any analytical technique to determine if the current territorial rating plans satisfied the statutory criterion that insurance rates are not unfairly discriminatory.

Out of our 17 fieldwork States, 11 have not done an actuarial or other statistical review of whether loss data justifies existing territorial boundaries. While they have data on the loss experience by territory, they do not review, for example, whether the territories are internally homogeneous. The insurance departments in these States do not know if there are areas within territories that have a markedly better or worse experience than the territory as a whole and are more similar to other territories than the territory of which they are a part. In four States, California, Connecticut, North Carolina, and South Carolina, the composition of territories is being reviewed or has been challenged by the insurance department.

Of particular note is Connecticut. The City of Hartford and a consumer group charged that the existing territorial rating system resulted in excessive and unfairly discriminatory rates in Hartford. Existing territories had been in existence for approximately 20 years. Data is not collected by cities or towns within territories, and there is no way of knowing if the current configuration of territories optimally reflects actual loss experience.

The Insurance Department held a hearing in December 1978 in response to a petition from the City of Hartford, which alleged that the territorial rating system in use was unconstitutional and in violation of State statutes. The Department analyzed the territorial data and reviewed the opposing submissions of the City of Hartford and the insurance industry. The Commissioner dismissed the constitutional challenge, but did rule that the existing territories resulted in rates that were unfairly discriminatory. His ruling was based in large part on the inability of the insurance industry to justify the existing configuration of territories (and its admission that the territories were not internally homogeneous), and its inability to justify the methodology by which loss data is used in computing the total premium. The Commissioner instructed the companies that continued approval of their rates is conditioned on making certain specified changes in how expense costs are allocated to territories and on establishing a system to collect experience data by town in order to test the validity of territorial configurations. The Connecticut Insurance Department's order, then, will result in the creation of a data base from which new territorial boundaries can be drawn if that proves necessary.

In Massachusetts and Texas, territories are established by a State rating board. The Massachusetts Insurance Department believes that the 14 territories outside Boston

are justified based on accident frequency. Boston's 10 territories are based on traditional neighborhood lines, and the Department drew those boundaries based on neighborhood factors rather than on the basis of previous loss experience. In Texas, the State Rating Board justifies territories on loss data taking the territories as units, but there is no analysis of whether the territories are homogeneous.

Limitations on data collection by the States

There is one important potential limitation on the States' ability to collect data--a limitation in the insurance laws of most States. The rating law of most States provides that "no insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it." Nine of the 17 fieldwork States have such a provision. Three of the States are silent on the subject, and five, Wisconsin, Massachusetts, New Jersey, North Carolina, and Texas permit the insurance commissioner to require that companies file data in any manner designated by the commissioner.

The prohibition against requiring companies' loss data on a different basis than normally used by a company potentially means that a department cannot assess the validity of those classifications and territories from that data. For example, if an insurance company had one classification for young drivers 21- to 24-years-old, an insurance department would not be able to separately request the loss data for the 24-year-olds to determine if they are close to the experience for that class or whether they are closer to the adult category. Departments are also limited in reviewing experience within a territory since only aggregate loss experience for each territory is reported. Five States reported that the prohibition was not a hindrance because they would not want anything other than data in the form normally provided by insurers or because they could request the insurers to provide needed data voluntarily. An official in Michigan, however, reported that the department's regulatory efforts were hindered by the restriction. Whether or not insurance departments are able to use their leverage to skirt the law, it should be noted that the NAIC's model law limitation on data collection, if strictly interpreted, would deprive regulators of data needed to analyze compliance with other State laws prohibiting unfair discrimination.

SUMMARY AND CONCLUSIONS

We have not conducted an independent evaluation of the validity of personal classifications or the integrity of territories in any State. Based on an examination of existing evaluations of those systems, we conclude that serious questions remain as to whether widely used classification systems conform with the prohibition against unfair discrimination--particularly with regard to territorial rating. The allegations regarding the lack of predictability and homogeneity in existing classes and territories are sufficiently well supported to warrant greater regulatory scrutiny.

The Federal Trade Commission has contracted for a major study of the economics of insurance discrimination that aims, in part, to examine the success and consequences of present classification schemes in assessing risk levels. The study will develop a model which can be used to determine the results when such variables as sex or age are excluded from rate classification methods. The FTC study promises to be the most extensive theoretical study on the subject since the SRI International study in 1977. We, therefore, believe it best to reserve comment on the adequacy of classification schemes pending the outcome of that FTC sponsored study.

We are, however, able to present conclusions about the adequacy of State insurance department regulation of classification schemes. While we offer no conclusions on constitutionality per se, it should be noted that the statutes governing classification plans in all States we visited are similar to the provisions of Michigan law that were found constitutionally deficient by the Michigan Supreme Court.

Even in the presence of statutes allowing wide discretion, insurance commissioners can apply higher standards of statistical proof. However, few States have undertaken their own evaluations of whether the current classification plans satisfy State prohibitions against unfair discrimination. We wish to emphasize that we do not conclude that the States should have found against the current plans. However, in the face of serious questions being raised about those plans, the State insurance departments should have been more aggressive in undertaking their own evaluation.

While it can be argued that classification plans, being national in statistical underpinning, should be addressed by the States jointly through the NAIC, no such requirement is present in the case of rating territories within each State. Again with few exceptions, State insurance departments have not assured the validity of rating territories despite the fact that in most cases the existing territorial boundaries

were established long ago and by a process about which no one has much information. While State insurance departments may be justified in awaiting the results of further study before acting on the issues raised by personal classification, they can assure the rights of their citizens only by undertaking their own reviews of the validity of rating territories.

Most of the fieldwork States reported that they were not hampered by laws limiting the collection of data to the format already used by each insurer. However, inasmuch as most departments did not attempt independently to verify classifications or territories, it cannot be concluded that that limitation would not hinder such evaluation. Because of the need for actuarially credible data, particularly in smaller States, insurance departments should be free to obtain data from insurers in a uniform format.

Because there are substantial economies of scale in studying the question of classification, there is an appropriate Federal role in studying or sponsoring studies of the risk classification system. Indeed, since State insurance departments have not yet examined the current classification plans with sufficient rigor to assure that they are not unfairly discriminatory, continued Federal consideration of risk classification is necessary. Inasmuch as the National Association of Insurance Commissioners has declined to follow through on its task force findings and recommendations, uniform remedies to deficiencies in the current classification system will probably have to come about through Federal legislation.

CHAPTER 7

INSURANCE AVAILABILITY

There is wide agreement that insurance is essential to personal security and community growth. As Michigan Insurance Commissioner Thomas C. Jones has written:

> "In short, for both society and the individual, automobile and homeowners insurance is essential. Society's stability and growth depend upon it and the financial equilibrium and sense of well-being of individual citizens demand it." 1/

Despite its essential nature, there has been a substantial problem of obtaining necessary insurance at an affordable price--or in some cases at any price. Indeed, in 1978, the Federal Insurance Administration (FIA) concluded that despite the residual market property insurance program known as the FAIR plan, "Without question, insurance availability and insurance affordability in urban areas are crises of monstrous proportions." 2/

The FIA has been joined by other knowledgeable observers in asserting that there is a serious problem of insurance availability in personal lines insurance in urban areas as well as availability problems in specialized lines affecting small businesses. Insurance companies have generally held that the availability problem in property and automobile insurance is not serious where residual market plans provide insurance not available through normal voluntary market channels. This chapter examines the response of State insurance departments to the issue of insurance availability, with a focus on automobile insurance.

REDLINING

Redlining is the most conspicuous availability problem. The FIA defines "redlining" as the "arbitrary refusal by the the industry to insure certain risks because of their location." The impact of redlining was noted by FIA:

1/Thomas C. Jones, Essential Insurance in Michigan: An Avoidable Crisis, Insurance Bureau, Michigan Department of Commerce, 1977, p. 4.

2/Insurance Crisis in Urban America, U.S. Department of Housing and Urban Development, Office of the Federal Insurance Administrator, 1978, p. 44.

"Insurance redlining today denies many urban property owners access to a voluntary insurance market. The practice is not based on any sound underwriting standards but rather on highly subjective criteria that would appear to result from unfounded generalizations or preconceptions about urban property risks. The effect of this practice is that many property owners are denied access to insurance at affordable prices." 1/

While redlining is mainly applied to residential and business property insurance, the practice allegedly has bearing on the writing of automobile insurance, and will therefore be discussed in this chapter. Regulatory responses to allegations of redlining bear directly on the mandate of insurance departments to prohibit unfair discrimination in the sale of insurance.

Insurance redlining takes its name from the former practice of insurance underwriters who outlined in red on maps entire districts or sections that were in a state of economic or social transition or evinced urban blight. These were deemed undesirable areas where no insurance would be written, even though such areas might include attractive neighborhoods and well-kept dwellings.

Because of the negative connotations of the term, the definition or redlining itself is not without controversy. The FIA noted in its discussion that by extended definition:

"The term has come to mean any discriminatory practice by the insurance industry in refusing to sell, write, underwrite, renew, or market policies because of the geographic location of the risk." 2/

The Advisory Committee to the National Association of Insurance Commissioners Task Force on Redlining cautioned that the definition should not include refusing to insure and other restrictions "when such action is based on sound underwriting and actuarial principles reasonably related to actual or

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1/U.S. Department of Housing and Urban Development, Office of the Federal Insurance Administrator, Insurance Crisis in Urban America, 1978, p. 44.

2/U.S. Dept. of Housing and Urban Development, Federal Insurance Administrator, Insurance Crisis in Urban America, 1978, p. 27.

anticipated loss experience of the individual or a group of individuals similarly situated." One issue, then, is whether the refusal to insure in an area is based on "sound underwriting and actuarial principles." 1/

Another issue is what constitutes refusal to insure. Among the practices designated as redlining by a report of State advisory committees to the U.S. Civil Rights Commission are the following: Selective placement of agents to reduce business in certain areas, terminating agents and nonrenewing their book of business, pricing insurance at such high levels that for all practical purposes it is unavailable, informally or formally instructing agents to avoid certain areas, and varying underwriting practices solely by zip code. 2/

The Federal Insurance Administration declared, with regard to property insurance, that

> "Insurance redlining is widely practiced by insurers. Insurance companies redline by means of zip code. As a result, risks are rejected not on the basis of objective underwriting standards but rather on a highly subjective perception of risk assumed for general geographic locations." 3/

Although the FIA judgment applied to property insurance, critics have charged that redlining is a common practice with regard to auto insurance in that insurers either refuse to sell or grossly overcharge residents of redlined areas.

Response of State insurance departments to redlining allegations

As with the issues of territorial and personal classification, we focused on the response of State insurance departments to these problems--specifically whether State insurance departments investigated claims of unfair discrimination in the sale of property and casualty insurance. We asked all

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1/Ninety Day Report of the Advisory Committee to the NAIC Redlining Task Force, March 1978, pp. 2-3.

2/Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin Advisory Committees to the United States Commission on Civil Rights, Insurance Redlining: Fact Not Fiction, 1979, pp. 4-5.

3/U.S. Department of Housing and Urban Development, Office of the Federal Insurance Administrator, 1978, p. 43.

the State insurance departments whether they had conducted any studies in the 5 years before June 1978 on "redlining" activities with respect to property or liability insurance. Of 45 States responding to that question, 16 (36 percent) reported that they were conducting such studies. We requested copies of those studies, but only four States submitted them.

Of course, State insurance departments should not be faulted for not addressing the issue of redlining if there are no allegations and little likelihood of a problem. In fact, territorial discrimination is an issue primarily in urban States, and in those States the problem is focused on older central city areas. Taking as our index of urbanization the percentage of population in a State living in Standard Metropolitan Statistical Areas (SMSAs) over 200,000, we designated as "urban" those States with 75 percent of the population in those SMSAs. Eighteen of the 45 respondent States are urban, and 27 are not. Urban States were more likely to conduct studies than nonurban States, but less than half of the urban States, 8 out of 18 urban States (44.4 percent), conducted studies while 29.6 percent of the nonurban States conducted such studies. The States by category are in table 29.

To find out if redlining exists, data must be collected based on some geographic unit. Some observers have advocated collecting data by neighborhood or zip code, while others caution against using small areas as a data collection base. If the problem is redlining by neighborhood, i.e., refusing coverage or otherwise avoiding business in particular neighborhoods regardless of the presence of individual good risks, it is necessary to collect data by the geographic unit that is allegedly being discriminated against. There are other ways to approach the redlining problem. The 90 day report of the NAIC Advisory Committee to the Redlining Task Force recommended more extensive use of market conduct examinations. 1/

1/However, two advisory committee members, from the U.S. Commission on Civil Rights, argued for geographic data collection based on neighborhoods or zip codes.

Table 29

State Insurance Department Studies on Redlining, 1974-78

States Responding That They Have Conducted Studies of Redlining

Urban (75% of population in SMSAs)	Nonurban (less than 75% in SMSAs)
Arizona	Alaska
California	Indiana
Colorado	Kentucky
Illinois a/	Missouri
Maryland	Montana
Massachusetts a/	Nebraska
Nevada	West Virginia
Pennsylvania a/	Wisconsin a/

States Responding That They Have Not Conducted Studies of Redlining

Urban	Nonurban
Florida	Alabama
Hawaii	Arkansas
Michigan	Delaware
New Jersey	Idaho
New York	Iowa
Ohio	Kansas
Rhode Island	Louisiana
Texas	Minnesota
Utah	New Hampshire
District of Columbia	New Mexico
	North Carolina
	North Dakota
	Oregon
	South Carolina
	South Dakota
	Tennessee
	Vermont
	Virginia
	Washington

States Not Responding to GAO Questionnaire

Connecticut	Mississippi
Georgia	Oklahoma
Maine	Wyoming

a/States that submitted copies of reported study to GAO.

For purposes of action against one company, market conduct exams might be adequate to examine discrimination. But for uncovering patterns of action and for more timely coverage, market conduct exams are simply too infrequent to be an adequate remedy. Thus geographic data collection is necessary. Such data collection would address the specific allegations raised with regard to redlining and other forms of unfair discrimination. Thus, it would include data on policies in force, new policies being written, cancellations and refusals by the insurer to renew existing policies. Such analysis would also include data on losses by neighborhoods within existing rating territories because marked discrepancies within territories would cast doubt on the validity of territorial boundaries. Without specifying the level of such collection, our questionnaire asked whether insurance departments collect data on new policies, policies in force, cancellations, nonrenewals, and losses "on a geographic basis." Because this is a relatively new issue, we also asked whether they planned to collect data on a geographic basis. The responses are shown in table 30. Note that less than 20 percent of the States collect anything other than loss data on a geographic basis.

Table 30

Insurance Department Data Collection Relevant to Discrimination

Data category	Number of departments Collecting data	Not collecting	No response	Number of departments Plan to collect	Do not plan to collect	No response
New policies	6	32	8	7	30	9
Policies in force	9	30	7	7	29	10
Cancellations	5	33	8	7	30	9
Nonrenewals	5	33	8	7	30	9
Loss data	14	24	8	10	23	13

While there may be ways to detect redlining other than special studies and geographic data collection, a systematic and comprehensive approach to investigating whether this most blatant form of unfair discrimination exists requires this kind of data collection system. Nonetheless, less than 20 percent of the States collect insurance information other than loss data on a geographic basis and less than half of the urbanized States have conducted any studies of redlining. Indeed, only four States sent us their reported studies.

UNDERWRITING PRACTICES

Underwriting is an insurance company's way of determining the acceptability of risks. Unlike classification categories, which are based on more objective criteria, underwriting is a subjective process. Questions have been raised about the propriety of certain underwriting practices, embodied in underwriting manuals or guides published by insurance companies. For example, an underwriting manual still in use in 1978 by the Continental Insurance Companies listed occupations that should be regarded as producing higher than average losses. These included antique dealer, automobile dealer, bartender, contractor, fashion designer, loan shark, painter, waiter, and waitress. The manual prefaces this list by stating:

> "While we admittedly cannot readily document our opinions on this and many other points, we nevertheless are convinced without the slightest reservation that when considered as a group rather than as individuals, persons engaged in some occupations have a much greater frequency of loss under Homeowner policies than do persons engaged in some other occupations." 1/

Although Continential reported to the Congress that parts of its manual are outdated and no longer used, the categories used in the manual may be found in other insurance company underwriting manuals apparently still in use.

The States have very limited authority over underwriting guidelines. Only 12 of 43 (29 percent) States responding to our questionnaire item on underwriting reported that they had

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1/Partially reprinted in U.S. Senate Committee on the Judiciary, Subcommittee on Citizens and Shareholders Rights and Remedies, Rights and Remedies of Insurance Policyholders, Hearings. 95th Congress, 2nd sess. (1978) p. 91.

the authority to forbid the use of particular guidelines. Sixteen States reported that they could review the guidelines and request justifications. Five States have no authority and 10 States cited some other form of authority such as the trade practice laws or laws against unfair discrimination.

Based on the practice in the fieldwork States, it appears that few State insurance departments review or even collect the underwriting guidelines used by insurance companies in their States. Generally, departments collect only some manuals or only portions of manuals.

Underwriting manuals are the written expression of underwriting practices suggested by insurance companies, and actual practices may be more or less restrictive than suggested in the manuals, depending on business conditions and other factors. Therefore, a more thorough review by departments of underwriting manuals and guidelines would not necessarily be an effective means of departmental regulation of underwriting practices. However, as part of a general review of insurance availability, departments would be in a better position to ascertain potential problems of unfair discrimination by examining the companies' official practices.

AUTOMOBILE INSURANCE AVAILABILITY

The problems of availability in automobile insurance differ from property insurance. All States have some sort of residual market plan to sell automobile insurance to people who cannot obtain insurance in the voluntary market --individual insurance companies offering coverage voluntarily. The most common residual market plan is the automobile insurance plan, better known as the assigned risk plan, but there are other types as well. Table 31 shows the types of plans and the States falling into each type. Despite the universal existence of auto residual market plans, there may still be an availability problem in that the concept of availability is a slippery one.

There is no universally accepted definition or concept of availability. Most regulators and industry sources regard availability from the consumer's perspective as solved by residual market plans. They consider the residual market as consisting only of drivers who are forced into the assigned risk plan because they cannot obtain insurance in the voluntary market. Others have told us that the market is larger, consisting not only of the assigned risk plan, but also of those paying higher nonstandard rates with high risk companies

and those who are uninsured. By this point of view, the extent of the availability problem cannot be measured solely by the size of a State's assigned risk plan.

The extent of availability

Thus the question of whether there is an automobile insurance availability problem hinges largely on the definition of "availability." We asked commissioners or their spokesmen in the fieldwork States if they thought their State had an availability problem. In nine of the 17 States availability was not considered a problem because of the existence of a well functioning market and an assigned risk plan. In an additional three States there is no availability problem to consumers because of a "mandatory offer" law requiring insurers to offer insurance to all comers and allowing them to cede unwanted risks to a reinsurance facility. In one of

Table 31

Type of Shared Market Program in Each State

States served by automobile insurance plans:

State	Effective date	State	Effective date
Alabama	May 17, 1948	Nebraska	July 1, 1946
Alaska	October 1, 1959	Nevada	February 15, 1950
Arizona	January 1, 1952	New Jersey	March 15, 1941
Arkansas	September 1947	New Mexico	July 1, 1948
California	January 19, 1948	New York	November 1, 1941
Colorado	July 1, 1948	North Dakota	June 1, 1945
Connecticut	July 15, 1940	Ohio	January 1, 1949
Delaware	September 4, 1947	Oklahoma	January 1, 1950
District of Columbia	June 1, 1953	Oregon	October 15, 1948
Georgia	February 1948	Pennsylvania	May 15, 1943
Idaho	November 1, 1949	Rhode Island	July 28, 1947
Illinois	October 1, 1940	South Dakota	July 1, 1949
Indiana	December 10, 1948	Tennessee	June 1, 1949
Iowa	June 15, 1948	Texas	January 1, 1952
Kansas	November 20, 1950	Utah	February 15, 1949
Kentucky	August 20, 1948	Vermont	March 1, 1941
Louisiana	November 1, 1949	Virginia	July 1, 1952
Maine	February 1, 1940	Washington	January 13, 1941
Michigan	August 12, 1943	West Virginia	July 31, 1947
Minnesota	January 1, 1949	Wisconsin	October 1, 1949
Mississippi	July 19, 1948	Wyoming	July 1, 1948
Montana	October 9, 1951		

Total: 43

States served by alternative residual market mechanisms:

State	Mechanism	Effective date
Massachusetts	Reinsurance Facility	January 1, 1974
North Carolina	Reinsurance Facility	October 9, 1973
Florida	Joint Underwriting Assn.	October 1, 1973
South Carolina	Reinsurance Facility	October 1, 1974
Hawaii	Joint Underwriting Plan	September 1, 1974
Missouri	Joint Underwriting Assn.	January 1, 1975
New Hampshire	Reinsurance Facility	April 1, 1975
Maryland	State Fund	January 1, 1973

Total: 8

Source: AIPSO Insurance Facts--1978. Automobile Insurance Plans Service Office.

those three States, however, only liability coverage is under the mandatory offer law, creating an availability problem for physical damage insurance. In four States, including one which said there was no availability problem per se, insurance departments considered affordability to be the problem and they said that in this sense there may be an availability problem.

In only one State did the insurance department say that there was an availability problem, a problem attributed to subjective underwriting procedures by insurers and to deficiencies within the assigned risk plan. In this midwestern industrial State, the department reported receiving an increasing number of complaints regarding availability.

The various measures of availability are shown in table 32, which lists a relatively straightforward indicator of availability--the percentage of cars in the automobile insurance plan, and two other indicators that are less precise and more problematical. The first is the estimated percentage of uninsured cars in each State. Despite the existence of compulsory insurance laws in 25 States by 1978, it is generally acknowledged that a significant but unknown proportion of drivers do not have the required coverage. Indeed, only 13 of these States have any verification procedure. Because not having automobile insurance is a violation of the law, precise figures are impossible to come by.

The second indicator is the proportion of premium volume accounted for by "nonstandard" or high risk company. While the total premium volume of these companies is available in each State, this does not readily translate into number of cars insured. Therefore, for comparative purposes, we have provided the nonstandard premium volume as a percentage of total auto premium volume. Unfortunately, none of the fieldwork States knew how many cars were insured at higher than standard rates. Moreover, some States do not permit such nonstandard insurance or have State-set rates, permitting only downward deviations.

Adequacy and affordability of coverage

As indicated by some insurance commissioners, the question of availability goes beyond only offering some coverage to everyone; the question includes the adequacy of that coverage and the affordability of insurance.

Table 32

Measures of Insurance Availability

State	Percent of cars In AIP a/ 1977	Uninsured a/ 1976	Percent of premium volume in nonstandard companies 1977
Alabama	.48	32.2	10.3
Alaska	3.3	23.9	17.3
Arizona	.1	12.0 (27-33%) b/	14.4
Arkansas	.6	3.8	10.5
California	2.4	16.8 (20-30%) b/	11.1
Colorado	.1	9.3	15.1
Connecticut	4.6	20.2 (7.9%) b/	0.8
Delaware	7.3	.8	3.1
D.C.	2.0	37.8	16.4
Florida	9.3	17.4	7.9
Georgia	3.9	9.9	14.0
Hawaii	2.1	5.8	14.6
Idaho	.1	21.9	9.8
Illinois	.7	11.8 (10%) b/	10.0
Indiana	.1	8.6 (8-9%) b/	6.1
Iowa	.1	1.9	8.4
Kansas	2.1	0 (5%) b/	8.7
Kentucky	.9	15.2	9.6
Louisiana	4.4	27.4	7.2
Maine	2.4	15.9	5.2
Maryland	5.7	9.5	7.7
Massachusetts	18.8	13.4	0.1
Michigan	2.7	10.2 (4-5%) b/	7.1
Minnesota	.7	2.4	8.0
Mississippi	2.0	23.3	7.2
Missouri	1.0	2.1	6.9
Montana	.1	3.6	12.3
Nebraska	.1	3.4	8.8
Nevada	.2	12.4	22.3
New Hampshire	8.3	10.1	0.1
New Jersey	18.7	16.4	0.8
New Mexico	.1	19.1	11.5
New York	9.4	15.0 (6-12%) b/	1.1
North Carolina	16.2	3.6	4.0
North Dakota	.2	0	11.6
Ohio	.1	26.3 (15%) b/	7.3
Oklahoma	.2	7.6	12.6
Oregon	.3	12.8	15.2
Pennsylvania	4.2	24.5	2.9
Rhode Island	4.0	26.8	0.8
South Carolina	N/A	8.9 (10-15%) b/	1.0
South Dakota	.1	0	9.6
Tennessee	2.3	18.5	8.3
Texas	3.1	22.2 (29%) b/	16.4
Utah	.03	2.4	12.2
Vermont	2.0	14.8	5.6
Virginia	7.2	12.5	6.7
Washington	1.7	9.2 (9-11%) b/	13.5
West Virginia	1.0	.5	9.4
Wisconsin	.2	7.3	9.0
Wyoming	.2	5.6	12.1
U.S.A.	4.07		8.4

Source: Insurance Information Institute, Automobile Insurance Plan Service Office

a/Based on the difference between automobile registration and automobiles insured.

b/1978 estimates of insurance departments.

In none of the States is the assigned risk plan a complete substitute for the voluntary market because the amount and type of coverage available from these plans may be limited. In recent years, however, assigned risk plan coverages have been expanded to bring them closer to those available in the voluntary market. 1/ By the end of 1977, only seven States did not have optional liability coverage of at least 25/50/10. Only six States did not have comprehensive and collision coverage offered through the automobile insurance plan. 2/

In those States where coverage is limited, motorists generally must turn to the substandard or high risk companies for coverage. For example, in North Carolina, the reinsurance facility does not include collision or comprehensive insurance, although the insurance department has been trying unsuccessfully to get legislation enacted to include physical damage coverage in the facility. Since these coverages are usually necessary to obtain financing for an automobile purchase, car buyers who are ceded to the reinsurance facility for liability coverage must turn to the substandard market for physical damage coverage. Because the substandard rates are higher than the maximum permitted rates, consumers seeking this insurance must sign a waiver (known as a consent to rate form) that allows the company to charge the consumer a higher rate.

Affordability is partly a subjective factor in that individuals differ in their perceptions of what goods and services they can afford. Nonetheless, if some motorists are charged significantly more for insurance than others and believe that they cannot afford the premiums they are being charged, there may be said to be an affordability problem. Whether or not these motorists should be charged higher premiums for the same coverage than others is an issue addressed in chapter 6. The issue to be considered in this section is the relationship between the residual market and affordability.

Although the automobile residual market plans are designed to provide coverage to everyone, they are not necessarily designed to offer coverage at the same rates. In our fieldwork States, we obtained the differences, if any, in rates between the voluntary market, the residual market plan,

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1/Finley Lee. Servicing the Shared Automobile Market, National Industry Committee on Automobile Insurance Plans, 1977, p. 21.

2/AIPSO Insurance Facts 1978, pp. 124-144.

and substandard companies. Table 33 shows the differences between the voluntary market rate, represented by the suggested ISO rate or State-set rate on the one hand, and the residual market plan rate and examples of a substandard company rate on the other. In eight of the States the residual market plan rate was at least 25 percent higher than the voluntary market.

Despite higher rates in most residual market plans, it should be noted that the plans are generally not self-sustaining, and suffer underwriting losses. These losses are made up by insurance companies' voluntary market business, and in this sense the voluntary market "subsidizes" the residual market. The difference between the underwriting ratios (the ratio of claims plus expenses to claims) in the voluntary market and the residual market as well as the effect of the residual market is shown on table 34. The plans lose money in most of the States. For example, 38 States had residual market plan underwriting losses in 1976, ranging from $0.38 per car in Nevada to $543.22 per car in North Dakota with a median loss of $45.35. 1/ Thus, the losses are not spread evenly. In terms of total underwriting loss, 95 percent of that loss was concentrated in 10 States as seen in table 35.

Given the level of losses in the residual market plans, the higher premiums charged in most plans are clearly warranted, the assigned risk plan population is viewed only as a group. Indeed, even those higher premiums are inadequate if the plans are to be self-sufficient.

Taken as a group, assigned risk plan drivers compile a worse record than those in the voluntary market. Heterogeneous groups, however, may mask considerable differences among individuals. We sought to determine who is subject to the adverse underwriting decision that leads to assigned risk plan placement and to determine what protection the individual has against unwarranted rejection from the voluntary insurance market.

In the aggregate, the number of cars placed in residual market plans depends largely on the health of the voluntary market--particularly on whether rates are perceived by insurers as adequate for that market. (In New Jersey, for example,

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1/National Industry Committee on Automobile Insurance Plans, Circular NIC 78-47.

Table 33

Rate Comparison for 1978 Standard Performance Compact Car

State	Adult male, pleasure use			Eighteen year old, commuting to work		
	ISO	Automobile insurance plan	Sub-standard a/	ISO	Automobile insurance plan	Sub-standard a/
Arizona (Phoenix)	382	721 b/	669	1,356	$2,235 b/	1,098
California (Los Angeles)	429	503	813 c/	1,523	962	1,446 c/
Connecticut (Hartford)	450	440	N/A	-	N/A	N/A
Illinois (Central Chicago)	684 Aetna	742	810	2,428	2,547	2,261
Indiana (Indian apolis)	355	465 b/	1,0007 c/	1,189	874	2,405
Kansas (Wichita)	268	324	648 c/	951	709	1,230 c/
Massachusetts	-	-	-	-	-	-
Michigan (Detroit)	466	815 b/	1,007 c/	1,654	2,521 b/	2,344
New Jersey (Newark)	651	700 b/	No substandard	2,311	N/A	N/A
New York (Brooklyn)	700	1,225 b/	861	2,485	2,379	2,389
North Carolina (Charlotte)						
liability	79	87	-	87	96	None
P.D.	98	-	540	98	None	540
Ohio (Cleveland)	599	864 b/	1,235 c/	2,126	2,503	2,485
South Carolina (Charleston)	234	234	None	830	830	-
Texas (Harris County)	-	140	662 c/	-	384 b/	1,407
Virginia (Richmond)	300	510 b/	298	-	1,271	758
Washington (Seattle)	323	405 b/	602 c/	1,065	1,067	1,085
Wisconsin (Milwaukee)	-	293	292	-	844	672

a/Mean rate of two leading substandard insurers in the State.

b/AIP Rate exceeds voluntary by at least 25 percent.

c/Substandard exceeds AIP by at least 20 percent.

Source: ISO and data provided by State insurance departments.

virtually all youthful drivers are placed in the assigned risk plan.) One recurrent issue is the number of "clean risks" placed in residual market plans. A clean risk for automobile insurance is usually defined as a driver who has had no accidents or moving violations for the previous 3 years. Insurers believe that a clean risk is not necessarily a good risk. Because accidents are such rare occurrences for individual drivers, insurers claim that a person can be free of accidents for 3 years and still have a relatively high likelihood of future loss. From the perspective of the individual, however, this adverse underwriting decision in the face of a clean driving record appears to be unfair--particularly if the individual then has to pay higher premiums and has available only limited coverage. Individuals who are safe drivers may be unable to get voluntary market coverage for a variety of reasons including redlining, the desire of insurers to reduce their total exposure in a particular State, and subjective underwriting.

We sought to determine the number of clean risks in the residual market plans of the States where we did fieldwork. In 10 States, the insurance department did not have any information on the number of clean risks in the residual market plan, but in three of those 10 there was no reason for the department to collect information because there was no adverse affect on the individual. For the remaining States, the number of clean risks in the plan ranged from 10 percent to 79 percent. (See table 36.) As can be seen, the greater the proportion of cars in the residual market plan, the larger is the number of clean risks in the plan.

Table 34

Automobile Insurance - Underwriting Ratios

Year	Industry underwriting	Auto insurance plans underwriting	Voluntary market underwriting	Effect of auto plans on industry underwriting
1968	102.98	135.16	102.28	0.70 pts.
1969	105.69	139.37	104.96	0.73 pts.
1970	102.91	132.86	102.17	0.74 pts.
1971	95.93	121.07	95.15	0.78 pts.
1972	95.69	116.61	94.95	0.74 pts.
1973	99.49	120.46	98.84	0.65 pts.
1974	102.56	122.87	101.98	0.58 pts.
1975	109.58	161.97	107.96	1.62 pts.
1976	105.51	150.18	103.81	1.70 pts.
Total	102.45	134.78	101.47	0.98 pts.

Source: Alliance of American Insurers.

Table 35

Concentration of Residual Market Losses

State	1976 auto residual market losses
New Jersey	$ -98,043,361
Massachusetts	-93,696,160
New York	-81,919,092
Florida	-57,502,567
South Carolina	-30,758,969
North Carolina	-25,760,222
California	-12,686,701
Pennsylvania	-7,899,685
Michigan	-6,879,605
Virginia	-5,847,862
Total 10 States	$-420,994,224
National Total	$-442,270,199

Source: Alliance of American Insurers.

Table 36

Clean Risks in the Residual Market Plan

State	Percentage cars in plan 1977 a/	Percentage of clean risks in plan 1976 - 1977
Indiana	0.10	10 b/
Ohio	0.14	10 b/
Michigan	2.65	30 b/
Texas	3.11	38
Connecticut	4.6	51
New York	9.4	70
New Jersey	18.68	79

a/Insurance Facts, 1978.

b/Department estimates.

CONSUMER RIGHTS

Insurers maintain that assignments to the residual market plan are based on the adequacy of rates for the proposed risk and on sound underwriting judgment. This is supported by data showing that the losses of drivers with surcharges or less than 3 years' driving experience are only about 10 percent higher than clean risks. Presumably, underwriting judgment has identified those clean risks that are, nonetheless, high risks.

Regardless of the justification for rejecting some insureds from the voluntary market, in many States the individual who is rejected suffers adverse consequences. We sought to determine insurance department policies and consumer rights with regard to nonrenewals, cancellations, and other denials of coverage in the voluntary market.

Protection against adverse underwriting decisions

The laws of all 17 fieldwork States protect consumers against cancellation during the policy period by specifying narrow grounds on which insurance may be cancelled. Typically, the only grounds for cancellation are nonpayment of premium and suspension or revocation of drivers license. A few States have provisions allowing cancellation for drunk driving convictions, conviction for car theft, and fraud or misrepresentation in the policy application. None of these States had cancellation provisions that impaired legitimate

consumer rights, once the policy has been in force for 2 or 3 months. The big exception is that 43 States allow a free underwriting period during which time an insurance company may cancel a policy for any reason. The unrestricted period is 60 days in 38 States, up to 90 days in 3 States, and 2 States have no laws protecting consumers against cancellation at any time. This practice is defended on the grounds that if insurers are to insure people immediately, they need to give themselves the protection of a "free look." While this situation is very convenient for insurance companies, there is little justification for such an open-ended grant of arbitrary discretion to insurers. Hawaii, Massachusetts, New Hampshire, North Carolina, and South Carolina are the only States that do not allow a free underwriting period. The present provisions in most States allowing cancellation for nonpayment and revocation of license could be augmented with a provision allowing cancellation for misrepresentation by the insurance applicant. Even if companies have good reasons for not wanting to be bound by their agents, a 60-day unrestricted free cancellation period without restriction puts consumers in an uncertain situation for an excessively long time. By contrast, the District of Columbia allows only a 30-day free underwriting period. 1/

The provisions governing nonrenewal are generally less restrictive than those governing cancellation, and insurers are allowed a wider latitude for nonrenewal. All States and the District of Columbia require advance notice of nonrenewal ranging from 10 to 60 days, with 30 days the typical notice required.

Consumers' right to be informed

Denial of first-time application for coverage, nonrenewals, and cancellations are adverse underwriting decisions. In many cases, they are based on broad marketing decisions and may represent an insurer's desire to retrench. However, adverse underwriting decisions may also be based on a perception of the individual as an undesirable risk. When that happens, the adverse underwriting decision is analogous to other adverse financial decisions such as the denial of credit, and consumers should be told the reasons behind these adverse decisions.

1/National figures from Alliance of American Insurers, Compendium of Insurance Charts, chart dated January 1978.

The Privacy Protection Study Commission, established by the Privacy Act of 1974, dealt extensively with personal data collection and its use in the insurance industry. The Commission recommended that insurance companies should inform applicants about the reasons for adverse underwriting decisions and to allow individuals to review, request correction, and dispute the information the insurer has about them. The Commission suggested that the Federal Government and State insurance departments implement its recommendations. The NAIC is now drafting model legislation. We sought to determine what policies were currently being pursued by the States in regard to citizens' privacy rights.

We found that as of the fall of 1978, not only are individuals not told why their applications are rejected, but State insurance departments also do not ascertain why individuals are rejected from voluntary market companies. None of the States in which we did fieldwork knew why individuals are placed in the assigned risk plan. The Virginia insurance department, however, has participated in a study of the characteristics of people in the assigned risk plan.

Among our fieldwork States, Massachusetts, North Carolina, and South Carolina require companies to accept all risks and then cede unwanted risks to the reinsurance facility. Consumers do not even know they have been ceded because there is no formal rejection of the consumer by the company. However, in North Carolina consumers are informed that they have been ceded and why. The question of consumer rights to information is relevant in the other 14 States, however. Of these, only three, California, Wisconsin, and Virginia require insurance companies to provide the reasons for rejection, and then only on written request by the consumer. The remaining 11 have no requirement.

One insurance department official justified the lack of an information requirement by observing that the release of the specific reason for rejecting an application might leave a company liable to a lawsuit. However, it is precisely because the lack of an information requirement protects the insurance industry rather than the individual that makes compulsory disclosure necessary. Since assignment to the assigned risk plan in most States carries adverse consequences, we believe that all States should protect the rights of their citizens by requiring that the reasons behind adverse underwriting decisions be disclosed.

The protection provided by State law is somewhat better in requiring the reasons behind cancellations and nonrenewals. Nearly all States require companies to give the reasons for cancellation. A survey of the law of all States shows that 16 jurisdictions require that the reason for cancellation be provided together with the cancellation notice. Twenty-eight States have the less satisfactory requirement that the reasons for cancellation be given upon the request of the insured.

Fewer States protect consumers rights with regard to nonrenewal. Fifteen require that the reasons accompany the nonrenewal notice. Fourteen States require that the reasons for nonrenewal be given at the request of the insured. The remaining 21 States and the District of Columbia have no statute stipulating that the reasons for nonrenewal be disclosed.

Although we did not survey insurance company programs in this area, it should be noted that one company, Aetna Life and Casualty Company, has voluntarily begun informing policyholders and applicants of any reasons for adverse underwriting decisions affecting them. Aetna announced that it will also provide the source of negative information affecting an applicant and provide the applicant an opportunity to dispute that information.

Particularly because the denial of insurance may make it more difficult to get insurance in the future, consumers should be informed of the reasons behind that denial. Nor is it sufficient to wait for a written request from the consumer--a requirement that places the burden of action upon the consumer. Since insurers presumably have specific reasons for denying insurance to an individual, they should not incur any substantial burden by being required to state those reasons to the individual at the time the decision is communicated.

Another major problem of consumer information is the relationship between the residual market plan and the substandard market. In seven of the fieldwork States, the rate in the substandard market was at least 20 percent higher than the residual market plan rate. Since these automobile insurance plans are designed for those who are refused coverage in the voluntary market at standard rates, it is difficult to understand why consumers would pay far more when they could get adequate coverage at far lower rates in the assigned risk plan.

One possible reason might be the stigma attached to having been ceded to the assigned risk plan. However, a recent study found that most consumers in the plans did not consider themselves stigmatized. 1/

A more plausible explanation was offered by an executive of a State automobile insurance plan who we interviewed:

> "In my opinion the reason why the substandard market exists is, simple enough, the agent. Most people know little if anything about insurance. The agent is critical in providing 'market knowledge.' There are two reasons why an agent may pick a higher cost substandard company over [the automobile insurance plan]. First he may be more familiar with the substandard companies policies and practices * * *. Secondly, there is, a matter of fact, a higher agent's commission associated with the higher premiums of substandard insurance * * *."

This executive did not, however, believe that the substandard market was useless. He noted that the substandard companies insure the "absolute dregs" of the driving population, people who are even worse risks than those insured by the assigned risk plan. He asserted that if the assigned risk plan were the only alternative to the voluntary market, assigned risk plan rates would probably have to be increased.

Consigning the worst risks to companies that charge even higher rates than the assigned risk plan might be equitable if those who were so assigned were indeed much worse risks. However, there is no evidence that this is so. Such individuals may or may not be the "dregs" of the market, and there is no data gathered by insurance departments to find out. Moreover, regardless of their loss potential, serious questions must be raised about their inability to avail themselves of a State-mandated program to provide them insurance at a lower cost than they end up paying.

1/ J. Finley Lee, Servicing the Shared Automobile Insurance Market, Executive Report, National Industry Committee, 1977, p. 42.

In those States with reinsurance facilities, there is no problem of this sort because consumers pay rates at or close to the standard rate with any company they choose. In other States, however, we found that most insurance departments do not make sure that consumers rejected from the voluntary market are fully informed about the alternative automobile insurance plan. A remedy would be to require that such information accompany the notification of rejection from the voluntary market.

SUMMARY AND CONCLUSIONS

Despite the many allegations of redlining and other unfair discriminatory practices, most insurance departments have not investigated the problem nor do they collect the necessary data to monitor insurance availability.

Availability, as measured by the proportion of cars in the residual market, is not a problem in most States. Some observers, however, note that a large proportion of drivers in the substandard market and the large number of uninsured drivers indicate a very real availability problem in terms of getting insurance at standard rates in the voluntary market. At a minimum level, all drivers can get some coverage in a market of last resort. While it may be argued that high-risk drivers should be consigned to the assigned risk plan or substandard market, the problem is that perfectly innocent low-risk drivers may also be denied coverage in the voluntary market. State insurance departments do not determine why individuals are denied voluntary market coverage or whether such denials constitute unfair discrimination. Moreover, other States do not have laws or department programs to inform consumers about adverse underwriting decisions affecting them and what their rights are. We found that in some States this situation gives rise to a serious problem related to availability. Not only do consumers in most automobile insurance plans pay higher premiums, but in some States we found that premiums in the substandard market are substantially higher than those available in the assigned risk plan. State insurance departments should protect consumer interests by monitoring the reasons that the consumers are denied coverage in the voluntary market, and ensuring that customers are informed of their options in the assigned risk plan.

CHAPTER 8

ORGANIZATIONAL ISSUES

The business of insurance is under a unique regulatory system. It is the only major interstate financial industry that is regulated primarily by the States. In contrast, the securities industry is under Federal regulation and the banking industry is under both Federal and State regulation. Moreover, because of the McCarran-Ferguson Act, the Federal Government is precluded from exercising antitrust and trade practice jurisdiction that would normally apply to businesses in interstate commerce.

Although there apparently was little question in the Congress about the desirability of the continued primacy of State regulation when the McCarran-Ferguson Act was passed, questions have been raised in the Congress and by consumer groups about the adequacy of State regulation, and suggestions have been made that Federal regulation or standards would be preferable in some areas. Discussions with insurance industry representatives and insurance commissioners reveal that the issue is widely perceived as a State versus Federal activity, and both the industry and the State regulators have opposed any expansion of Federal regulatory activity over the business of insurance.

While the organizational issues are more complex than suggested by the simple dichotomy of State versus Federal regulation, the claim of regulators and the industry that State regulation is superior is central to the current discussion of many insurance issues. The claimed advantages of State regulation and our findings with respect to those claims are discussed in the next section. Subsequent sections discuss the role of the National Association of Insurance Commissioners, the alleged "revolving door" between the insurance industry and the State regulatory community, and other organizational and jurisdictional problems.

The claimed advantages of State regulation

Apart from the specific goals related to the protection of insurance consumers, it is clear that one underlying goal shared by State regulators and the insurance industry is to continue the almost exclusive role of the States in regulating insurance. They agree, too, that despite the variations in law, resources, and regulatory philosophy, needed uniformity can be provided by the NAIC. A typical sentiment, expressed to us by one insurance commissioner was:

"I do not feel that there should be any 'balance between Federal and State roles in regulating the insurance industry.' There is not a thing about regulating insurance that the Federal Government could do as well as, to say nothing of better than, the states are doing."

Several arguments are advanced about the superiority of State versus potential Federal regulation. First is the virtue of federalism. As the noted insurance authority Professor Spencer Kimball has written:

"The very basis of our Federal system is at issue. Decentralization and dispersion of political power is in itself an important value in a democratic society* * * Undue concentration of power in Washington is unwise from any point of view. Any problems that can be dealt with adequately at the state level should be handled there in preference to Washington." 1/

A second reason, cited by the NAIC, is simply that State regulation already exists, replete with experienced personnel administering regulatory systems in all 50 States. Any Federal system, in contrast, would have to start from scratch and would result in the creation of a new Federal agency. 2/

The third argument for State regulation is that, like federalism generally, the system promotes pluralism, experimentation, and vitality. The South Carolina Department of Insurance informed us that:

"The (Insurance) Commission believes that one of the fundamental strengths of coordinated state regulation is its ability to find solutions to the various regulatory problems of the Insurance Industry with the efforts, talents, and initiatives of the 50 Insurance Departments of these

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1/Spencer Kimball and Herbert Denenberg, Insurance, Government, and Social Policy (Irwin Dorsey, 1969).

2/"The Disadvantages of Federal Insurance Regulation as Highlighted by the Brooke Bill." Statement of Jon Hanson before the ABA Committee on Life Insurance Law, Health Insurance Law and Public Regulation of Insurance, January 13, 1977.

United States. This approach not only recognizes that problems differ from State-to-State for economic, philosophical, social, and political reasons but also fosters flexibility and innovation in the development and application of regulatory techniques. It permits experimentation on a limited basis to find the answers to problems which may ultimately require a great degree of uniformity."

A fourth argument is that State regulation is more responsive to the public and to unique local needs. Thus, the Maryland Division of Insurance remarked that:

"The chief advantage of regulation by the states is that each state attunes its regulation to the locally prevailing conditions and requirements. The problems existing in one state may differ considerably from those in another part of the country."

Inherent in the argument, of course, is the assumption that many or most insurance regulatory issues do differ by State.

There is, finally, a somewhat perverse rationale for State regulation. An NAIC spokesman stated:

"An extremely important and unique advantage to State regulation is that the threat of a national alternative always hangs over it. State insurance regulatory agencies are subject to review, investigation and embarrassment by Congress which admittedly has the power to abolish the system if it so chooses. * * *Such congressional oversight no doubt stimulates State regulators to do a better job." 1/

Analysis of the advantages of State regulation

Federalism

State regulation of insurance as a manifestation of federalism is clearly an important value and one that the Congress recognized when it passed the McCarran-Ferguson Act. The issue, however, is one of political philosophy and not necessarily an appropriate one for us to analyze. It is, of

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1/Ibid.

course, up to the Congress to determine whether the circumstances of insurance regulation continue to be such that the value of decentralization of Government authority outweighs other policy goals. We only note that the importance of federalism has not stopped the Congress from asserting Federal authority when there was a need for uniformity or for the protection of citizens' rights.

State regulation already exists

One former regulator told us that this was the only advantage of State regulation. There is no doubt that there is in place a complex and extensive system of State regulation. Our review found that although most insurance departments were short or devoid of such expert personnel as actuaries, the senior staff of the departments had many years' experience. We did not evaluate the costs or other problems associated with a major transfer of regulatory authority to the Federal Government. We note, however, that there is nothing inconsistent about the advantageous existence of State regulation and various proposals to institute Federal standards that would be enforced by the States. State insurance departments are involved in regulating all phases of the insurance business. Therefore, Federal standards in any particular area would probably not necessitate the addition of a new administrative burden on the States.

Pluralism and innovation

One advantage of federalism is the potential for greater innovation that exists when many units of Government exercise authority instead of authority residing in a single central Government. This potential benefit is clearly realized in insurance regulation, although there is no way of knowing whether greater innovation would be possible (or desirable) under a centralized system.

Perhaps the most prominent example of recent State innovation, although one opposed by the insurance industry, is the prohibition of the use of age and other classification factors by Massachusetts and North Carolina. Their challenge to conventional systems of risk classification has prompted national debate on a system of pricing that had not been critically analyzed before. Other States, and the Congress, have subsequently held hearings and commissioned further studies on this important issue.

Other notable examples of innovation among State insurance departments include the efforts of the California

Insurance Commissioner to obtain an agent commission rate that was more equitable to consumers in the assigned risk plan and other higher priced categories, and the efforts of former Wisconsin Commissioner Harold Wilde to institute higher standards for supplemental health insurance and for life insurance cost disclosure requirements.

While having separate insurance authority in all the States leads to innovation in regulatory approach, the system of regulation in some States actually has retarded the introduction of new insurance products and marketing techniques. For example, reflecting the opposition of some segments of the insurance industry, many States prohibited companies from offering multiline insurance policies such as homeowners insurance, which combined both fire and casualty insurance in a single policy with a single premium. It was not until 1955 that the last State (Ohio), lifted its prohibition of multiple line companies.

Several insurance companies have indicated that they are less likely to introduce innovations such as good student auto insurance discounts in States with what they regard as very restrictive regulation. This reluctance is due to the fear that they would be locked into the innovation even if it proved to be a failure.

Threat of Federal regulation

It is difficult to assess whether particular State actions were taken because of a fear of further Federal involvement or whether these actions would have occurred anyway. Even if the States are impelled to act in order to stave off Federal involvement, however, the results are not necessarily beneficial to consumers. For example, the life insurance industry has been urging States to enact the NAIC model statute on life insurance cost disclosure, a move that would effectively preempt action by the Federal Trade Commission. Critics of the NAIC model, however, assert that the FTC proposed method of life insurance cost disclosure would be much more useful to consumers.

Moreover, when the North Carolina legislature overturned the State insurance department's regulation on life insurance cost disclosure and substituted the NAIC model, proponents of the NAIC model denounced the department's action as resulting from "an intrusion by the Federal Government into the area of insurance regulation." This characterization presumably resulted from the fact that Federal Trade Commission witnesses had previously testified at the department's administrative hearings.

Similarly, a representative of State Farm Life Insurance Company warned that some of the proposals of the Privacy Protection Study Commission in 1977 posed threats to life and health insurers because the proposals called for the Federal Trade Commission to specify requirements for recordkeeping and for disclosing reasons for adverse underwriting decisions. The State Farm representative warned that the FTC might "attempt to control adverse underwriting by specifying what conditions could be considered and how they could be considered."1/ He urged industry support for the NAIC model statute as a way of averting more drastic Federal legislative proposals.

It therefore does appear that the fear of FTC and other Federal actions has been the impetus behind enactment of some life insurance cost disclosure and some privacy protection legislation, but not necessarily the proposals that are in the consumer's best interests.

Responsiveness to local needs

Considerable evidence shows that State insurance departments respond to the unique insurance needs within their State. For example, an investigation by the Connecticut Insurance Department confirmed complaints of unfairly discriminatory territorial rating in Hartford. The California Insurance Department participated in an investigation of illegal title insurance kick-backs which resulted in heavy fines being levied against title insurance companies.

However, in the course of our study it also became apparent that many insurance problems were not congruent with State boundaries, and State insurance departments have no unique advantages in dealing with such problems. For example, the availability problems of property insurance are characteristic of many older urban areas, while farm areas have other insurance needs. Cities like Chicago and New York probably have more insurance problems in common than they do with the rural areas within their own States. While State insurance departments may be uniquely knowledgeable about the problems of large cities within their jurisdiction, these problems are not unique to any State, but rather are rooted in demographic

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1/The Journal of Commerce and Commercial, May 29, 1979, p. 8.

and economic situations common to many cities across State boundaries. Moreover, with regard to the problem of redlining, most State insurance departments do not have adequate procedures for learning about the extent of alleged unfair discrimination.

Although the States have the sole regulatory authority over most aspects of insurance business, for some lines of insurance State departments have only national and not State data about the appropriateness of rates. For example, there have been many problems with supplemental health insurance such as Medicare supplement ("Medigap") and cancer insurance. In particular, actuarial work done by us showed that some companies have very low loss ratios (i.e., the proportion of premiums returned to policyholders in the form of claims payments). For example, two companies had Medigap policy loss ratios of 35 percent and 40 percent. Among five companies whose cancer insurance policies were examined, none had a loss ratio of greater than 55 percent and the payouts were as low as 19 percent for one company and 13 percent for one type of policy offered by that company. Despite evidence of these problems, only one of our fieldwork States, New Jersey, had compiled data on the loss experience of "Medigap" insurance. Additionally, New York maintained loss ratios for companies whose business was almost exclusively in those sublines. Both these States do not allow the sale of cancer insurance. Other States did not have ratios for their States or even national loss ratios for these sublines.

The loss ratios may be largely the same from State to State or they may be different due to differences in State law, demographic factors, claims handling procedures, or other factors. State insurance departments, however, do not know whether their State experience is different. Thus, if there are factors unique to the State that cause its citizens to be disadvantaged by supplemental health policies, the insurance departments are not able to respond to those problems.

Are there problems of diversity?

For all the benefits derived from a diverse and decentralized regulatory system, there may also be substantial costs attached to that diversity, as insurers are faced with 50 sets of State insurance codes, many of which are similar but not identical. Consequently, we asked insurance industry representatives if the necessity of dealing with 50 State insurance departments presented a substantial regulatory burden. Company officials agreed on the following points.

First, dealing with multiple jurisdictions does not impose substantial costs. Rate filings would have to be calculated on a localized basis in any case. No company official believed that the administrative process of complying with different regulations in different States imposed significant costs on the companies. Second, the problems of diversity were not due to a lack of uniformity, but to the actions of a few States regarded as "problem States" by most of the property-casualty industry. Finally, most thought that in areas where a lack of uniformity would have caused problems, such as financial reporting and examination, there was sufficient uniformity.

We note that insurance companies' attitudes toward the relative virtues of uniformity and diversity are frequently colored by the belief that greater uniformity would only be achieved at the expense of greater involvement by the Federal Government in insurance regulation. Whatever benefits may be obtained by this uniformity are viewed as not being worth the cost. When asked about the desirability of greater uniformity, one insurance company official remarked, "Would you rather be regulated by 50 monkeys or King Kong?"

Although insurance companies may not incur any significant increase in costs from regulatory diversity, the system may be wasteful in duplicating activities in which there are substantial economies of scale. For example, as noted in chapter 3, most insurance departments process a similar number of policy forms. If these policy forms receive any degree of regulatory scrutiny, it is wasteful to analyze them separately in each State. To the extent the forms are standardized, it is even more wasteful to review them at the individual State level.

The need for Federal Government action

Although many commissioners and industry officials view Federal involvement in insurance matters as unwarranted interference, some commissioners suggested that the Federal Government could make a positive contribution to the resolution of particular insurance problems.

For example, the New York Insurance Superintendent suggested a variety of Federal actions that he believed would reduce automobile insurance claims costs and thereby lower insurance premiums. These included requiring airbags, more stringent crashworthiness standards, and a far greater Federal effort to deal with the interstate and international trafficking in stolen cars and car parts.

The New Jersey Insurance Commissioner stated that he is totally opposed to Federal regulation of insurance, but proposed that a useful Federal role would be to collect, audit, and analyze the loss data used by insurers to prepare their rate filings. He indicated great distrust of the validity of this data as presented to the State insurance departments, but indicated that a lack of resources in his and other departments prevented the performance of necessary audits.

The former commissioner in Massachusetts suggested that it would be appropriate for the Federal Government to assume the regulation of the solvency aspects of insurance companies.

The former Wisconsin commissioner suggested a variety of ways in which the Federal Government could assist State insurance departments to perform more effectively. These include financial grants similar to the Law Enforcement Assistance Administration program, technical assistance by Federal actuaries and other experts, seminars, staff exchange programs, and other ways to tap the resources of the Federal Government. He also suggested the possible need for Federal standard setting for health insurance policies and no-fault automobile insurance, and in other areas where NAIC model laws have not accomplished the goal of necessary uniformity.

The view that the Federal Government might provide functions useful to State regulators, insurance companies, and consumers is decidedly a minority view. Our questionnaire to insurance departments asked commissioners to suggest the proper balance between Federal and State roles in regulating insurance. Only the commissioners of Wisconsin and Pennsylvania suggested any constructive Federal role, while both desired the continued primacy of State regulation.

To a substantial extent, the need for uniformity, cooperation, and joint action in dealing with a major interstate commerce industry is satisfied by the National Association of Insurance Commissioners, whose role is discussed in the following section.

THE ROLE OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The National Association of Insurance Commissioners (NAIC) consists of the heads of the insurance departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. NAIC's basic purpose is to provide necessary uniformity, cooperation, and expertise to the various States and territories as they individually regulate the

business of insurance. While the NAIC has no legal regulatory authority, it is an inherent and significant part of the system by which the business of insurance is regulated. The primary functions of the NAIC are to

--draft model laws and regulations for voluntary adoption by the States;

--gather and distribute information on regulatory matters, such as license revocations and securities valuations;

--maintain computerized financial data aimed at early detection of insurer insolvency; and

--conduct studies of nationally significant insurance issues.

The recommendations of the NAIC are the result of the work of committees, subcommittees, and task forces staffed by State commissioners and insurance department personnel. A more detailed description of its functions, supplied by the NAIC, appears in appendix II.

Despite its regulatory importance, the NAIC is not a large organization. Executive and administrative functions are performed by a relatively small staff in the central office in Milwaukee. The NAIC's expenditures for fiscal year 1978 were $842,790--an amount that was exceeded by most State insurance departments. Of that amount, $403,000 was for salaries. These resources are substantially bolstered by the work performed by State insurance commissioners and their staffs. For the 13 States able to provide the information, the average amount of the time devoted to NAIC activities was 113 staff days, or about one-half of one staff year. Interestingly, there was little relation between the size of a State and the amount of time the department devoted to NAIC activities. A smaller number of departments were able to break down the time spent into two categories: subcommittee and task force work occupied about 59 percent of the time, while attending national and regional meetings occupied 41 percent of the time. The States also support the NAIC financially through assessments that constitute about half the NAIC's budget.

We did not evaluate the effectiveness of the NAIC, but we did ask State insurance departments to indicate the assistance they received from the Association. Nearly all States listed the financial reporting and valuation services.

Many other States indicated that the NAIC was useful as a forum for the interchange of information on specific problems and general topics. Only two States indicated they received no significant assistance from the NAIC.

While many insurance departments cited the information clearing house role of the NAIC, we found that the organization had little of the information that we sought on the resources and activities of the State insurance departments. In particular, the NAIC does not know how many States have adopted their model laws and regulations, which are published commercially in cooperation with the NAIC. But for many model laws, there is no information on insurance statutes and regulations except in the publications of insurance trade associations. Whatever its services to the States, the NAIC cannot be relied upon as a major source of information about insurance regulatory activities.

Nonetheless the NAIC is clearly essential to the individual State systems that regulate companies in interstate (and international) commerce. Particularly for financial regulation, it is essential that an organization like the NAIC provide a uniform reporting format, uniform valuation of securities, and a coordinated examination system.

INDEPENDENCE OF INSURANCE REGULATORS

In any regulatory setting, it is important that regulators be impartial and responsive to broad public interests. Nonetheless, one of the most common and longstanding criticisms of regulatory agencies is that they are overly responsive to the very industries they regulate, even to the extent of being "captured" by them. While these criticisms generally apply to Federal regulatory agencies, the same have been leveled at State insurance regulators, who are charged with being responsive primarily to the insurance industry rather than consumers. There is not necessarily a constant tension between the well-being of the insurance industry and the well-being of consumers. The ultimate promise of an insurance contract hinges on the financial health of insurance companies. The industry's welfare, however, does not require that its interests be placed above those of consumers who should be represented by regulators. It is not the purpose of this study to examine in great depth the question of regulatory independence from industry. Rather, we reviewed two issues of regulatory independence that are suggestive of this issue's broader complexities: (1) the question of "revolving door" regulatory appointments, (2) the independence of the NAIC from the insurance industry.

A revolving door between the insurance commission and the industry?

Critics charge that a major example of industry dominance of insurance departments is the "revolving door" appointment, whereby insurance regulators are chosen from the insurance industry and then return to it after short terms of service. Under such circumstances, regulators' points of view may be formed by their industry background and their judgment may be shaped by the anticipation that they will be returning to the industry. Another common problem, as demonstrated by a recent study of Federal regulators, is the lack of relevant background and qualifications for a regulatory position. 1/ In insurance regulation, as in other areas, a special knowledge is necessary, and it is often difficult to find well-qualified candidates who possess this knowledge and who have not worked for the regulated industry. Despite the need for knowledgeable and experienced people, relying predominately on regulators whose career are tied to the regulated industry certainly diminishes the appearance of impartiality and probably diminishes regulatory independence.

Is it true, as frequently alleged, that most State insurance commissioners are revolving door appointments? In 23 States, or half the ones for which we have information, the commissioner had previous employment experience in the insurance industry, either with an insurance company, an insurance agency, or as an insurance attorney. In contrast, in 17 States, the commissioner had previous experience in the insurance department. In only nine States did the commissioner have only an insurance industry background; in the others the commissioner most frequently had previous insurance department experience.

Table 37 shows the employment history of incumbent insurance commissioners, and includes all previous jobs. The most frequently cited background is previous insurance department employment.

Although we cannot say that most commissioners come from the industry, about half of them do have industry backgrounds, and the number has increased since the O'Mahoney study data in 1959, as seen in table 38.

1/U.S. Senate, Committee on Government Operations, Study on Federal Regulation, vol. I, The Regulatory Appointments Process, 95th Cong., 1st sess. (1977).

Table 37

Employment History of Incumbent Commissioners (1978)

Professional background	Number of States	Percent of commissioners responding
Previous insurance department employee	17	37
Insurance company executive	16	35
Insurance agent or broker	10	22
Attorney - insurance	9	20
Attorney - other	12	26
State or local government employee or official	13	28
Academe	3	7
Other	15	33
Total	95	a/

a/Exceeds 100 percent as more than one category can be checked.

Table 38

Employment History of Incumbent Commissioners (1959)

Professional background	Number	Percent
Insurance industry	15	24
Insurance department	12	19
Other (non-insurance)	35	56
Total	62	99

Source: S. Report 1834, p. 132.

The figure reported for 1959 (19 percent) does not include individuals who had worked in the insurance department at one time but became commissioner while working in the industry. The figures for 1978 in table 36 do include these individuals and thus the increase in department experience may be overstated slightly.

Our information supports the O'Mahoney report's finding that more commissioners are chosen from the regulated industry than from the ranks of the insurance department. Further, the number of commissioners that have had previous experience in both the industry and the department (10 or 22 percent) reflects the flow of personnel between the regulators and the regulated industry.

Data on previous commissioners is incomplete, but confirms the trend of an increase in the number of insurance commissioners coming directly from industry (43 percent). The number chosen from insurance departments is stable at 19 percent in comparison with the O'Mahoney data. Table 39 also shows that the insurance industry is the most likely employment for commissioners leaving the department. The highest single category is insurance company (28 percent) and employment by a company, agency or association accounts for 34 percent of employment after being commissioner. If employment in law firms were added, the percentage of those who are in a position to use their former position as commissioner to assist the insurance industry rises to 44 percent. The other important single category is public office: 20 percent of former commissioners enter higher public office after leaving the insurance department. These opportunities could encourage commissioners to leave regulation and thus lead to shorter tenure in office.

Is the NAIC sufficiently independent?

Some critics of State regulation allege that the National Association of Insurance Commissioners is, on balance, oriented toward the welfare of the insurance industry and is heavily dependent on the industry. Indeed, some regulators have even expressed that view. New Jersey Insurance Commissioner James J. Sheeran blasted the NAIC as nothing but an "industry association," not concerned with the welfare of consumers. In particular, two manifestations of this alleged lack of independence are frequently cited.

First, it is charged that the industry dominates the advisory committees to the various committees and task forces that study insurance issues and help formulate NAIC model

Table 39

Employment History of Previous Commissioners

Employing institution	Before		After	
Insurance department	4	(19%)	3	(7%)
Insurance company	6	(29%)	11	(27%)
Insurance agency	0	(0%)	1	(3%)
Insurance association	0	(0%)	1	(10%)
Law firm	3	(14%)	4	(10%)
Public office	5	(24%)	8	(20%)
Academe	2	(10%)	2	(5%)
Other	1	(5%)	4	(10%)
Retired	N/A	N/A	4	(10%)
Deceased	N/A	N/A	2	(5%)
Total	2	(101%) a/	40	(100%)

a/Does not add to 100 percent due to rounding.

laws and regulations. Indeed, until 1977 these groups were officially known as "industry advisory committees" whose membership, presumably, was exclusively composed of insurance industry representatives. The NAIC Consumer Participation Subcommittee confirmed that the NAIC did not include consumer participation in its proceedings. In 1977, the NAIC constitution was amended to read that in making appointments to advisory committees

> "* * * due consideration shall be given to including on the advisory committee representatives of those interests likely to be affected by action of the appointing body including the insurance industry, consumers, and those relying on the insurance." 1/

1/National Association of Insurance Commissioners, Proceedings, 1978, vol. I.

However, the NAIC Proceedings show that the amendment does not mandate consumer participation in advisory committees nor was it intended to. As one Commissioner said, "* * * this amendment doesn't mandate anything, it suggests, due consideration shall be given to including. We could consider such a committee and decide we shouldn't have it."

We requested a list of NAIC advisory committees and their compositon from NAIC, but the Executive Secretary of the NAIC reported that it did not have such a list. We subsequently found, however, that a number of advisory committees are listed in the NAIC Proceedings with their members and affiliations. Approximately 11 advisory committees have been convened since the change in the NAIC constitution. Of these, seven were composed exclusively of industry members. The total membership of these 11 committees was 114 from industry, four consumer representatives, two government agency employees, and two academics.

There are, however, serious constraints on the amount of effective consumer participation presently possible in NAIC proceedings. The lack of resources has been a major obstacle to public participation in regulatory proceedings generally, and insurance regulation is no exception. The travel and other costs incurred by consumer representatives are not paid, although reportedly efforts are made to meet in cities where the consumer representatives are headquartered. Similarly, the NAIC considered but did not adopt a proposal to fund consumer participation at NAIC meetings. Commissioner Kinder of California cited a lack of funds as the reason that the NAIC cannot defray the costs of consumer participation.

The change in the NAIC constitution and the NAIC's general awareness of the need for consumer participation are very recent developments. Therefore, the almost exclusive reliance on insurance industry for advisory committee members and other support may be changing. Nonetheless, nearly the entire body of NAIC model statutes and regulations was drafted under a process that apparently was devoid of any consumer participation.

Second, the NAIC meetings are generally numerically dominated by insurance companies. The semiannual meetings and most zone meetings find the regulators heavily outnumbered by insurance industry members, with very few representatives from other governmental bodies or consumer groups. Indeed, the registration fees from company representatives pay the administrative expenses of the meetings. (Insurance department representatives are not assessed any registration fee

but must pay their own transportation and lodging expenses.) At the semiannual meetings, many large insurance companies and trade associations maintain "hospitality suites" to provide refreshments to participants. Additionally, insurance commissioners and their spouses are taken out to meals and otherwise entertained by insurance industry representatives. In short, the official meetings of the NAIC are not characterized by an arms-length relationship between regulator and regulated industry.

Comments by the State insurance departments

Several insurance commissioners, in replying to an earlier draft of this report, objected to our discussion of the issue of regulatory independence. The letters of comment are excerpted in chapter 9 and presented in full in appendix VIII. In particular, several commissioners stated that our discussion of the revolving door issue impugns the integrity of commissioners who have been employed in the insurance industry. Some commissioners also objected to our treatment of the independence of the NAIC on the same grounds and also because they viewed participation by the industry as essential to the regulatory process.

We did not conclude that most commissioners are "revolving door" appointments, or that there is necessarily anything wrong with an individual working for an insurance department after having been employed by the insurance industry or taking a position in the industry after leaving the department. People with integrity act in ways they perceive to be in accord with the responsibilities of whatever position they hold. For the most part, the issue is not one of integrity, but judgment. Consumers do have some interests at odds with those of insurance companies and agents. Insurance industry officials may believe very sincerely that the programs they favor and the services they sell are already in the consumers' best interests. Nonetheless, there are other points of view and other interests at stake. A regulator with an industry background may quite innocently retain the industry perspective--a perspective that is not always at odds with the interests of consumers but certainly is on occasion. All we state is that a regulatory system should seek balance between the need for firsthand expertise and for regulatory independence.

Much the same comment applies to our treatment of NAIC independence. Again, the question is one of judgment and impartiality. What the U.S. Senate Governmental Affairs

Committee said about Federal regulatory agencies applies just as well to State regulatory agencies:

> "* * * we do not need to subscribe to the theory of regulatory "capture" in order to explain this tendency toward industry domination. Rather the reason appears to be simply in the fact that regulatory agencies respond to the inputs they receive--in the same fashion as any decisionmaking body." 1/

As noted by an earlier report to President Kennedy:

> "* * * it is the daily machine-gun like impact on both the agency and its staff of industry representation that makes for industry orientation on the part of many honest and capable agency members as well as agency staffs." 2/

CONCLUSION

While we found evidence for all the claimed advantages of State regulation, there were also cases where the advantages were not realized or where State regulation was counterproductive. In particular, the evidence is very mixed with regard to the purported greater responsiveness of State regulators to local needs. Many insurance problems are, in fact, not local problems. Even for local problems such as big city availability, many departments do not maintain the data necessary to address those problems. Most departments are also unable to respond to the special needs of the elderly with regard to supplemental health insurance. Only two of 17 departments were able to provide loss ratios, a rough measure of the value of policies, for health insurance policies aimed largely at the elderly.

1/U.S. Senate Committee on Governmental Affairs, Study on Federal Regulation, vol. III, Public Participation in Regulatory Agency Proceedings, 95th Cong., 1st sess. (1977) p. 2.

2/James M. Landis, Report on the Regulatory Agencies to the President-Elect, printed for the use of the Committee on the Judiciary, U.S. Senate, 86th Congress 2d sess. (1960), p. 70.

While the so-called "revolving door" problem may be overstated by critics of State regulation, there still is less than an arms-length relationship between the National Association of Insurance Commissioners and the insurance industry. Although the situation has changed somewhat in the last year, there is still a substantial imbalance in the proceedings of the NAIC. There is almost no consumer participation, but almost no limit to the extent of industry participation.

CHAPTER 9

COMMENTS FROM THE STATE INSURANCE DEPARTMENTS

We sent copies of an earlier draft of this report to the insurance commissioners in all the States in which we did fieldwork and to the National Association of Insurance Commissioners (NAIC). The NAIC told us that they would be unable to comment in the time we requested, but would do so later. We received comments from California, Connecticut, Illinois, Indiana, Kansas, New Jersey, and Ohio. Relevant portions of these comments and our responses, where appropriate, are presented on the pages that follow. Comments calling to our attention minor errors, which we have corrected, are not present.

The letters in their entirety are presented in appendix VII. Comments in these letters that are not responded to in this chapter have either been taken into account through revision or provide extra information about a State's activities that has not been addressed in this report.

LETTER FROM WESLEY J. KINDER INSURANCE COMMISSIONER, CALIFORNIA

* * * * *

"Chapter 3: You take passing recognition of the fact that '* * * larger states have far more domestic insurers than small states', but apparently overlook significance of domicile in the basic responsibility for solvency regulation. Perhaps tables 3 and/or 4 could be extended to show the number of insurers domiciled in each state. (You may have this information as suggested in chapter 4, page 2.) An additional factor here would be the number of domiciliary insurers writing in one or more additional states.

"Two factors which can add significantly to department expenditures are prior approval rate regulation and liquidation/rehabilitation costs. With respect to the latter, in many states such costs are borne by Guarantee Associations and are outside of department budgets. Comparisons by state are relatively meaningless without recognizing such differences."

* * * * *

"With respect to 'professional resources', the groups included as professionals may result in some distortion of the evaluation. For example, CPCU and CLU are indicative of a different professional standard than lawyers and actuaries. You have emphasized the importance of actuaries, and properly so; however, it is questionable that even the largest departments have need for more than one life actuary and one casualty actuary. Detail work can be done by non-professionals under the direction of the professional."

OUR REPLY

We agree that departments may have different expenditures based on their differing responsibilities, and we do not wish to imply that all departments have the same obligations. We have included information on the number of domestic companies relative to the departments' budgets, but other information, such as liquidation/rehabilitation costs is not available to us for all States.

We fully agree that the categories of lawyers and actuaries reflect different professional standards than CLU and CPCU. We included these latter categories so that insurance departments could state their professional staff mix as completely as possible. The need for actuaries would depend on the number of separate rate filings that require prior approval or are subject to disapproval. We agree that rate analysts can do a good deal of detailed work under the supervision of a trained actuary, but we doubt whether only one life and one casualty actuary would be sufficient if insurance departments were to attempt original actuarial analysis of rate filings, analysis of classification plans, analysis of the value of health and life insurance policies, and other matters requiring specialized quantitative skills.

* * * * *

"On pages 6-53/54 you refer to certain wording in an NAIC model law and cite an example to illustrate its limitation. We have that law in California but do not share your concern about its limitation. If an insurer establishes a classification for drivers 21 to 24 years old we believe it would not be "inconsistent with the rating system" to require data for ages 21, 22, 23, and 24 separately. If an insurer

did not use age as a classification factor it might be 'inconsistent' to require any data on age. All classification plans must meet the 'not unfairly discriminatory' test and that requirement must not be overlooked when interpreting 'inconsistent with the rating system'."

OUR REPLY

We are not aware of any judicial interpretations of this point, but it would seem that categories not used by an insurer (e.g., ages 19-24 if an insurer uses 21 years old as a cutoff point) are inconsistent with the insurers' rating plan. If this interpretation is correct, and a department cannot require data in a form that is inconsistent with the rating plan, then the law is superfluous. We assume, however, that the law would be implemented just as written.

"Chapter 8: Certain references in this chapter and earlier give an impression that NAIC functions somewhat independely. It is a voluntary association of the Commissioners to achieve the objectives set out. It should not be regarded as a separate entity.

"The fact that industry representatives outnumber commissioners and staff at the semi-annual meetings seems to be regarded as an evil. How could the numbers be otherwise, considering the number of insurers? Since NAIC activity is directed, in part, to proposed model legislation the industry affected cannot be denied input nor knowledge of the development of proposed legislation. The subcommittee work that goes on at the meetings can be quite technical and insurers may send several representatives to the meeting, each with expertise in a special area.

"At one time NAIC Advisory Committees were made up entirely of industry representatives. Currently, there must be at least one consumer representative on each advisory committee. It is difficult to get consumer representatives to serve on committees since we are unable to reimburse the for time and expenses. The NAIC has a special subcommitte responsible for encouraging and developing consumer participation.

"The registration fees from industry do pay for the administrative expenses of the meeting. As cited earlier, all costs of regulation should be borne by the insurers. (Indeed, it is the policyholders who pay the bills; and it seems appropriate that policyholders, rather than all taxpayers, should.) It should be noted that no registration fees are charged to any government representatives, state or federal, academics or consumer representatives."

OUR REPLY

We do not regard the numerical dominance of insurance industry officials at NAIC proceedings as "evil" in the sense of being unethical. In chapter 8 we reply to this comment as well as the comments of several other commissioners on the issue of regulatory independence.

LETTER FROM JOSEPH C. MIKE
COMMISSIONER OF INSURANCE, CONNECTICUT

"The GAO report states that: '* * * Securities and Exchange Commission and the Federal Trade Commission--the two Federal agencies that are somewhat parallel to insurance departments in that they have broad jurisdiction over financial and trade practice matters.'

Doubt that they have volume of different documents comparable to policy forms, manuals, rating plans. Do they have equivalent of rate filings to review? Do they have claim cases to resolve comparable in volume to our Claims Section? I believe the parallel is greatly over-simplified."

OUR REPLY

We do not imply that the work of the ICC, FTC, and the SEC is completely parallel to insurance departments in its details--only insofar as it involves rather comprehensive control over many aspects of regulated industries in the case of the ICC and SEC, and a broad range of trade practice regulatory activities in the case of the FTC.

* * * * *

"The GAO report states that: 'Furthermore, in the case of automobile insurance, we are able to test whether that theoretical competitive potential can be realized in practice.'

"I don't believe competition in the area of auto insurance can be tested, since too many factors are not taken into account, the greatest of which is the agency system."

* * * * *

"The GAO report: 'tests prior approval states against file and use.'

Only three states were used (New Jersey, Pennsylvania, and California). Of the three, I do not feel that New Jersey is a typical prior approval state as even the report noted earlier that New Jersey average filing was delayed one year while most states averaged a few months. Also, those states with prior approval, just as those with no-fault, are subject to different conditions as to accident experience, claim experience, etc. This in fact is why they have prior approval and/or no-fault. They are attempting to solve a problem. The other states do not have these problems or at least not to the same extent so do not go to prior approval or no-fault."

OUR REPLY

We have revised the draft report to more adequately take into account the limitations on competition in the automobile insurance market. As noted in chapter 5, there are limitations on our analysis, but we do not agree that competition in auto insurance is not susceptible to analysis. It would require a substantial amount of information and a major analytical effort, but the automobile insurance market is just as susceptible to economic analysis as any other market. Commissioner Mike's comments on the use of New Jersey, Pennsylvania, and California presumably relate to the Department of Justice study of insurance regulation, not our study, since we used all States in the analysis he refers to.

* * * * *

"The GAO report states that: '* * * the average percentage of drivers in the automobile insurance plan in the 31 prior approval states was 6.6% compared to only 2.0% in the II open competition states.'

"I feel this statement is misleading because many open competition states do not have mandatory or compulsory insurance. Therefore, if you do not want to pay high assigned risk rates and cannot get into the voluntary market, you don't get insurance. A proper test would add the assigned risk and uninsured population together."

OUR REPLY

As noted in the text, we revised the draft and found that even controlling for whether a State has mandatory insurance or not, prior approval States have larger assigned risk populations.

* * * * *

"GAO's 'discussion of class, age, sex, etc.'

"This section quotes New York law on class, but includes a portion on individual risk rating plans which have nothing to do with private passenger auto for the individual and is always confused by laymen."

OUR REPLY

This section of the New York law on risk classification was, in fact, supplied to us by the New York State Insurance Department as the relevant section for automobile insurance.

* * * * *

"GAO's table 4 - Measures of Insurance Availability'

"This states that uninsured motorist population in Connecticut is 20.2% based on registered autos less

insured autos. I would like to see the definitions of registered autos and uninsured autos. I suspect there is a mix between commercial vehicles, public vehicles, composite rate vehicles, etc. Which distorts the figures."

OUR REPLY

We agree that estimates of uninsured automobiles may be inaccurate, but they are presented only as estimates. We asked all departments we visited for the number of uninsured cars, but few departments had anything but rough estimates.

"GAO states that: 'Assigned risk plans have a large number of 'clean' risks.'

"This could be deceptive. We have proven that over 20% of applications stating no accident involvement in the past three years actually have had such an incident."

OUR REPLY

With regard to assigned risk plans, we are aware that a number of people claiming to be clean risks are not. This number probably varies from State to State, depending on applicants' perceptions of the likelihood of getting away with a falsehood and the consequences of a blemished driving record. However, even by the Commissioner's own reckoning, 80 percent of the applicants claiming to have no accident involvement are telling the truth.

LETTER FROM RICHARD L. MATHIAS
DIRECTOR OF INSURANCE, ILLINOIS

"First, the report concludes (pages 4-8) that 'based on the relatively small number of insolvencies, the deficiencies in the process of financial regulation apparently does [sic] not manifest itself [sic] in any substantial solvency problem.'

"This may or may not be true. A critically important consideration in the area of financial regulation is the extent to which proficiency in such regulation can have an ameliorative effect

on the magnitude and severity of loss in insolvencies. Overlooking this facet of financial regulation which involves the point in time at which an insolvency is discovered leads to an incomplete theory of financial regulation."

OUR REPLY

Although we generally agree with this statement, we still believe that the number of insolvencies is a useful indicator for comparative purposes. Because our primary focus was not financial regulation, we did not get into the issue of the degree and distribution of financial losses caused by insolvencies. As noted in the body of the report, the whole subject of financial regulation may require further scrutiny, particularly in light of the findings of the Illinois Department of Insurance.

* * * * *

"In chapter eight, the report discusses abuses in 'Medigap' insurance. Enclosed for your use is a copy of our recent buyers guide for Medigap purchasers which is part of an ongoing program to crack down on abuses here in Illinois. It was somewhat disappointing, however, that the draft report did not more clearly point out that the whole medigap controversy stems largely from the creation of a supplemental market by reason of the confusion and incompleteness of the Medicare system."

OUR REPLY

In interviews with GAO, insurance department officials from other States also said that much of the problem of so-called "Medigap" insurance stems from deficiencies in the Medicare program. While problems with and perceptions of the Medicare program may lead older people to buy this insurance, that situation does not justify a lack of effective State supervision of these insurance policies.

LETTER FROM H.P. HUDSON
COMMISSIONER OF INSURANCE, INDIANA

* * * * *

"Your report seems to be critical of the fact that state regulators and the NAIC have not resolved issues which have only come to the forefront in the last few years. I think we should recognize that as inflation has caused the cost of insurance to increase because of the increased cost of things for which insurance pays, citizens and legislators alike have become more aware and questioning of the insurance mechanism. Likewise, as new products have evolved resulting from such things as the Medicare program, new practices have evolved from the insurance mechanism which have only recently surfaced. State regulators and the NAIC have not ignored these questionable practices, in my judgment, but have attempted to respond to them as promptly as prudence, manpower and time allows [sic]. I am not aware of any issue which has surfaced at the federal level which has not been equally as timely considered by State regulators and the NAIC."

OUR REPLY

The fact that problems have only recently come to the forefront does not mean that they did not exist previously--only that they have not been publicized. We believe that regulators should anticipate the need for reform and respond to well-publicized demands for reform. However, our analysis is static rather than dynamic. We have not made judgments as to whether States are moving at the proper pace, and our evaluation only relates to whether particular problems were addressed at the time of our fieldwork (generally, the fall of 1978).

* * * * *

"Until we in government possess that 'all knowing' and 'all seeing' onmipotent [sic] wisdom which allows us to develop the absolute superior resolution to problems, we certainly have to allow for input from those affected. That is the system of democratic government under which we operate and I

personally believe the NAIC would be remiss if it did not provide such an opportunity to industry and consumers alike which are impacted by the determinations of that body. Even your insinuation that the NAIC is culpable inasmuch as the cost of its formal meetings is borne by industry, is questionable. Were it not for industry and consumer interest for information during those deliberations, those meetings would be conducted at a minuscule cost.

"Finally, it is my judgment that the ill effects of the so-called 'revolving door' is nothing short of a myth. To suggest that a person with any previous exposure (or even subsequent exposure) to the insurance industry cannot effectively and conscientiously carry out his subscribed oath of duties is absurd. I have not discerned any difference in the integrity or dedication to duty evolving from persons who came from the industry as contrasted to persons who came from outside the insurance industry. Again, if there are specific facts to the contrary, I think the report should so disclose rather than concluding guilt by speculative inference."

OUR REPLY

The comment about regulatory independence is addressed in chapter 8.

LETTER FROM FLETCHER BELL
COMMISSIONER OF INSURANCE, KANSAS

"I have reviewed the draft report, 'State Regulation of the Business of Insurance,' and wish to commend those involved in the conduct of the study for what I consider to be a thorough exploration of significant issues. Unfortunately, the report in its current form goes beyond a reporting of facts and information by its frequent inclusion of subjective conclusions and its exclusion of pertinent information that would permit a more accurate evaluation of its content. For example, the report properly notes the study of the insurance company examination system conducted by McKinsey and Company

for the NAIC. The report report improperly concludes, however, that few, if any changes resulted from the McKinsey and Company recommendations. To the contrary, if those conducting the study would have reviewed the published NAIC Proceedings subsequent to delivery of McKinsey and Company's final report, they would have found that each recommendation contained therein has been addressed by the NAIC and most of them have been incorporated in the examination system. More specifically, the report fails to inform its user that, as a direct result of the McKinsey and Company study, two completely new Examiners Handbooks were developed, adopted by the NAIC, and are now used by insurance department examiners. One Handbook contains detailed procedures for scheduling and conducting a financial condition examination and the other handbook accomplishes the same purpose with respect to market conduct examination. Furthermore, in a follow-up critique requested by the NAIC, the project director of the McKinsey study advised that the handbooks incorporated their essential recommendations. In addition, the report makes no mention of the Examiners Training Program now being developed by the Griffith Foundation and scheduled for implementation in 1981. Finally, the report makes no mention of the current NAIC efforts to develop a practical but meaningful program to require a certification of fire and casualty loss reserves by a qualified loss reserve specialist. Obviously, the failure to recognize the time necessary to achieve results from significant changes and the omission of the many, positive, steps taken as a result of the McKinsey study were necessary to reach the conclusion that further study of insolvency and financial regulation is warranted. Needless to say, study and analysis in these areas is an unending activity of state insurance regulators but the context in which this conclusion is reached in the report is grossly misleading."

OUR REPLY

We noted that the NAIC addressed the recommendations made by the McKinsey study. However, McKinsey and Company informed us that the firm has not done any formal follow-up work with the NAIC. Our findings in chapter 4, moreover, were not based on whether the NAIC had passed resolutions regarding financial regulation or had considered these matters, but whether the States had actually put those recommendations into practice. Based on the replies of the State insurance departments, most of those recommended practices were not being used in mid-1978.

* * * * *

"Similarly, the draft report seems to concentrate rather heavily on perceived short-comings of state insurance regulation with respect to the development and use of consumer complaint data, market conduct examinations and distribution of consumer information. Frankly, I agree with most of the GAO observations but, again, I believe the report fails to disclose information which is quite relevant to a fair evaluation of state insurance regulatory activity in this area. Specifically, it seems to me the report should note that, while state insurance regulators have long performed a valuable service by providing assistance to individual policyholders and claimants, the concept of separate, specialized market conduct examinations and the use of consumer complaint data as a regulatory tool are relatively recent innovations. Generally speaking, these activities have become an inherent part of state insurance regulation only in this decade and, if one reads the draft report carefully, it is apparent that states are still experimenting with various types of data collection programs and market conduct activities. Thus, these activities are still in an evolutionary phase. Therefore, even though there are current deficiencies, the laboratory of state experimentation will produce the necessary adjustments and the resulting system will reflect the strengths of various individual state programs and eliminate the weaknesses. Even with this additional information the report might be

critical of state regulation for not initiating this kind of activity sooner. If so, it would be a valid criticism but it would be one that could be raised with respect to virtually any progressive undertaking."

OUR REPLY

As noted in the reply to the Indiana department, we agree that our analysis focuses only on a particular point in time. We do not, however, agree with Commissioner Bell's assessment of the timeliness of regulatory actions. Market conduct examinations were recommended by the McKinsey study in 1974, and all of those we examined had significant shortcomings. It does not require great innovation to use complaint data systematically as a regulatory tool. For regulators not to utilize input from affected consumers must be counted as a fundamental deficiency.

* * * * *

"Finally, in a somewhat different vein, I must take exception to the manner in which the draft report treats the issue of the so-called "revolving door" phenomonen and the independence of the NAIC. As far as I can discern, there is not one thread of factual evidence contained in the report to support a contention that a conflict of interest between insurance regulators and the insurance industry exists or that the products and programs produced by the NAIC are designed to benefit the insurance industry at the expense of insurance consumers. Yet, by inference and innuendo, the draft report, clearly attempts to leave the reader with this impression. As a result, the draft report attacks or at least raises questions about, the integrity of every individual insurance regulator and every individual member of the NAIC as well as members of the NAIC staff."

OUR REPLY

The comments on regulatory independence are addressed in chapter 8.

LETTER FROM JAMES J. SHEERAN
COMMISSIONER OF INSURANCE, NEW JERSEY

* * * * *

"The report does not convey the magnitude of New Jersey's effort to reform the driver classification and territorial rating systems. Moreover, the report seems to overlook the fact that an examination of the territorial rating system is very much a part of our ongoing study.

"Our reform effort started to take shape almost a year ago when the Department began the research preparatory to holding a public hearing. The hearing began on January 24, has convened on more than 40 days since then and is not expected to conclude until sometime in the fall. Consultants hired by the Department, rather than merely reporting to us, have worked closely with us in what has proved to be a productive team effort. When concluded, our study will have been the most comprehensive of any ever made in this country."

OUR REPLY

We agree with Commissioner Sheeran's characterization of the scale of New Jersey's assessment of the driver classification and territorial rating system, and have revised the draft to more accurately indicate the scope of this effort.

* * * * *

"Finally, I would express my disagreement with your conclusion that regulation of auto insurance rates is not justified. It has been my experience that the only competition among auto insurers is for the cream of the crop. The industry is too willing to consign too many people, especially those with good driving records, to the secondary market.

"Moreover, I think that New Jersey's rate regulation has made a difference in pricing. We have insurance available in New Jersey at prices that are much lower than the companies would charge if there were no prior approval required."

OUR REPLY

We have noted that it may be appropriate to regulate rate relativities and we agree that risk selection is part of the way in which insurers compete. Nonetheless, we believe that base insurance rates for the voluntary market need not be regulated as long as there is sufficient regulatory effort to ensure that the beneficial effects of competition are realized. We agree that New Jersey's rate regulation has made a difference in pricing, but nearly all insurance company officials we interviewed told us that their New Jersey private passenger auto insurance business is unprofitable. We, however, have no findings on whether New Jersey prices are held unreasonably low by regulation.

LETTER FROM W. KENNETH BROWN
DIRECTOR OF CONSUMER SERVICES, NORTH CAROLINA

* * * * *

"The North Carolina Department has made tremendous strides in providing consumers with necessary insurance information. Our review indicates that real competition in the marketplace is minimal and information about possible cost savings and/or the true value of an insurance product is difficult for consumers to obtain. Efforts to make this information available or require the companies to make it available meets with tremendous and often successful lobbying efforts by the insurance industry in the General Assembly; * * *."

OUR REPLY

We agree that information about the relative value of insurance policies is currently difficult to obtain. We note that other knowledgeable observers have also informed us that insurance companies, industry groups, and others have resisted the dissemination of information that would allow consumers to make price and quality comparisons. We believe that such interference with the use of buyers' guides and the disclosure of other useful information interferes with competition in the insurance market.

LETTER FROM HARRY V. JUMP
DIRECTOR OF INSURANCE, OHIO

* * * * *

"We would like to take this opportunity to express our complete disagreement with the above captioned report's comments about this Department's review of automobile insurance rate charges. These comments began on p. 10 of chapter 5, 'Price Regulation of Automobile Insurance'.

"Far from being 'largely a formality,' this Department's rate reviews include an extensive review of each automobile insurance rate filed with us. The purpose of this review is to make certain that each such filing is in compliance with the statutory standards established by the Ohio legislature in Section 3937.02 of the Ohio Revised Code. We would like to point out that Section 3937.02 (D) prohibits such rates from being excessive, inadequate or unfairly discriminatory; our review encompasses this statutory prohibition.

"While it is true that no member of our staff is a Fellow of the Casualty Society Actuaries, the relevant point is that each member of our staff is thoroughly qualified to review automobile insurance rate filings to determine compliance with Section 3937.02. Far from being 'unable to question' automobile insurance rate filings, we subsequently disapproved one hundred forty-three such filings in 1978 alone.

"The report's statement that no rate adjustment has ever been subsequently disapproved is simply not correct. For example, in June, 1975 the Ohio Department of Insurance issued Notices of Hearing to Reserve Insurance Company, Leader National Insurance Company, Globe American Casualty Company, Progressive Casualty Insurance Company, State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company. The reason that the Department issued these Notices of Hearings was that the Department believed these insurers automobile insurance rates filed for Cleveland, Ohio were inadequate, excessive or unfairly discriminatory in violation of Section 3937.02 of the Ohio Revised Code. The hearing process ultimately resulted in

enactment of a statute, Section 3901.21 of the Ohio Revised Code to prohibit automobile insurers from splitting rates within a municipality.

"Finally, we agree with the report's last sentence in this paragraph, ending on page 11. The underlying philosophy of a file and use system, such as that enacted by the Ohio legislature in Chapter 3937 of the Ohio Revised Code, is that the principal regulator of rates is competition, not the regulatory authority. This philosophy, inherent in any file and use system, views competitive forces in the marketplace as the preferred regulator of prices.

"File and use systems are based on the premise that the most effective way to produce rates which are not excessive, inadequate, or unfairly discriminatory is through rate competition among insurers."

OUR REPLY

We have deleted the term "largely a formality," but we do maintain that rate review in Ohio is far from intensive. In a lengthy interview with us, officials of the department's property and casualty division agreed that

--the Ohio Insurance Department performs no independent actuarial assessment to verify company-supplied data;

--the department does not have the capacity to assure the soundness (i.e., adherence to commonly accepted actuarial standards) of the actuarial methodology used to develop base rate revisions, trend factors, permissible loss ratios, and so on; and

--the department is primarily concerned with assuring the completeness and computational accuracy of the filing.

We have revised the draft to state that no "recent" filing has been disapproved. However, it should be noted that the example cited by the Superintendent is not an acation on a base rate filing for a statewide rate increase. Rather, the example describes the department's action in prohibiting the named insurers from splitting Cleveland into two territories.

APPENDIX I

SURVEY OF STATE REGULATION OF INSURANCE
U.S. GENERAL ACCOUNTING OFFICE

GUIDELINES

We would appreciate your answering all applicable questions. A few questions, however, may involve data that are not readily available in some departments or which would involve an extensive data search. If this is the case for any particular question, please write "not available" and go on to the next question.

If you need more space on any narrative question, please use additional sheets noting the question number.

I. RESOURCES AND PERSONNEL

1.a) What is the budget (total allocation) of your department for fiscal year 1978?

$ _____ (4-11)

b) Have you requested a budget increase in the past two years for additional staff (or consultants) or new programs?

/61/ 1. Yes /4/ 2. No (12)

If yes, please list types of staff and programs.

_____

_____

c) Are other resources of the State government, which are not reflected in your budget, available to the insurance department (e.g., use of attorneys from the Attorney General's Office)?

/35/ 1. Yes

/10/ 2. No (13)

d) If yes, please estimate the approximate annual dollar value of such services for FY 1978.

$ _____ FY 1978 (14-20)

2.a) What is the total number of full time/full time equivalent personnel in each of the following categories?

Total full time/full time equivalent personnel _____ (21-24)

Composed of:

total clerical _____ (25-27)

total professional _____ (28-30)

b) Of the professional staff, how many are in each of the following categories of professional and academic training?

Attorney	246	(31-33)
Economist (PhD)	4	(34-36)
CPA	39	(37-39)
CLU and CPCU	64	(40-42)
Certified Financial Examiners	300	(43-45)
Actuaries	158	(46-48)

c) Of the actuaries, how many are members of the following professional societies?

Society of Actuaries:

Fellows	22	(51-52)
Associates	16	(53-54)

Casualty Actuarial Society:

Fellows	12	(57-58)
Associates	14	(59-60)

American Academy of Actuaries:

Members	48	(61-62)

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3. Please list below major professional consulting services (e.g. actuaries, computer systems) purchased by your department and the amount spent on these services during fiscal year 1978. Do not include contract examiners.

Type of Service	Amount
_____	$ _____ (63-67)
_____	_____ (68-72)
_____	_____ (73-77)

4.a) What is the usual system of legal representation when your department goes to court?
(Check only one.) (78)

/10/ 1. Department is represented by its own staff attorneys.

/26/ 2. Department is represented by attorneys from the Attorney General's office who specialize in insurance matters.

/4/ 3. Department is represented by attorneys from the Attorney General's office who do insurance work infrequently or sporadically

/3/ 4. Other (Please specify) _____

_____

_____

b) Is there any area of litigation that is consistently different from the system of representation (in court) checked above? (79)

/12/ 1. Yes (Please specify) _____

_____

_____

/32/ 2. No

Card No. 1 (80)
Dupl (1-3)

5. Please estimate the amount of revenues collected by your state from the insurance industry in the last fiscal year. How much, if any, of this amount was specifically allocated to insurance regulation?

Revenue Source	Collected	Specifically allocated to insurance regulation
Premium taxes	$ _____ (4-10)	$ _____ (52-59)
Fees from licensing insurance companies	$ _____ (11-17)	$ _____ (60-66)
Fees from licensing insurance agents and brokers	$ _____ (18-24)	$ _____ (67-73)
Fines and penalties	$ _____ (25-30)	$ _____ (74-79)

Card No. 2 (80)
Dupl. (1-3)

Assessment or reimbursement for examination	$ _____ (31-37)	$ _____ (4-10)
Other major sources (Please specify) _____ _____	$ _____ (38-44)	$ _____ (11-17)
All other _____ _____	$ _____ (45-51)	$ _____ (18-24)

APPENDIX I

6. Please provide the annual salary (or salary range if more than one official) of each of the following insurance department officials:

. Commissioner $ _____ (25-27)

. First Deputy(s) $ _____ (28-30) to (31-33)

. Chief Examiner(s) $ _____ (34-36) to (37-39)

. Actuary(s) $ _____ (40-42) to (43-45)

. Attorney(s) $ _____ (46-48) to (49-51)

. Examiner(s) $ _____ (52-54) to (55-57)

7. What is the term of the State Insurance Commissioner?
(Check one) (58)

/1/ 1. Set term of two years

/ / 2. Set term of three years

/16/ 3. Set term of four years

/1/ 4. Set term of five years

/16/ 5. At the pleasure of the governor

/6/ 6. At the pleasure of other state official

/2/ 7. Other (Please specify) _____

_____

/3/ 8. Set term of six years

8. When did the incumbent first take office as commissioner?

_____ / _____
Month Year
(59-62)

9. What is the professional background of the incumbent commissioner?
(Please check all that apply)

/17/ 1. Previous insurance department employee (63)

/16/ 2. Insurance company executive (64)

/10/ 3. Insurance agent or broker (65)

/3/ 4. Holder of academic position specializing in insurance (66)

/9/ 5. Attorney, insurance related (67)

/12/ 6. Attorney, other (68)

/13/ 7. State or local government employee/official (69)

/15/ 8. Other (please specify) _____ (70)

_____

Card No. 3 (80)
Dupl (1-3)

10. Please give the names and dates of service of each of your state's last three insurance commissioners?

Name	Service from: (month/year) to (month/year)
_____	/ (4-7) to / (8-11)
_____	/ (12-15) to / (16-19)
_____	/ (20-23) to / (24-27)

11. How many years have the following officials been in the insurance department (including total years of service prior to present position)?

Chief deputy _____ yrs (28-29)

Chief legal officer _____ yrs (30-31)

Chief examiner _____ yrs (32-33)

12. Please estimate the budget for professional training programs (both internal and external) for your department for FY78.

Total training program budget:

$ _____ (34-39)

APPENDIX I

II. WORKLOAD

13. How many examinations were conducted, or participated in, by your department in 1977?

Total Number of Examinations _____ (40-42)

Of these, how many were:

. Domestic companies examined only by your department? _____ (43-45)

. Joint CPA-Department audits? _____ (46-47)

. CPA examinations accepted by your department? _____ (48-50)

. Domestic companies subject to zone examination? _____ (51-53)

. Zone examinations of foreign companies? _____ (54-55)

. Special examinations (please explain)? _____ (56-57)

_____

_____

14. During 1977, how many separate rate filings were filed with your department requiring prior approval?

. Total Number of Filings? _____ (58-61)

. How many rate hearings were held? _____ (62-63)

. How many rate filings were disapproved? _____ (64-66)

. How many were modified/amended? _____ (67-69)

. How many were withdrawn? _____ (70-72)

Card No. 4 (80)
Dupl. (1-3)

15. How many applications for licensing of insurers were processed in 1977?

	Domestic	Foreign
. Total number of applications	_____ (4-5)	_____ (6-7)
. Number disapproved	_____ (8-9)	_____ (10-11)
. Number withdrawn	_____ (12-13)	_____ (14-15)

16.a) How many policy form filings were processed in 1977?

Total number of policy form filings _____ (16-18)

b) How many were disapproved? _____ (19-21)

17. How do you assess the competency of applicants for insurance agent licenses? (Check all applicable) (22)

/42/ 1. Examination (23)

/16/ 2. Required training or course work (specify number of hours _____) (24-25)

/ 3/ 3. Other (please specify) _____

_____ (26)

18. How many applications for agent licenses were processed in 1977?

_____

III. TRADE PRACTICES AND COMPETITION

19. How extensive is the insurance commissioner's authority to issue rules or regulations describing conduct that is prohibited as an unfair trade practice or unfair method of competition? Check the one that best applies. (Check only one) (31)

/13/ 1. May not enlarge upon nor extend the provisions of the unfair trade practices statute.

/27/ 2. New categories of unfair practices beyond the statute may be specified.

/ 3/ 3. Other (please specify) _____

_____

/ / 4. Do not have such authority.

20.a) Do the general antitrust statutes of your state apply to the business of insurance?

/27/ 1. Yes (32)

/16/ 2. No

b) If yes, who may enforce those laws? (Check all that apply)

/10/ 1. Insurance department (33)

/27/ 2. Attorney General (34)

/5/ 3. Other (please specify) (35)

_____

APPENDIX I

21. In the case of a merger of foreign insurers, do you have the authority to preclude the merged entity from doing business in your state because of the anticompetitive effects of the merger? (Check one)

/49/ 1. Yes (36)

/14/ 2. No

22. For each of the practices listed below, please give the total number of notices of charges brought or complaints instituted by your department during 1977.

	Number of Notices or Complaints
. Misrepresentation and false advertising of policy contracts	(37-40)
. False information and advertising generally	(41-44)
. boycott, coercion and intimidation	(45-48)
. unfair discrimination	(49-52)
. rebates	(53-56)
. other unfair or deceptive sales practices	(57-60)
. unlawful replacement (twisting)	(61-64)
. failure to pay claims	(65-68)
. failure to remit premiums	(69-72)

Card No. 5 (80)
Dupl (1-3)

23. How often does your department use informal procedures, rather than formal procedures, in dealing with practices listed in question 22. (Check one)

/1/ 1. Never (4)

/3/ 2. Rarely

/12/ 3. Occasionally

/23/ 4. Frequently

/5/ 5. Very frequently

24. How many times during the period Jan. 1, 1975 thru Dec. 31, 1977 did your department suspend or revoke the licenses of:

an insurance company? _____ (5-7)

an agent/broker _____ (8-11)

IV. RATES

25.a) If your state has an open competition or file and use system, does the insurance commissioner have the authority to reimpose a prior approval system of rate regulation for any line of insurance in which competition is found to be inadequate? (Check one)

/11/ 1. Yes (12)

/14/ 2. No

/19/ 3. Not applicable

b) If yes, how many times has this authority been exercised since your state instituted open competition?

_____ No. times exercised (13-14)

26. Does your department have the authority to disapprove title insurance rates for being excessive? (Check one)

/28/ 1. Yes (15)

/12/ 2. No

If yes, how many times from 1975 through 1977 has your department disapproved title insurance rates and/or effected a reduction in rates directly or indirectly?

_____ No. of times (16-18)

APPENDIX I

27. Does your department have the authority to disapprove credit life insurance rates as being excessive?
(Check one) (19)

/33/ 1. Yes

/6/ 2. No

If yes, how many times from 1975 through 1977 has your department disapproved credit life insurance rates or effected a reduction in rates directly or indirectly?

_____ Number of times (20-22)

28. Does your department have the authority to disapprove credit health insurance rates as being excessive?
(Check one) (23)

/36/ 1. Yes

/4/ 2. No

If yes, how many times from 1975 through 1977 has your department either disapproved credithealth insurance rates and/or effected a reduction in rates directly or indirectly?

_____ Number of times (24-26)

29. In evaluating the reasonableness of rates, is the investment income of insurers calculated?
(Check one) (27)

/7/ 1. Never calculated

/4/ 2. Rarely calculated

/8/ 3. Sometimes calculated

/10/ 4. Usually calculated

/14/ 5. Always calculated

V. EXAMINATION AND AUDIT.

30. What early warning solvency testing program does your state use?
(Check one) (28)

/18/ 1. NAIC early Warning

/ / 2. Other early warning systems

/23/ 3. NAIC and other

/1/ 4. None

31. Does your department use a computer software audit package for examination purposes?

/8/ 1. Yes (29)

/35/ 2. No

32. Of the examiners employed in your department, do any specialize in each of the following major lines of insurance? If yes, please provide the number of examiners in each category?

	Yes	No	Number
Total no. of examiners _____ (30-32)			
Life and Accident and Health	1 /14/ (33)	2 /22/	_____ (34-35)
Property-liability	/14/ (36)	/23/	_____ (37-38)

33. Approximately what percentage of your department's examinations are conducted primarily by contract examiners?

_____% of all domestic examinations conducted primarily by contract examiners (39-41)

_____% of all your examinations conducted primarily by contract examiners (42-44)

34. Approximately what percentage of total domestic examinations in the past three years were on a surprise basis (that is, not announced to the company in advance)?

Property-liability _____% (45-47)

Life and Accident and Health _____% (48-50)

35. If your department performs separate market conduct surveillance examinations, who performs such examinations?
(Check one) (51)

/16/ 1. A special market conduct examination staff

/4/ 2. All examiners

/10/ 3. Other (please specify) _____

_____

/13/ 4. The department does not perform separate market conduct examinations

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36. How are examinations paid for? (Check one) (52)

/35/ 1. Companies are assessed specifically for each examination

/1/ 2. Companies are assessed for the examination process in general, but not for each examination separately

/4/ 3. Examination costs come out of general departmental budget

/3/ 4. Other (please specify) _____

/2/ 5. Revolving fund

37. How are the travel and maintenance expenses of examiners usually financed? (Check one) (53)

/30/ 1. Entirely by company examined

/2/ 2. Partially by company examined

/4/ 3. By the department

/4/ 4. Other (please specify _____

/3/ 5. Revolving credit

38. During the period Jan. 1, 1978 thru Dec. 31, 1977, how many times did your department examine the insurance-related records of a holding company affiliated with a domestic insurer?

_____ No. of times (54-56)

39. For what lines of insurance does your state have guarantee funds? (Please check applicable categories)

/22/ 1. Life (57)

/24/ 2. Accident and Health (58)

/43/ 3. Property-Liability (59)

/7/ 4. Other (please specify) (60)

40. Has your state enacted the NAIC model guarantee fund act for: (Check one for each row)

	1 Yes	2 No	
property-liability	/35/	/9/	(61)
life and accident and health	/20/	/21/	(62)

41. Please list domestic insolvencies over the past five years.

Name of company	Date of insolvency	Line(s) of insurance	Prior annual national premium volume for the 3 years prior to insolvency	Primary cause

42. How many mergers, consolidations, and/or reinsurance arrangements have been arranged, facilitated or accepted, by your department over the last five years in order to avoid insolvency?

_____ (63-65)

APPENDIX I

VI. COMPLAINTS, CLAIMS, AND OTHER CONSUMER PROTECTION MATTERS

43. How much legal authority does your department have to order companies to pay or increase payment of claims? (Check one)

/6/ 1. complete authority (66)

/20/ 2. partial authority

/18/ 3. no authority

Card No. 6 (80)
Dupl. (1-3)

44.a) How many complaints were received by your department in 1977 from the following sources?

. Insurance Agents _____ (4-8)

. Insurance Companies _____ (9-13)

. Consumers _____ (14-19)

b) Of the consumer complaints, approximately what percentage did your department consider valid?

_____% (20-22)

c) Of the complaints considered valid, approximately what percentage resulted in a disposition in the consumer's favor?

_____% (23-25)

45. How are consumer complaints indexed in your files:
(Check all applicable categories)

/39/ 1. by company name (26)

/30/ 2. by agent/broker name (27)

/19/ 3. by status of complainant (28)

/8/ 4. by a zip code (29)

/19/ 5. by reason for complaint (30)

/23/ 6. by line of insurance (31)

/24/ 7. Other (please specify) (32)

_____

_____

46. Are complaint summaries or summary data available to the public?

/34/ 1. Yes (33)

/10/ 2. No

47. How many full time/full time equivalent persons handle consumer complaints?

Number of professionals _____ (34-35)

Number of clerical personnel _____ (36-37)

48. How often does your department check the complaint records of the domicile state when a foreign insurer applies for a license? (Check one)

/22/ 1. Always (38)

/5/ 2. Frequently

/8/ 3. Occasionally

/7/ 4. Rarely

/2/ 5. Never

49. Which of the following NAIC model statutes and regulations (or their equivalents) has your state enacted?
(Check all that apply)

/21/ 1. Uniform unfair claims settlement regulation (39)

/31/ 2. Unauthorized insurers model statute (40)

/30/ 3. Unauthorized insurers process act (41)

/6/ 4. Model regulation for complaint records (42)

/28/ 5. Unfair trade practices statute (1977 revision) (43)

Please list titles of any consumer guides published or distributed by your department over the past three years. (44-45)

_____

_____

_____

_____

_____

APPENDIX I

50.a) Have you officially endorsed any proposed method of life insurance cost disclosure?

(Check one) (46)

/21/ 1. Yes

/22/ 2. No

b) If yes, is it the NAIC life insurance solicitation model statute?

/16/ 1. Yes (47)

/6/ 2. No

c) If you answered "no" in part (b), please enclose a copy or describe the main features.

VII INSURANCE AVAILABILITY

51. a) How extensive is your department's authority to require justification of individual company property and casualty underwriting guidelines? (Check one). (48)

/12/ 1. Can forbid companies from using particular guidelines

/16/ 2. Can review guidelines and request justifications

/10/ 3. Other (Please specify)____

_____

_____

/5/ 4. No authority

51. b) If applicable, how often were the guidelines reviewed in the last three (3) years?

_____ (49-51)

52. Has your department conducted any studies in the last five years on alleged unfair territorial discrimination practices ("redlining") in the availability of property or liability insurance. (Check one) (52)

/16/ 1. Yes (If so, we would appreciate your sending us a copy)

/29/ 2. No

53. Please provide names and citations of statutues or regulations on geographic discrimination in insurance.

54. If your department has proposed any statutes or regulations in addition to those listed above, please enclose copies.

55. Has your department conducted studies to determine the age, sex, and race of persons in the personal lines residual markets? (Check one) (53)

/7/ 1. Yes

/37/ 2. No

If yes, we would appreciate your sending us a copy.

APPENDIX I

56. If the information is available, please provide the percentage of persons in each residual market that fall into each of the following categories.

	Automobile assigned risk	FAIR Plan
White	_____ % (54-56)	_____ % (66-68)
Non-White	_____ % (57-59)	_____ % (69-71)
Under 25 Years old	_____ % (60-62)	_____ %
Male	_____ % (63-65	_____ % (72-74)

57. Does your department collect, or plan to collect, the following data on a geographic basis?

	Collect Data (Check one) 1 Yes	2 No	Plan to Collect (Check one) 1 Yes	2 No
New policies	/6/	/32/ (4)	/7/	/30/(9)
Policies in force	/9/	/30/ (5)	/7/	/29/(10)
Cancellations	/5/	/33/ (6)	/7/	/30/(11)
Non-renewals	/5/	/33/ (7)	/7/	/30/(12)
Loss Data	/14/	/24/ (8)	/10/	/23/(13)

VIII REGULATION OF POLICYHOLDER RIGHTS IN MUTUAL INSURANCE COMPANIES

58. Since Jan. 1, 1975, how many times has your department challenged the procedures used by mutual insurance companies for:

notification of _____ (14-15)
annual meetings
solicitation of proxies _____(16-17)

failure to disclose financial information to policy holders _____ (18-19)

59. Do you support the 1964 NAIC resolution suggesting the application of stock company disclosure rules to mutual companies? (Check one) (20)

/23/ Support

/17/ Have not taken a position

/1/ Do not support

/2/ Other (Please specify) _____

_____

_____

APPENDIX I

60. Does your state issue any regulations applicable to mutual insurance companies on the following subjects? (Check one box for each subject)

	1. Yes	2. No
a) Policy holder voting rights, proxy requirements, specified method of voting, and quorums for voting	/22/	/19/ (21)
b) Annual meeting requirements	/18/	/23/ (22)
c) Selection procedures for directors	/15/	/26/ (23)
d) Availability of, and assessment of costs for, lists of policy holders prior to nomination or election of directors.	/7/	/33/ (24)
e) Requirements for public (non-insurance industry) members	/3/	/35/ (25)
f) Management contracts	/16/	/25/ (26)
g) Relationships between a mutual and an affiliated stock company	/14/	/24/ (27)
h) Policy holder fights upon conversion or other change(s)	/13/	/25/ (28)
i) Dividend requirements	/16/	/24/ (29)

/ We would appreciate your sending us a copy of the regulation for any category you have checked "yes" in the above question. /

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61. If you have any comments on this questionnaire or related topics, please use the space below. Thank you.

APPENDIX I

SUPPLEMENTARY SECTION

If you wish, we would appreciate the benefit of your views on the appropriate balance between federal and state roles in regulating the insurance industry. In particular, we would be interested in what you believe to be the major problems of insurance regulation and how the Federal government or the insurance industry could aid in resolving those problems and contribute to more efficient and effective realization of regulatory objectives. You may send your response to us anonymously, if you desire. We have provided a separate return envelope for this section.

TYPES OF RATE REGULATION a/

(1) State-Made Rates. This system represents the ultimate in state government control of insurance prices. The insurance department determines and promulgates the rates to which the insurer must adhere. [146]

(2) Mandatory Bureau Rate Systems. These states require that an insurer obtain membership in a rating organization before it can write a given line of insurance. Members may be able to deviate from bureau rates with insurance department approval. The bureau must obtain prior approval before promulgating rates.

(3) Prior Approval Laws. The prior approval approach continues as the most commonly used alternative, as to one or more lines of insurance. The principal features of statutes in this category include the following: (a) Rates and supporting data must be filed with the state insurance

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145. For a detailed discussion concerning the difficulties in classifying the rate regulatory laws, see *Hartman supra* note 142, 360-63. Both the New York Insurance Department and the Insurance Services Office have prepared state-by-state classifications of the rating laws: *See N. Y. Ins. Dept. Report* 75-81 (1969) and Brustman, "Analysis of Casualty Insurance Rating Laws," April 1, 1972 (printed by Insurance Services Office), which contain footnotes providing greater detail. However, Table I is more up to date and is structured somewhat differently for the purposes of this study.

146. In Texas, the State Board of Insurance has long promulgated fire and casualty insurance rates. In June 1973, the legislature amended the law, effective September 1, 1973, with respect to motor vehicle rates. An insurer may file a uniform percentage increase or decrease from the motor vehicle rates promulgated by the Board. Such deviation requires prior approval by the Board (or the running of the "deemer" period). The Board shall approve the application if it finds that the resulting premiums will be just, adequate, reasonable, not excessive and not unfairly discriminatory. *Tex. Ins. Code* Art. 5.03 (1973).

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a/ National Association of Insurance Commissioners, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business, Vol. 1, May 1974.

commissioner. (b) Rate filings do not become effective until one of two things happen, depending upon the statute. Statutes patterned after the model bills use the deemer provision. That is, the rate does not become effective until the specified waiting period expires during which period the filings are reviewed by the department. Other statutes require an affirmative approval by the commissioner before the rates may be used. The term "prior approval" has been applied to both types of statutes.[147] (c) Rates may not be excessive, inadequate nor unfairly discriminatory. (d) The commissioner may disapprove rates which do not meet these standards either during or after the waiting period. However, filings not disapproved within the period are deemed approved. (e) Insurers may opt to cooperate in making rates with other insurers through bureau membership or subscribership or they may file rates independently. Bureau members or subscribers may deviate from bureau rates upon application to the commissioner.

(4) Modified Approval Laws. This type of law represents a hybrid between the prior approval laws and the so-called file and use laws. A rate revision based solely upon a change in the loss experience is effective immediately upon filing, subject to subsequent disapproval by the commissioner. A rate revision based upon a change in expense relationships or rate classifications is subject to prior approval.[148]

(5) File and Use – Adherence to Bureau Rates Required. Under file and use rating laws – often termed "subsequent disapproval" laws – rates become effective immediately upon filing with no affirmative action by the commissioner required. In some states the file and use provisions apply to all lines and in others to just casualty lines. Several file and use statutes require adherence to bureau rates. That is, members or subscribers to a rating bureau must adhere to the filings made on its behalf by the bureau in the absence of filing for a deviation. File and use laws establish the same rate criteria as that usually contained in the prior approval and

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147. In practice, for various reasons the deemer provision may be rarely used. Insurers fear a subsequent disapproval after they put rates into effect by use of the deemer. Insurers might also be concerned over possible commissioner resentment for not obtaining prior approval. *Kentucky Legislative Research Commission, Insurance: A Study of the Administration at the Kentucky Rating Laws* 4 Research Rep. No. 46 (1967).

> Whatever the reason why the deemer is not exercised, the effect is clear – each filing to reach the department is reviewed within the deemer period or an extension and is either approved, disapproved, or withdrawn.

Id.

148. This is said to have been a compromise between the proponents of the California no file type law and agent organizations. 1 *Proceedings of the NAIC* 332, 333 (1969).

APPENDIX II

the no file states, i. e. rates shall not be excessive, inadequate or unfairly discriminatory. The differences are primarily procedural. The market impact of a file and use law depends upon how it is administered. In effect, such a law could be the equivalent to a prior approval law. On the other hand, a file and use statute could be administered so that, in effect, it more closely resembles a no filing statute.[149]

(6) File and Use – Bureau Rates Advisory Only. This category differs from the preceeding category in that bureau rates are advisory only. There is no requirement that they must be adhered to.

(7) Use and File – Bureau Rates Advisory Only. This category is similar to category (6) except the rates may take effect immediately while the filings need not be made until some specified future time. For the purpose of this study, categories (6) and (7) could be combined. However, to be as consistent as possible with terminology and categories used by others, this distinction is made.

(8) No File – Bureau Rates Advisory Only. The California rating law[150] is the grandfather of no file statutes with no requirement of adherence to bureau rates. The law makes no requirement that rates be filed or affirmatively approved by the commissioner in any way. Rates adopted by an insurer may be put into effect immediately. The standards for a valid rate are generally similar to those in the model bills. Rating organizations are advisory only. They are specifically prohibited from requiring that any member or subscriber adhere to their rates, rating plans and forms. Both insurers and rating bureaus must maintain adequate information as to their rates. Such information must be made available to

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149. In practice, the deemer provision is administered in New York so as to require prior approval of rates, for two reasons. Insurers and bureaus rarely rely on the deemer provision. An insurer that institutes a new rate or form without actual approval runs the risk of subsequent disapproval and the consequent dislocation and expense of issuing revised rates and forms to thousands of producers and policyholders. Secondly, the Department tends either to act within the specified time period or to call for additional information deemed necessary to a proper review of the filing, thereby extending the time period. The original purposes of the deemer provision, to assure prompt action on filings and to eliminate prior approval where it is not really necessary, have largely been negated by administrative practice.

Thus, New York has been a prior approval state for nearly all rates, forms and rating plans in property and liability lines, whether the filing consists of major revisions or a single special risk.

N. Y. Ins. Dept. Report 83 (1969).

150. *Calif. Ins. Code* Sec. 1850 *et seq.*

the commissioner. Rating and underwriting examinations are the primary means by which the commissioner maintains compliance with the law. The commissioner is authorized to take action to secure termination of any violation of the law.

(9) No File, No Rating Standards and No Rates in Concert. Following the expiration of its "open competition" rating law on August 1, 1971, Illinois was left with no rating law.[151] In 1972, the state enacted a law authorizing "advisory organizations" which are defined to include persons, other than insurers, who compile insurance statistics, prepare insurance policies and underwriting rules, make surveys and inspection or carry on insurance research and furnish that which it compiles to insurance companies. Such organization must obtain a license. It must conduct its operation in accordance with the requirements of the statute and it is subject to the regulatory jurisdiction of the insurance department. The statute expressly prohibits insurers from agreeing with each other or with an advisory organization to adhere to the use of any statistics, policy or underwriting rules. Of course, since there is no rating law *per se* the insurers are not subject to any filing requirements.

For the purpose of this study, "open competition" rating laws are defined to include those states listed in categories (6) to (9) in Table I. The dividing line between categories (5) and (6) rests upon the presence or the absence of a requirement to adhere to bureau rates. Later in this study we will consider the statutory provisions of the open competition rating laws in more detail.[152] For the moment, suffice to say the current status of the rate regulatory laws reflects a broad range of approaches. A comparison between this pattern and that which existed immediately after the widespread enactment of the model laws in the late 1940's demonstrates a significant trend towards a more competitive rate regulatory environment.

C. Rationale Underlying The Trend to More Competitive Rating Laws

The significant movement towards rating laws with an increased competitive orientation has been based upon several expressed rationales. This section will attempt to summarize the reasons espoused from both the industry and the regulatory viewpoints. A closer look at the theory of the open competition rating laws and the results under them will be undertaken later in this study.

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151. For further discussion of the Illinois situation, see text *infra* at 420-422.

152. See text *infra* at 395 *et seq.*

APPENDIX III

REGRESSION EQUATIONS

To determine if the cost of automobile liability insurance is dependent on the type of State rate regulation, we used a regression model of the determination of insurance cost. This appendix briefly describes the method and the empirical results. A full discussion of the results is provided in chapter 5, pages 88-93.

The adjusted loss ratio for a State is the proxy for the cost of insurance there. Both single year (1977) and 5-year average loss ratios are examined. The regression equations isolate the regulatory effect (prior approval v. competitive rating) by including a dummy (or categorical) variable for regulatory type, as well as other relevant factors. In essence, this breaks the States into two classes and estimates the average difference between loss ratios in prior approval and competitive rating States, holding other factors equal. (The procedure is equivalent to analysis of variance.) It should be emphasized that the coefficient of the regulatory form dummy variable is not a measure of the cost of regulation, but an estimate of difference between the two regulatory forms.

There are two basic forms of the model used. One explicitly recognizes that New Jersey's loss ratio is significantly above the national average while the "basic" model does not include this information. This basic model postulates that the loss ratio (L) is a function of department resources and market structure variables (collectively x_i) and regulatory form (R):

$$L = a_0 + \sum_{i=1}^{n} a_i x_i + a_{n+1} R + e$$

(e_i is a random error term). The department resource and market structure variables are described in chapter 5, page. Each coefficient (a) estimate is a statistical estimate of the impact of the associated independent variable on the dependent variable (i.e., the loss ratio). The second model includes a dummy variable to include the variation in loss ratios explained by New Jersey:

$$L = b_0 + \sum_{i=1}^{n} b_i x_i + b_{n+1} R + b_{n+2} NJ + e$$

In addition to the coefficient estimates (and statistical tests for the significant of explanatory variables), regression analysis provides a basis for estimating the proportion of the variation in the dependent variable which is explained by the entire equation or by a particular independent variable. These are, respectively, the multiple and partial correlation coefficients, and are presented here and discussed in chapter 5, page 91-92.

PRESENTATION OF RESULTS

Each equation discussed in chapter 5 is presented here. For easy reference, the equations are presented in tabular form; the equation numbers serve as a reference to the text of chapter 5.

The equations were estimated using the Statistical Package for the Social Sciences (SPSS) stepwise regression program.

Many of the variables we had expected to be significant determinants of the loss ratios were not satisfactory explanatory variables. In fact, the most important variable observed was the New Jersey dummy variable.

APPENDIX III

EQUATION 1

Dependent Variable

Mean industry liability loss ratio (1973-75)

$F = 3.43$

$\bar{R}^2 = 0.20$

$R^2 = 0.28$

Independent Variables	Regression coefficient	R^2 change
Constant	52.23	
Department staff ÷ $\sqrt{\text{population}}$*	0.18 (0.09)	0.15
Market share of direct writers	0.13 (0.08)	0.09
Budget ÷ population	0.38 (0.29)	0.04
Trained professionals - total professionals	-0.2×10^{-2} (0.01)	0.00

Note: Standard errors of coefficient estimates are presented in parentheses below coefficient.

*Statistically significant at 0.05 level or greater.

APPENDIX III

EQUATION 2

Dependent Variable

Mean industry liability loss ratio (1973-77)

$F = 6.49$

$\bar{R}^2 = 0.46$

$R^2 = 0.54$

Independent Variables	Regression coefficient	$\bar{R}^2$ change
Constant	51.10	
Rating law type (categorical variables)	0.61 (1.73)	0.00
New Jersey (categorical variable)*	20.67 (4.83)	0.27
Department staff ÷ population	1.19 (0.71)	0.17
Department budget ÷ $\sqrt{\text{population}}$	0.66 (0.33)	0.05
Market share of direct writer	0.13 (0.07)	0.05
Elected commissioner (categorical variable)	0.98 (2.12)	0.00

*Statistically significant at 0.05 level or greater.

APPENDIX III

EQUATION 3

Dependent Variable

Mean industry physical damage ratio (1973-77)

$F = 2.05$

$\bar{R}^2 = 0.14$

$R^2 = 0.27$

Independent Variables	Regression coefficient	R^2 change
Constant	74.79	
Market share of direct writers	-0.13 (0.68)	0.18
Percent of trained professionals*	0.21 (0.01)	0.06
Commissioner selection	-2.03 (2.13)	0.02
Rating law type (dummy)	-0.97 (1.73)	0.01
State staff ÷ population	-0.30 (0.73)	0.00
State budget variable	0.11 (0.03)	0.00

*Statistically significant at 0.05 level or greater.

APPENDIX III

EQUATION 4

Dependent Variable

1977 Industry liability loss ratio

$F = 1.40$

$\bar{R}^2 = 0.07$

$R^2 = 0.23$

Independent Variables	Regression coefficient	R^2 change
Constant	63.81	
Rating law type (dummy)	-0.79 (2.48)	0.02
New Jersey (categorical variable)	19.58* (6.93)	0.19
Percent of trained professionals	0.01 (0.02)	0.02
State budget variable	-0.24 (0.48)	0.02
State staff ÷ population	0.52 (1.04)	0.04
Market share of direct writers	-0.03 (0.10)	0.02
Commissioner selection	-0.68 (3.05)	0.01

*Statistically significant at 0.05 level or greater.

APPENDIX III

EQUATION 5

Dependent Variable

Industry property damage loss ratio (1977)

$F = 1.68$

$\bar{R}^2 = 0.11$

$R^2 = 0.27$

Independent Variables	Regression coefficient	R^2 change
Constant	66.95	
Rating law type	-2.94 (2.61)	0.04
Percent of trained professionals	0.04 (0.02)	0.09
Department staff ÷ population	-1.24 (1.10)	0.08
New Jersey (categorical variable)	8.17 (7.30)	0.03
Budget ÷ $\sqrt{\text{population}}$	-0.36 (0.50)	0.01
Elected commissioner	-2.15 (3.21)	0.01
Market share: direct writers	-0.01	0.00

APPENDIX III

EQUATION 6

Dependent Variable

Mean industry liability loss ratio (1973-77)

$F = 6.09$

$\bar{R}^2 = 0.44$

$R^2 = 0.53$

Independent Variables	Regression coefficient	R^2 change
Constant	52.04	
New Jersey (categorical variable)	20.44 (4.86)	0.26
Department budget ÷ population	0.49 (0.24)	0.15
Market share: direct writers	0.12 (0.07)	0.05
Department staff ÷ $\sqrt{\text{population}}$	0.14 (0.07)	0.06
Rating law type	0.58 (1.74)	0.00
Percent of trained professionals	-0.2×10^{-2} (0.01)	0.00

APPENDIX III

EQUATION 7

Dependent Variable

Mean industry liability loss ratio (1973-77)

$F = 2.75$

$\bar{R}^2 = 0.18$

$R^2 = 0.29$

Independent Variables	Regression coefficient	R^2 change
Constant	51.77	
Staff ÷ population	1.22 (0.88)	0.16
Budget ÷ $\sqrt{\text{population}}$	0.70 (0.40)	0.06
Market share: direct writers	0.12 (0.07)	0.07
Percent of trained professionals	-0.3×10^{-2} (0.01)	0.00
Elected commissioner	0.32 (2.61)	0.00

APPENDIX III

EQUATION 8

Dependent Variable

Mean industry liability loss ratio (1973-77)*

$F = 3.70$

$\bar{R}^2 = 0.26$

$R^2 = 0.36$

Independent Variables	Regression coefficient	R^2 change
Constant	52.04	
Budget ÷ population	0.49 (0.24)	0.21
Market share: direct writers	0.12 (0.07)	0.07
Department staff ÷ $\sqrt{\text{population}}$	0.14 (0.07)	0.08
Regulatory law type	0.58 (1.74)	0.00
Percent of trained professionals	-0.2×10^{-2} (0.01)	0.00

*New Jersey excluded from this analysis.

APPENDIX III

EQUATION 9

Dependent Variable

Mean industry physical damage loss ratio (1973-77)*

$F = 2.12$

$\bar{R}^2 = 0.15$

$R^2 = 0.28$

Independent Variables	Regression coefficient	R^2 change
Constant	74.29	
Market share: direct writers	-0.12 (0.07)	0.18
Percent of trained professionals	0.02 (0.01)	0.06
Elected commissioner	-2.23 (2.15)	0.02
State budget variable	-0.20 (0.24)	0.01
Department staff $\div\sqrt{\text{population}}$	-0.04 (0.07)	0.01
Rating law type	-0.75 (1.72)	0.00

*New Jersey excluded from this analysis.

APPENDIX IV

1978
VIRGINIA AUTO INSURANCE
CONSUMER'S GUIDE

Prepared by
BUREAU OF INSURANCE
STATE CORPORATION COMMISSION
COMMONWEALTH OF VIRGINIA

APPENDIX IV

January 1, 1978

AUTOMOBILE SAMPLE INSURANCE RATE TABLE*

STATEWIDE AVERAGE RATES FOR VIRGINIA'S 50 LARGEST COMPANIES BY MARKET SHARE

Name of Company	Married Male Age 45	Single Male Age 20	Single Female Age 20
I. Family Auto Policy Rates			
Aetna Casualty & Surety Co.	258	522	258
Aetna Insurance Co.	307	680	355
Allstate Insurance Co.	207*	600*	327*
American Interinsurance Exchange	589	1,601	589
American Motorists Ins. Co.	246	542	246
American Mutual Ins. Co. of Boston	295	652	340
Colonial Penn Ins. Co.	246	610	303
Commercial Union Ins. Co.	251	632	300
Continental Casualty Co.	259	712	371
Continental Insurance Co.	320	707	369
Criterion Insurance Co.	296	629	296
Dairyland Insurance Co.	589	1,174	589
Early Settlers Insurance Co.	258	584	258
Erie Insurance Exchange	225**	502**	225**
Excel Insurance Co.	359	642	529
Federated Mutual Ins. Co.	268	589	308
Fidelity & Casualty Ins. Co.	320	707	369
Fireman's Fund Ins. Co.	268	591	361
Globe Indemnity Co.	316	641	316
Government Employees Ins. Co.	199	484	222
Great America Ins. Co.	302	662	346
Harleysville Mutual Ins. Co.	239	522	239
Hartford Accident & Indemnity Co.	326	718	375
Home Indemnity Co.	341	756	395
Ins. Co. of North America	315	638	315
Liberty Mutual Fire Ins. Co.	230†	494†	230†
Lumbermens Mutual Casualty Co.	246	542	246
Maryland Casualty Co.	293	652	341
Nationwide Mutual Ins. Co.	254	496	254
New Hampshire Ins. Co.	319	708	368
Peerless Insurance Co.	323	714	372
Penn. National Mutual Casualty Co.	287	634	332

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Phoenix Insurance Co.	214	437	214
Reliance Insurance Co.	303	669	333
Royal Globe Ins. Co.	316	641	316
St. Paul Fire & Marine	329	498	317
Selected Risks Ins. Co.	322	714	372
Shelby Mutual Ins. Co.	322	714	372
State Farm Fire & Casualty Co.	386	940	460
State Farm Mutual Auto. Ins. Co.	232	562	274
Travelers Indemnity Co.	274	561	274
Unigard Mutual Ins. Co.	322	714	372
USAA Casualty Co.	281	401	281
United Services Automobile Assoc.	226	322	226
U. S. Fidelity and Guaranty Co.	295	651	340
United States Fire Ins. Co.	308	675	355
Universal Underwriters Ins. Co.	322	714	372
Utica Mutual Ins. Co.	270	624	270
Va. Farm Bureau Mutual Ins. Co.	238	534	238
Virginia Mutual Ins. Co.	255	524	255

II. Special Package Auto Policy Rates

Aetna Casualty & Surety Co.	216‡	456‡	216‡
Globe Indemnity Co.	251	534	251
Harleysville Mutual Ins. Co.	199	433	199
Hartford Accident & Indemnity Co.	260	582	303
Ins. Co. of North America	246	523	246
Liberty Mutual Fire Ins. Co.	235	504	235
Maryland Casualty Co.	278	613	320
Peerless Insurance Co.	268	591	309
Penn. National Mutual Casualty Co.	240	530	278
Royal Globe Insurance Co.	251	534	251
Shelby Mutual Insurance Co.	268	591	309
U. S. Fidelity & Guaranty Co.	245	540	282
Virginia Mutual Insurance Co.	249	511	249

* Includes $1,000 Medical Payments

** Includes $25,000 Property Damage

† Includes $10,000 Property Damage Plus $1,000 Death Benefits

‡ Includes $55,000/2,000/1,000 limits,
All others include $60,000/2,000/1,000 limits

* This table shows which companies have rates that are generally higher or lower, but the relative position of a company's rates may vary substantially in particular cases. (See page 19 for explanation.)

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Massachusetts Automobile Insurance Policy

ALLSTATE INSURANCE COMPANY

Regional Office
70 Batterson Park Road
Farmington, Connecticut 06032
(203) 674-7000

The name and phone number of your Allstate Agent appears in ITEM 1. on the COVERAGE SELECTIONS PAGE.

This is your new automobile insurance policy. The Division of Insurance has rewritten the old policy and simplified it. You can now understand just what insurance you have and how much it costs.

Please read your policy. Part of the policy is a page marked "Coverage Selections". You should keep it in the pocket on the back cover of the policy. It shows the types and amounts of coverage you have purchased. As you read the policy, check the Coverage Selections page to make sure it shows exactly what you intended to buy. If there is any question, call your agent or company right away.

This policy form has been approved by James M. Stone, Commissioner of Insurance.

APPENDIX V

Introduction 1

This insurance policy is a legal contract between the policy-owner (you) and the company (we or us). It insures you and your auto for the period shown on the Coverage Selections page.

As long as you pay your premium and any Merit Rating surcharges when due, we agree to provide you or others the benefits to which you or they are entitled. The exact terms and conditions are explained in the following pages.

There are two basic categories of insurance described in this policy, Compulsory Insurance and Optional Insurance.

Compulsory Insurance

There are four Parts to Compulsory Insurance. They are all required by law. Every auto registered in Massachusetts must have them.

Optional Insurance

There are eight Parts to Optional Insurance. Some of them extend the coverage or the amounts of protection provided by Compulsory Insurance. Some of them provide protection not found in Compulsory Insurance. You do not have to buy any of these eight Parts if you do not want to.

Auto insurance claims arise in hundreds of different ways. Autos are sometimes stolen or damaged. Accidents may injure people in your auto, people in other autos or pedestrians. You may be responsible for an accident or someone else may be. An accident may happen in Massachusetts or out of state. Different situations require different kinds of insurance.

Please read the whole policy to see what kinds of insurance are available to cover these different situations. At the same time, you should check the Coverage Selections page to make sure it correctly indicates the coverages you purchased. Each coverage you purchased will show a premium charge next to it. If no premium charge is shown, you do not have that coverage.

Sometimes you and we will agree to change this policy. The only way that can be done is by an "Endorsement" added to the basic policy form. All endorsements must be in writing. They then become part of this policy.

We are pleased to have you as a customer and hope you have a safe and accident-free year. But if you need us, we are here to help you. If you have an accident or loss, or if someone sues you, contact your agent or us.

Do the same if you have any questions or complaints. If you think we have treated you unfairly at any time, you may contact the Division of Insurance. In Boston call (617) 727-3341. In Springfield call (413) 736-8340.

APPENDIX V

2 Our Agreement

This policy is a legal contract under Massachusetts law. Because this is an auto policy, it only covers accidents and losses which result from the ownership, maintenance or use of autos. The exact protection is determined by the coverages you purchased.

We agree to provide the insurance protection you purchased for accidents which happen while this policy is in force.

You agree to pay premiums and any Merit Rating surcharges when due and to cooperate with us in case of accidents or claims.

Our contract consists of this policy, the Coverage Selections page, any endorsements agreed upon, and your application for insurance. Oral promises or statements made by you or our agent are not part of this policy.

There are many laws of Massachusetts relating to automobile insurance. We and you must and do agree that, when those laws apply, they are part of this policy.

APPENDIX V

Compulsory Insurance 3

There are four Parts to Compulsory Insurance. They are called Compulsory Insurance because Massachusetts law requires you to buy all of them before you can register your auto. No law requires you to buy more than this Compulsory Insurance. However, if you have financed your auto, the bank or finance company may legally insist that you have some Optional Insurance as a condition of your loan.

The amount of your coverage and the cost of each Part is shown on the Coverage Selections page.

Your Compulsory Insurance does not pay for any damage to your auto no matter what happens to it.

Part 1.
Bodily Injury To Others

Under this Part, we will pay damages to people injured or killed by your auto in Massachusetts accidents. Damages are the amounts an injured person is legally entitled to collect for bodily injury through a court judgment or settlement. We will pay only if you or someone else using your auto with your consent is legally responsible for the accident. The most we will pay for injuries to any one person as a result of any one accident is $5,000. The most we will pay for injuries to two or more people as a result of any one accident is a total of $10,000. This is the most we will pay as the result of a single accident no matter how many autos or premiums are shown on the Coverage Selections page.

We will *not* pay:

1. For injuries to guest occupants of your auto.

2. For accidents outside of Massachusetts or in places in Massachusetts where the public has no right of access.

3. For injuries to any employees of the legally responsible person if they are entitled to Massachusetts workers' compensation benefits.

The law provides a special protection for anyone entitled to damages under this Part. We must pay their claims even if false statements were made when applying for this policy or your auto registration. We must also pay even if you or the legally responsible person fails to cooperate with us after the accident. We will, however, be entitled to reimbursement from the person who did not cooperate or who made any false statements.

If a claim is covered by us and also by another company authorized to sell auto insurance in Massachusetts, we will pay only our proportional share. If someone covered under this Part is using an auto he or she does not own at the time of the accident, the owner's auto insurance pays up to its limits before we pay. Then, we will pay up to the limits shown

APPENDIX V

4 Compulsory Insurance (Continued)

on your Coverage Selections page for any damages not covered by that insurance.

Any payments we make to anyone or for anyone under Bodily Injury Caused By An Uninsured Auto (Part 3) or Bodily Injury Caused By An Underinsured Auto (Part 7) will reduce the amount of damages that person is entitled to recover from anyone covered under this Part.

Part 2. Personal Injury Protection

The benefits under this Part are commonly known as "PIP" or "No-Fault" benefits. It makes no difference who is legally responsible for the accident.

We will pay the benefits described below to you and other people injured or killed in auto accidents. For any one accident, we will pay as many people as are injured, but the most we will pay for injuries to any one person is $2,000. This is the most we will pay no matter how many autos or premiums are shown on the Coverage Selections page.

We will pay three kinds of benefits:

A. Medical Expenses

We will pay all reasonable expenses incurred as a result of the accident for necessary medical, surgical, X-ray and dental services. This includes prosthetic devices. It also includes ambulance, hospital, professional nursing and funeral services.

B. Lost Wages

If an injured person is out of work because of the accident, we will pay lost wages up to 75% of his or her average weekly gross wage or equivalent for the year ending on the day immediately before the accident. We will not pay for the loss of any other type of income. If the injured person was unemployed at the time of the accident, we will pay up to 75% of the amount he or she actually lost in earning power as a result of the accident.

C. Replacement Services

We will reimburse the injured person for reasonable payments made to anyone outside his or her household for necessary services that he or she would have performed without pay for the benefit of the household, had he or she not been injured.

We will pay PIP benefits to or for:

1. You, or any other person, if injured while occupying your auto with your consent.

2. You, or anyone living in your household, if injured while occupying an auto which does not have Massachusetts Compulsory Insurance or if struck by an auto which does not have Massachusetts Compulsory Insurance.

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3. Any pedestrian, including you, if injured by your auto in Massachusetts or any Massachusetts resident who, while a pedestrian, is struck by your auto outside of Massachusetts.

Benefits are paid only for expenses or losses actually incurred within two years after the accident.

If the accident is in Massachusetts, or if it is outside Massachusetts and the injured person does not sue for damages, we will pay benefits within a reasonable time – usually thirty days. If the accident is outside Massachusetts and the injured person does sue, then we can wait for a settlement or judgment before paying benefits.

Some people have a wage continuation program at work. If so, we will pay them only the difference between the total we would ordinarily pay under this Part and the amount of the program payments. We will, however, reimburse the program if it allows benefits to be converted into cash or additional retirement credit. Sometimes program benefits are reduced or used up because of payments to the person injured in an accident. In that case we will pay for lost wages resulting from any other illness or injury that person has within one year of our last payment. The exact amount of our payments under this paragraph will be determined by Massachusetts law.

We will *not* pay PIP benefits to or for:

1. Anyone who, at the time of the accident, was operating or occupying a motorcycle or motorized bicycle, including a Mo-Ped.

2. Anyone who contributed to his or her injury by operating an auto (a) while under the influence of alcohol, marihuana, or a narcotic drug, (b) while committing a felony or seeking to avoid arrest by a police officer, or (c) with the specific intent of causing injury to himself, herself or others.

3. Anyone who is entitled to workers' compensation benefits for the same injury

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When you purchased this Part you were given the choice of either excluding yourself, or yourself and household members, from some or all of the PIP coverage. The portion of each claim you may have agreed not to be covered for is called a "deductible". You paid a smaller premium if you chose a deductible. In that case, we will only pay up to the difference between $2,000 and the amount of your deductible. The deductible is shown on the Coverage Selection page.

If anyone is entitled to PIP benefits and also to benefits under another Part of this policy, we will pay from this Part first.

APPENDIX VI

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The Nature and Scope of its Operations

The National Association of Insurance Commissioners (frequently called the NAIC) was organized in 1871. Its membership consists of the chief insurance regulatory authorities of the 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. As such, it is the oldest association of state officials.

The insurance business is conducted in the United States on a nationwide basis but it is not regulated federally. Each state provides the necessary regulation within its own boundaries. In order to integrate the activities of the states and to prevent conflict which would hamper the national operation of the business, it is essential to have some central vehicle to tie the activities of the states together. The National Association of Insurance Commissioners (NAIC) fulfills this role.

A. Objectives

Article 2 of the Constitution provides that the purposes of the NAIC are to:

(1) promote uniformity in legislation affecting insurance,
(2) encourage uniformity in departmental rulings under the insurance laws of the several states,
(3) disseminate information of value to insurance supervisory officials in the performance of their duties,
(4) establish means to fully protect the interests of insurance policyholders, and
(5) preserve to the several states the regulation of the business of insurance.

To achieve these purposes, the NAIC utilizes (1) an extensive committee system, and (2) a permanent NAIC staff located in two offices.

B The NAIC Committee System

The NAIC operates through an extensive committee system. In addition to the Executive Committee and four parent standing committees, several subcommittees are appointed covering the full range of insurance regulatory problems. These committees and subcommittees draw upon the expertise of various insurance departments in developing information and/or policy for adoption by the NAIC as a whole.

The NAIC holds two national meetings each year. These meetings consist of a series of hearings held by the various committees and subcommittees on current regulatory problems. They provide a forum for the Commissioners, the industry, and interested members of the public to discuss regulatory problems, particularly those of an interstate nature. Furthermore, the committee system provides a mechanism for bringing to bear a wide range of expertise on regulatory problems and for developing possible solutions. During the open session any interested party is afforded an opportunity to be heard. During the executive session, programs and recommendations are developed. Some subcommittees also hold interim meetings during the year

depending upon the scope of their projects.

C. The Objective of Uniformity

In addition to exchanging information and expertise, an important objective is to blend an appropriate degree of uniformity in state insurance regulation with variations to accommodate local needs and problems. Four examples illustrate how the NAIC facilitates this process.

(1) Annual Statement

Through its Blanks Subcommittee the NAIC provides the form for the annual statement for use from coast to coast. Since conditions in the business are constantly changing, the form must be revised from year to year. These blanks are signed under oath by responsible executive officers of each company, are filed in the office of the insurance commissioner in each state as a matter of public record and they furnish a major part of the statistical data on the insurance business. If each state undertook to prescribe its own form instead of using the NAIC form, there would be chaos.

(2) Examination of Insurers

(a) Examination Calls. The NAIC provides, through its Financial Condition, Examinations Reporting Committee, a centralized machinery for conducting examinations of insurance companies. Many insurers do business from coast to coast. If each state exercised its power to examine each company individually, there would be immense duplication of effort, unnecessary expense, conflicting reports of examination, etc. The NAIC has devised the convention system of examination. Under this plan, the United States is broken down into six zones. The NAIC coordinates these examinations under which each zone is represented rather than each state. The Zone Chairman designates states on a rotation basis to represent the zone. The reports of examinations are filed as public documents with the Insurance Commissioner of each state in which the company does business.

(b) Examiners Handbook. The NAIC, through the appropriate subcommittee, prepares and keeps up to date an Examiners Handbook. This helps maintain uniform quality of the examinations conducted under the auspices of the NAIC.

(c) List of Qualified Examiners. The NAIC maintains and distributes on a quarterly basis a list of examiners to assist states in the examination process.

(3) Valuation of Securities

Through its Valuation Office in New York, the NAIC values on a uniform basis the securities held in portfolios of virtually every insurance company in the United States. If each state attempted to value these securities individually, there would be duplication of expense and conflicting valuations. In the absence of this

uniformity, it would be most difficult, if not impossible, for the companies to complete their annual statements to meet year end requirements.

The NAIC has the power, through its Valuation of Securities Subcommittee (composed of Commissioners and technical staff), to change the valuation of securities on a countrywide basis in periods of national emergency. The recommendations of the NAIC in this respect must be implemented by the individual states. Thus, in 1932 when President Roosevelt was compelled to close the banks, the NAIC provided an effective machinery for dealing with the same crisis in the insurance business without the need of additional legislation or action by the President.

(4) Model Bills and Regulations

To facilitate legislative and regulatory action on common problems occurring in many states, the NAIC provides a vehicle to draft model insurance regulatory bills and regulations for use in those states where appropriate and needed. This saves duplication of effort and provides every state with information as to how other states have dealt with similar problems. The model bills and regulations serve as guidelines to individual states which, in turn, adopt them, modify them or use something else, depending upon local needs and problems. Commencing in recent years, each volume of the NAIC Proceedings contains a list of model bills and regulations adopted to date and citations as to where the text can be found in the Proceedings.

D. NAIC State Offices

The NAIC maintains two offices.

(1) Valuation of Securities Office

This office values insurance company securities for Annual Statement purposes (see above). The office is located in New York City in the financial district. It is financed by assessments levied against insurance companies under special statutes enacted in a number of states, by state contributions and by the sale of various reports compiled by that office. Its operating budget for the current fiscal year ending April 30, 1978 is approximately $520,000.

(2) Central Office

The NAIC Central Office functions in eight primary areas: (a) administrative matters, (b) federal legislative and regulatory activity in Washington, (c) NAIC committees' and subcommittees' support, (d) insurance department support, (e) research on fundamental insurance regulatory problems, (f) NAIC data base and statistical reporting, and (g) medical malpractice closed claims data base and non-admitted insurers information. The office is located in Milwaukee, Wisconsin. The Central Office is financed by the sale of various materials such as the Proceedings and various studies, and by assessments levied against the individual

states according to a pro-rata formula adopted by the Commissioners making up the NAIC. The budget for the current fiscal year ending April 30, 1978 is approximately $760,000.

E. NAIC Central Office

(1) Administrative Functions

This function can be classified into the following categories. First, the Central Office conducts several activities in conjunction with the two NAIC national meetings each year. Second, the Central Office prepares and published NAIC Proceedings. These constitute the official record of NAIC action. They contain research, memorandums, briefs, etc., thereby providing a continuous source of information concerning regulatory activities of the states which are considered by the NAIC. Third, the Central Office periodically prepares and distributes the NAIC calendar as to when and where various subjects will be brought up for consideration, copies of NAIC committee and subcommittee lists, etc. to state insurance departments and other interested persons. Fourth, the Blanks Subcommittee agenda compilation and distribution system has been implemented.

(2) Washington Function

The Central Office screens Federal bills to ascertain those of interest to the NAIC, analyzing such bills and tracking their progress through the legislative process. Time is spent in Washington monitoring hearings and visiting with Congressional and administration staff personnel to learn what is going on. Furthermore, efforts are being made to establish and maintain good liaison with various Federal departments. On occasion, a member of the staff may serve as backup man to the Commissioner who is testifying on behalf of the NAIC. Commonly the staff works with the Commissioner in drafting his written testimony. At the same time the Central Office attempts to keep each Insurance Department informed through distribution of status reports, synopsis of bills, background memorandums and whatever else is necessary.

(3) NAIC Committee and Subcommittee Support

Central Office Staff support has been assigned to various subcommittees and task forces. This involves work on, for example, improving the early warning tests, the annual statements, uniform complaint handling system, special projects, development of medical malpractice data, drafting model laws or legislation and handling NAIC litigation.

(4) Insurance Department Support

Staff support to insurance departments (as distinguished from support to NAIC Committees) includes the following major activities:

(a) The Central Office provides the machinery for coordinating examination calls and for compiling and distributing up to date lists of examiners on a quarterly basis to each department.

(b) Compilation and distribution of agents whose licenses have been suspended or revoked is made on a monthly basis. Experience has demonstrated that such agents often move to another state. This machinery provides a method to deal with the problem.

(c) Responses to numerous requests for information are made.

(d) Individual company solvency and profitability results are distributed periodically to the departments.

(e) Central Office maintains the year to date file of complaints pooled by the states on the NAIC complaint data base system.

(5) Research Function

Pursuant to a resolution adopted at the June 1968 meeting in Portland, Oregon, the concept of the Central Office was enlarged to embrace in-depth research on regulatory problems. Attached is the Statement of Policy as to the research function of the Central Office. The Central Office functions in a staff capacity. It is not a policy making body. Research activities in this office have been conducted concerning numerous subjects. Below appears a list of the major Central Office studies which have been published. At the time of publication, copies were sent to each department. Except for those published in some outside publication (e.g. law review), usually the studies also find their way into the NAIC Proceedings.

Report of the Special Committee on Automobile Insurance Problems by Jon S. Hanson and Robert E. Dineen - 1969 - 200 pages [2 Proceedings of the NAIC 593-690 (1969)]

Preliminary Study of the Taxation of the Insurance Industry by Jon S. Hanson - 1969 [2 Proceedings of the NAIC 953-978 (1970)]

Measurement of Profitability and Treatment of Investment Income in Property and Liability Insurance by Jon S. Hanson and Robert E. Dineen - 1970 -316 pages [2 Proceedings of the NAIC 738-951 (1970)]

A Background Study of the Regulation of Credit Life and Disability Insurance by Bruce W. Clements - 1970 - 191 pages [1 Proceedings of the NAIC 299-497 (1971)]

Regulation of Mass Marketing in Property and Liability Insurance by Jon S. Hanson and Robert E. Dineen - 1971 - 244 pages [1 Proceedings of the NAIC 90-343 (1972)]

Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business by Jon S. Hanson, Robert E. Dineen, and Michael B. Johnson - 1974 - 767 pages [Supplement to 1974 Proceedings of the NAIC]

The Private Insurance Industry and State Insurance Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation by Jon S. Hanson, 6 Toledo Law Review 677-738 (1975)

An Overview-State Insurance Regulation by Jon S. Hanson, 31 CLU Journal, 20 (Apr. 1, 1977)

Federal Preemption of State Insurance Regulation Under ERISA by David J. Brummond - 1976 - 70 pages [Iowa Law Review - Vol. 62/No. 1 - 57-127 (1976)]

The primary research is done by the Central Office staff itself. However, on occasion, with respect to some specific matter, consulting accountants, life actuaries, casualty actuaries, and economists have been used.

The NAIC Central Office is developing a regulatory research library to enable the staff not only to provide the research and support function but also the states with an additional source of information. In addition, staff works in conjunction with NIARS in the development of a looseleaf service containing NAIC model laws and legislation.

(6) NAIC Data Base and Statistical Reporting System

At the December, 1971 meeting in Miami, the NAIC adopted a statistical reporting system for both solvency tests and profitability figures of property and liability insurers. Subsequently, the NAIC adopted by line by state profitability formulas. Similarly, the NAIC at the December, 1972 meeting adopted a life insurance solidity test program. Insurers submit a copy of their annual statements along with the appropriate fee. Commencing in 1977, the operational responsibility to process the data and generate reports was transferred to the Central Office which runs the tests and figures according to the formulas adopted by the NAIC. These results are then made available to the various insurance departments. Furthermore, at the same time the departments receive the data, each insurer participating in the program receives a package of information containing both the individual company's test results.

The administrative burden to implement the Statistical Reporting System was delegated to the Central Office. This includes developing and revising computer specifications, distributing information and materials to insurance departments and participating companies, answering inquiries, developing and implementing a computer system and programs, inputing and editing data, error correction and processing reports.

(7) Medical Malpractice Closed Claim Data Base

APPENDIX VI

The Central Office has continued the development and implementation of the medical malpractice closed claims data base adopted by the NAIC at the June 1975 meeting in Seattle. The administrative responsibility to implement the system was delegated to the Central Office. This involves designing the processing system, designing the computer edits and writing the programs. Personnel to code, edit and transcribe reports are trained and supervised. Medical malpractice insurers fill out the NAIC questionnaire for each closed claim and submit the forms to the Central Office which edits the information, arranges for its keypunching, enters the data into the computer, generates reports, follows up in obtaining missing information and corrects incorrect information. In addition, the Central Office handles numerous requests for special information from both individual states and outside organizations.

The staff assists in designing summary reports and explanations of data. Computer programs are written to produce the reports and explanations of data covering approximately 24,000 claims in one year.

In addition to the closed claim data, the staff prepared an up-to-date listing of state medical malpractice legislation which is included in the report and a compilation of case law involving the constitutionality of medical malpractice reform legislation.

(8) Non-Admitted Insurer Information Function

The NAIC, through its Non-Admitted Insurers Information function, keeps track of the activities of unlicensed alien insurers in the United States. Some are reputable companies or organizations fulfilling legitimate insurance needs which are not provided by admitted companies. Others are fly-by-night so-called "paper" companies set up to fleece the public. The NAIC provides information on these companies and helps monitor their activities.

Pursuant to the action of the NAIC, the activities of the NAIIO have been integrated into the activities of the Central Office. The operational responsibilities were formally transferred to the Central Office on March 1, 1977. The Non-Admitted Information officer is now functioning in accordance with the priorities established by the Regulatory Information (EX2) Subcommittee – e.g. compiling and reviewing financial and other information about non-admitted alien insurers, performing the listing function, reviewing the investigatory function, etc.

(9) Assessment Formula

The assessment formula for the Central Office, revised at the Portland meeting, June 20, 1968 reads as follows:

> The the current assessment formula (known as Plan I) to finance the enlarged Administrative Service Office be revised to provide that state contributions be assessed in direct proportion to premium volume to meet the budget except

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that no state will be assessed an amount less than $1,000 per year.

The states finance the regulation of the insurance business through premium taxes and special fees for the operation of the Insurance Department. On a nationwide basis, total premium tax and fee revenue was approximately $1.79 billion in 1974. In 1974 funds spent for Insurance Department operation approximated $92.2 million. For the fiscal year ending April 30, 1978, the budgeted assessments against the states for the Central Office amounted to $460,700. Even if it is assumed that nationwide figures did not increase from those of 1974, the budgeted assessments constitute slightly less than 1/2 of 1% of Insurance Department budgets and slightly more than 2/100 of 1% of total premium tax and fee revenue.

APPENDIX VII

EXECUTIVE SECRETARY'S OFFICE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

633 W. WISCONSIN AVENUE SUITE 1015 MILWAUKEE, WISCONSIN 53203 414-271-4464

JON S. HANSON
EXECUTIVE SECRETARY
DIRECTOR OF RESEARCH

June 29, 1979

Mr. Harry S. Havens, Director
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Havens:

We have your letter of June 22, received on June 25, to which was attached the draft copy of your report entitled, "State Regulation of the Business of Insurance."

After visiting with the officers of the NAIC, it was concluded that we would be unable to prepare meaningful comments for you within the time frame available. However, we have great interest in your report and will probably avail ourselves of the opportunity to submit comments at a later date. In the meantime, we do anticipate that you will receive comments, at least of a preliminary nature, from several of the states.

Thank you for making this report available to us. We are reading it with great interest.

Best regards.

Sincerely,

Jon S. Hanson
Executive Secretary
Director of Research

ms

cc: The Hon. H. P. Hudson
The Hon. Wesley J. Kinder

APPENDIX VII

STATE OF CALIFORNIA — EDMUND G. BROWN JR., Governor

DEPARTMENT OF INSURANCE
600 SOUTH COMMONWEALTH AVENUE
LOS ANGELES, CALIFORNIA 90005
(213) 736-2551

July 3, 1979

Harry S. Havens, Director
United States General Accounting Office
Program Analysis Division
Washington, D.C. 20548

Dear Mr. Havens:

We appreciate the opportunity to review the Draft of a Proposed Report on "State Regulation of the Business of Insurance". The limited amount of time available does not give us the chance to offer a detailed and organized analysis, but the following commentary may be of value to you.

Chapter 3: You take passing recognition of the fact that '... larger states have far more domestic insurers than small states', but apparently overlook the significance of domicile in the basic responsibility for solvency regulation. Perhaps Tables 3 and/or 4 could be extended to show the number of insurers domiciled in each state. (You may have this information as suggested in Chapter 4, page 2.) An additional factor here would be the number of domiciliary insurers writing in one or more additional states.

Two factors which can add significantly to department expenditures are prior approval rate regulation and liquidation/rehabilitation costs. With respect to the latter, in many states such costs are borne by Guarantee Associations and are outside of department budgets. Comparisons by state are relatively meaningless without recognizing such differences.

California attempts to cover the cost of insurance regulation through fees and charges to insurers. Since the fee schedule changes infrequently, the pattern is an excess of income over outgo in the year of a fee schedule change, break-even for the year or two following, and then an increasing deficit until the schedule is again updated.

With respect to 'professional resources', the groups included as professionals may result in some distortion of the evaluation. For example, CPCU and CLU are indicative of a different professional standard than lawyers and actuaries. You have emphasized the importance of actuaries, and properly so; however, it is questionable that even the largest departments have need for more than one life actuary and one casualty actuary. Detail work can be done by non-professionals under the direction of the professional.

Many states utilize legal services of the State Attorney General and you might analyze the budgets of the several departments to determine the extent of this utilization of 'outside' professional resources.

An increasingly time-consuming activity is responding to inquiries and requests for information by federal agencies, congressional committees, subcommittees and inter-agency task forces. We recognize the need to cooperate fully in this activity, but it does use up limited resources.

On pages 3-31 you attribute a statement to an official of the California Insurance Department that some of the department's best staff members leave for better paying jobs in the insurance industry. This is not so. Recent losses of senior people can be attributed to retirement benefit situations. We do find it difficult to recruit experienced personnel because of a freeze on state salary levels resulting from Proposition 13. That is a state government problem, and not only a Department of Insurance problem.

Chapter 6: On pages 6-32, Table 4, you identify California in column 2. We are <u>not</u> a file and use state, but we do have authority to disapprove a classification. The California Department of Insurance is analyzing classification plans and relativities as a part of our rating examinations?

The NAIC at its June 1979 meeting adopted the attached resolution.

On pages 6-53/54 you refer to certain wording in an NAIC model law and cite an example to illustrate its limitation. We have that law in California but do not share your concern about its limitation. If an insurer establishes a classification for drivers 21 to 24 years old we believe it would not be "inconsistent with the rating system" to require data for ages 21, 22, 23 and 24 separately. If an insurer did not use age as a classification factor it <u>might</u> be 'inconsistent' to require any data on age. <u>All</u> classification plans must meet the 'not unfairly discriminatory' test and that requirement must not be overlooked when interpreting 'inconsistent with the rating system'.

Chapter 8: Certain references in this chapter and earlier give an impression that NAIC functions somewhat independently. It is a voluntary association of the Commissioners to achieve the objectives set out. It should not be regarded as a separate entity.

The fact that industry representatives outnumber commissioners and staff at the semi-annual meetings seems to be regarded as an evil. How could the numbers be otherwise, considering the number of insurers? Since NAIC activity is directed, in part, to proposed model legislation the industry affected cannot be denied input nor knowledge of the development of proposed legislation. The subcommittee work that goes on at the meetings can be quite

APPENDIX VII

technical and insurers may send several representatives to the meeting, each with expertise in a special area.

At one time NAIC Advisory Committees were made up entirely of industry representatives. Currently, there must be at least one consumer representative on each advisory committee. It is difficult to get consumer representatives to serve on committees since we are unable to reimburse them for time and expenses. The NAIC has a special subcommittee responsible for encouraging and developing consumer participation.

The registration fees from industry do pay for the administrative expenses of the meeting. As cited earlier, all costs of regulation should be borne by the insurers. (Indeed, it is the policyholders who pay the bills; and it seems appropriate that policyholders, rather than all taxpayers, should.) It should be noted that no registration fees are charged to any government representatives, state or federal, academics or consumer representatives.

Lastly, and most importantly, I am disturbed by your reference to finding examples of the appearance of conflicts of interest. By this very general statement you leave each of us charged with a serious breach of integrity and without any way of defending ourselves. Surely, you cannot finalize the report without correcting this grievous error. If you have evidence of conflicts of interest then cite the specific instances. If not, remove the inference from your report. The manner in which the report reads now does a grave disservice to all commissioners, and I cannot believe that it does a service for GAO.

As time permits we will respond more completely to your proposed report.

Very truly yours,

WESLEY J. KINDER
Insurance Commissioner

WK:hp

APPENDIX VII

STATE OF CONNECTICUT

DEPARTMENT OF BUSINESS REGULATION
DIVISION OF INSURANCE

July 9, 1979

Harry S. Havens, Director
United States General Accounting Office
Program Analysis Division
Washington, D.C. 20548

Re: "State Regulation of the Business of Insurance"

Dear Mr. Havens:

The following are the comments you requested in connection with the GAO draft report, "State Regulation of the Business of Insurance":

Page	Comment
2-11	"In a competitive market, we would expect price differences to be related to quality differences." Price difference related more to selection of insureds, i.e., underwriting criteria than quality. On third party claims, it is not too important to an insured how the company handles claims, ie, promptness, fairness, etc., since the insured is not directly involved.
3-14	". . . Securities and Exchange Commission and the Federal Trade Commission -- the two Federal agencies that are somewhat parallel to insurance departments in that they have broad jurisdiction over financial and trade practice matters." Doubt that they have volume of different documents comparable to policy forms, manuals, rating plans. Do they have equivalent of rate filings to review? Do they have claim cases to resolve comparable in volume to our Claims Section? I believe the parallel is greatly over-simplified.
3-32	Concern over short terms of Commissioners. Short term may be better than long term for the following reasons: 1. New, fresh ideas and different perspectives on various areas of regulation. 2. Commissioner can be compared to a vice-president of a private corporation. The changeover (not termination but movement due to promotions) results in these positions

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being short term without ill effects, generally speaking.

3. Management of many organizations deliberately move key people around periodically in order to promote fresh ideas, etc.

4-16 Breakdown of Complaint Disposition

I feel the discussion and chart may be misleading. "No Relief" cases include, for example, "premium correct" 330 cases. "No Relief" leaves me with the feeling the Department should have, but could not do anything. Actually, many of the complaints were unwarranted. I would prefer to divide "No Relief" as follows:

Not Legitimate Complaints		Other Action Prevents Dept. Assistance	
Comparative Neg.	137	Atty. Retained	230
Cancel. Upheld	322	Entered Arbitration	131
Non-renewal Upheld	59		
Premium Correct	330		
Claims Corr. Paid	727		
Claims Denied Properly	1115		

4-17 "In fact, the Massachusetts report stated that 'We can safely say that approximately 9 out of every 10 consumers who contact the CSS (Consumer Service Section) have a legitimate gripe.'"

Of the 10,133 complaints, I count over 2,500 cases which do not have legitimates gripes.

4-19 ". . . there are improvements needed in order to make complaint handling a useful tool of regulatory policy."

While I agree that more review of complaint statistics should be done, I feel we have a good system in Connecticut whereby complaints received are coded, leading to a computer printout summarizing complaints received. Analysis is done on a continous basis to determine if the complaint pattern shows a failure by a company or insurance system requiring corrective action. Much of our proposed legislation is generated from complaint reviews.

5-4 Criticism of prior approval states - either "rubber stamps" or overly restrictive.

I don't think Connecticut fits either group. Generally, we are timely to the extent company responds to our questions promptly and differences can be supported.

5-26 "Furthermore, in the case of automobile insurance, we are able to test whether that theoretical competitive potential can be realized in practice."

I don't believe competition in the area of auto insurance can be tested, since too many factors are not taken into account, the greatest of which is the agency system.

5-32 Tests prior approval states against file and use.

Only three states were used (New Jersey, Pennsylvania and California). Of the three, I do not feel that New Jersey is a typical prior approval state as even the report noted earlier that New Jersey average filing was delayed one year while most states averaged a few months. Also, those states with prior approval, just as those with no-fault, are subject to different conditions as to accident experience, claim experience,etc. This in fact is why they have prior approval and/or no-fault. They are attempting to solve a problem. The other states do not have these problems or at least not to the same extent so do not go to prior approval or no-fault.

5-54 " . . . the average percentage of drivers in the automobile insurance plan in the 31 prior approval states was 6.6% compared to only 2.0% in the 11 open competition states.

I feel this statement is misleading because many open competition states do not have mandatory or compulsory insurance. Therefore, if you do not want to pay high assigned risk rates and cannot get into the voluntary market, you don't get insurance. A proper test would add the assigned risk and uninsured population together.

5-56 ". . . the Commissioner in Connecticut implemented his decision requrring insurance companies to realign their rating territories by holding up rate approvals until they would do so."

This statement is incorrect. When reviewing rates is the obvious time to test for unfair discrimination - to allow a rate change and ignore my own decision would be ridiculous.

5-56 "Moreover, the time and effort that goes into automobile insurance rate regulation could be more fruitfully applied to directly confronting the market failures discussed above or to protecting consumers in non-competitive insurance markets."

Why should only one or the other be done - if both are important, then do both.

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Page 4

6-1 through
6-33 Discussion of class, age, sex, etc.

This section quotes New York law on class, but includes portion on individual risk rating plans which have nothing to do with private passenger auto for the individual and is always confused by laymen.

6-46 Commercial Union identifies and rates rural drivers working and driving to the city.

This will not help the city people - the higher rates will help those rural drivers' neighbors.

6-52 "The [Connecticut] Department did not analyze territorial data itself, but instead reviewed the opposing submissions of the City of Hartford and the insurance industry."

This is incorrect. We did analyze the territorial data and , in fact, I believe all or almost all such data at the hearing came from our exhibits, etc.

7-7 Table I - Studies on Redlining

Connecticut has conducted a study of redlining and a staff report has been submitted to me and released to the public (copy attached). I have also directed staff to prepare regulations prohibiting practices identified as redlining.

7-18 Table 4 - Measures of Insurance Availability

This states that uninsured motorist population in Connecticut is 20.2% based on registered autos less insured autos. I would like to see the definitions of registered autos and uninsured autos. I suspect there is a mix between commercial vehicles, public vehicles, composite rate vehicles, etc. which distorts the figures.

7-27 Assigned risk plans have a large number of "clean" risks.

This could be deceptive. We have proven that over 20% of applications stating no accident involvement in the past three years actually have had such an incident.

Very truly yours,

Joseph C. Mike/bph

Joseph C. Mike
Commissioner

JCM/bph

APPENDIX VII

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
CHICAGO, ILLINOIS 60601

OFFICE OF THE DIRECTOR

June 29, 1979

Mr. Harry S. Havens
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Havens:

I appreciate the opportunity to comment on the draft GAO report concerning state regulation of insurance.

The draft report, though necessarily an overview type of document, does present much useful information and does add force in its recommendations to a number of ongoing efforts to improve insurance regulation.

Several points deserve comment at this time, though the ten-day limitation on comment by no means provides enough time to thoroughly evaluate the material in the report.

First, the report concludes (pages 4-8) that "based on the relatively small number of insolvencies, the deficiencies in the process of financial regulation apparently does (sic) not manifest itself (sic) in any substantial solvency problem."

This may or may not be true. A critically important consideration in the area of financial regulation is the extent to which proficiency in such regulation can have an ameliorative effect on the magnitude and severity of loss in insolvencies. Overlooking this facet of financial regulation which involves the point in time at which an insolvency is discovered leads to an incomplete theory of financial regulation.

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Second, (pages 4-6) the report states that only Wisconsin uses an appreciable number of CPA exams in its financial regulatory process. Illinois requires a CPA audit to be submitted by each domestic company and Massachusetts requires such reports from all licensed companies. The Illinois experience demonstrates these CPA audits to be extremely useful.

Third, (pages 4-5) the report flatly states that a discriminant analysis early warning test developed by Aetna demonstrated greater predictive power than the early warning test of the NAIC. Though there is a certain amount of accuracy in the statement, it is far too complicated and complex a matter to be dismissed with two sentences. I have taken the liberty of enclosing for use by your staff a copy of a recent Illinois Insurance Department publication entitled, "Property and Liability Solidity Testing Programs: An Analysis." This report describes and analyzes the state of the art in early warning testing in some detail.

Fourth, the reports comments on market surveillance are most timely. At the most recent meeting of the NAIC, the Illinois Department distributed a well-received report entitled, "Market Conduct Surveillance in Illinois: A Program for Improvement." The report presents a critical, unvarnished analysis of current performance examination procedures and provides a prescription for change.

The draft report also contains a number of important statements about market structure and performance. Unfortunately, while these are primarily statements made inferentially from apparently extensive statistical work, very little backup information is provided. We would be interested in knowing if the data used in your work are available in machine-readable form since we are now nearing completion in a market structure study that parallels your work in some respects.

In chapter eight, the report discusses abuses in "Medigap" insurance. Enclosed for your use is a copy of our recent buyers guide for Medigap purchasers which is part of an ongoing program to crack down on abuses here in Illinois. It was somewhat disappointing, however, that the draft report did not more clearly point out that the whole medigap controversy stems largely from the creation of a supplemental market by reason of the confusion and incompleteness of the Medicare system.

Should I have further comments within the ten-day period, or afterwards, I will not hesitate to provide them.

Again, thank you for your courtesy in making the draft report available.

Sincerely,

Richard L. Mathias
Director of Insurance

RLM:pm

Encls.

APPENDIX VII

STATE OF INDIANA

INDIANAPOLIS, 46204

THE DEPARTMENT OF INSURANCE
509 STATE OFFICE BUILDING

July 3, 1979

Mr. Harry S. Havens, Director
Program Analysis Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Havens:

I have not had the opportunity to thoroughly examine your draft report entitled "State Regulation of the Business of Insurance" and the 10 days you allowed for comment does not allow me adequate time to thorougly evaluate same. Nevertheless, I have been able to give it a cursory reading.

This preliminary examination causes me to believe your people have attempted a fair presentation of the facts and information contained therein, but it appears you have drawn numerous speculative conclusions without adequate foundation contained in the report for those conclusions.

I would also hasten to add that staff people you assigned to conduct the evaluation of this Department performed their task in yeoman fashion with an apparent attitude of fair and objective inquiry.

Your inference of inadequacy as to the size of the NAIC staff and its budget is questionable. When considering the staff charge and recognizing it is supplemented by State Department people, it appears adequate to me. You further failed to acknowledge that we are presently in the process of expanding staff to include an economist which we think will round out the skills necessary for the NAIC Central Office to perform its responsibilities more adequately.

You further allude to deficiency in performance inasmuch as the Central Office could not advise you the degree to which states have implemented the model laws and regulations. During the past year we launched an effort to make this determination and much progress has been made in that regard. However,

State Form 3568

APPENDIX VII

it has never been our thought that all states are desirous of utilizing all model laws and regulations of the NAIC due to the unique differences in the societies of the several states.

You allude to Task Forces being made up of insurance industry people. Task Forces are composed entirely of Commissioners and Insurance Department regulatory personnel. Advisory Committees do have industry people as well as consumer interest within their structure.

Appropriate state regulation is a constantly evolving and changing procedure. The laboratory of the several states is very much a part of the experimentation and development of proper regulatory procedures. The Market Conduct activity to which you alluded is part of this evolving process. Your conclusions about the response to the "Medigap" matters and life insurance cost disclosure by the NAIC and individual states also seems to bring forth subjective conclusions without adequate fact.

Adequate and informative consumer information is something that has been in the forefront of state regulators for a number of years. How to make this information informative recognizing the complexity of the issue and the relative low degree of understanding of technical information by the consumer causes it to be a rather illusive matter. Practically all states are dealing with this matter in one fashion or another and no one seems to have found the absolute uniform wisdom to cause consumers to be more informed and make more wise purchase decisions. Again, experimentation within the several states is aiding considerably as to what will and will not work to the interest and benefit of the citizen.

Your report seems to be critical of the fact that state regulators and the NAIC have not resolved issues which have only come to the forefront in the last few years. I think we should recognize that as inflation has caused the cost of insurance to increase because of the increased cost of things for which insurance pays, citizens and legislators alike have become more aware and questioning of the insurance mechanism. Likewise, as new products have evolved resulting from such things as the Medicare program, new practices have evolved from the insurance mechanism which have only recently surfaced. State regulators and the NAIC have not ignored these questionable practices, in my judgment, but have attempted to respond to them as promptly as prudence, manpower and time allows. I am not aware of any issue which has surfaced at the federal

APPENDIX VII

level which has not been equally as timely considered by state regulators and the NAIC.

I am further bothered that you chose to conclude that there has been less than an arm's length relationship between the NAIC and industry. I have only been around the regulatory ranks for just short of four years, but I have never seen a more dedicated group of people, generally speaking, than state regulators I have come in contact with during that four years. The conclusions drawn in your report tend to impugn the integrity of every state regulator which I think is grossly unfair. There appears to be no factual evidence contained in your report to substantiate this questionable integrity. If your people found questionable activities, I think those activities should have been specifically recited or at least have been enumerated in a general sense. The NAIC deliberations take on all the earmarkings of a legislative process. I don't think state regulators, members of the Congress or members of federal agencies possess all the wisdom in the world nor do we have insight sufficient to design remedial resolutions to problems without at least allowing for the input of the persons or businesses affected.

Until we in government possess that "all knowing" and "all seeing" onmipotent wisdom which allows us to develop the absolute superior resolution to problems, we certainly have to allow for input from those affected. That is the system of democratic government under which we operate and I personally believe the NAIC would be remiss if it did not provide such an opportunity to industry and consumers alike which are impacted by the determinations of that body. Even your insinuation that the NAIC is culpable inasmuch as the cost of its formal meetings is borne by industry, is questionable. Were it not for industry and consumer interest for information during those deliberations, those meetings would be conducted at a minuscule cost.

Finally, it is my judgment that the ill effects of the so-called "revolving door" is nothing short of a myth. To suggest that a person with any previous exposure (or even subsequent exposure) to the insurance industry cannot effectively and conscientiously carry out his subscribed oath of duties is absurd. I have not discerned any difference in the integrity or dedication to duty evolving from persons who came from the industry as contrasted to persons who came from outside the insurance industry. Again, if there are specific facts to the contrary, I think the report should so disclose rather than concluding guilt by speculative inference.

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The factual information contained in your draft report reflects a diligent work effort and is to be applauded as a rather thorough explanation of the subject matter. Your people are to be commended for an excellent work product but I think it would be a much improved product if you were to remove the subjective conclusions where there is an absence of factual foundation or else recite any factual evidence leading to those conclusions.

Again, please know that I have not had an opportunity to thoroughly evaluate your draft report and while I have been somewhat critical in this letter, I hope that my thoughts are presented in a manner so as to be constructive. I would like to have the opportunity to comment further once I have the time to more thoroughly evaluate your work.

Sincerely yours,

H. P. Hudson
Commissioner

HPH:as

APPENDIX VII

FLETCHER BELL
COMMISSIONER OF INSURANCE

June 29, 1979

Mr. Harry S. Havens, Director
Program Analysis Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Havens:

I have reviewed the draft report, "State Regulation of the Business of Insurance", and wish to commend those involved in the conduct of the study for what I consider to be a thorough exploration of significant issues. Unfortunately, the report in its current form goes beyond a reporting of facts and information by its frequent inclusion of subjective conclusions and its exclusion of pertinent information that would permit a more accurate evaluation of its content. For example, the report properly notes the study of the insurance company examination system conducted by McKinsey and Company for the NAIC. The report improperly concludes, however, that few, if any changes resulted from the McKinsey and Company recommendations. To the contrary, if those conducting the study would have reviewed the published NAIC Proceedings subsequent to delivery of McKinsey and Company's final report, they would have found that each recommendation contained therein has been addressed by the NAIC and most of them have been incorporated in the examination system. More specifically, the report fails to inform its user that, as a direct result of the McKinsey and Company study, two completely new Examiners Handbooks were developed, adopted by the NAIC, and are now used by insurance department examiners. One Handbook contains detailed procedures for scheduling and conducting a financial condition examination and the other handbook accomplishes the same purpose with respect to market conduct examinations. Furthermore, in a follow-up critique requested by the NAIC, the project director of the McKinsey study advised that the handbooks incorporated their essential recommendations. In addition, the report makes no mention of the Examiners Training Program now being developed by the Griffith Foundation and scheduled for implementation in 1981. Finally, the report makes no mention of the current NAIC efforts to develop a practical but meaningful program to require a certification of fire and casualty loss reserves by a qualified loss reserve specialist. Obviously, the failure to recognize the time necessary to achieve results from significant changes and the omission of the many, positive, steps taken as a result of the McKinsey study were necessary to reach the conclusion that further study of insolvency and financial regulation is warranted. Needless to say, study and analysis in these areas is an unending activity of state insurance regulators but the context in which this conclusion is reached in the report is grossly misleading.

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APPENDIX VII

Similarly, the draft report seems to concentrate rather heavily on perceived short-comings of state insurance regulation with respect to the development and use of consumer complaint data, market conduct examinations and distribution of consumer information. Frankly, I agree with most of the GAO observations but, again, I believe the report fails to disclose information which is quite relevant to a fair evaluation of state insurance regulatory activity in this area. Specifically, it seems to me the report should note that, while state insurance regulators have long performed a valuable service by providing assistance to individual policyholders and claimants, the concept of separate, specialized market conduct examinations and the use of consumer complaint data as a regulatory tool are relatively recent innovations. Generally speaking, these activities have become an inherent part of state insurance regulation only in this decade and, if one reads the draft report carefully, it is apparent that states are still experimenting with various types of data collection programs and market conduct activities. Thus, these activities are still in an evolutionary phase. Therefore, even though there are current deficiencies, the laboratory of state experimentation will produce the necessary adjustments and the resulting system will reflect the strengths of various individual state programs and eliminate the weaknesses. Even with this additional information the report might be critical of state regulation for not initiating this kind of activity sooner. If so, it would be a valid criticism but it would be one that could be raised with respect to virtually any progressive undertaking.

Finally, in a somewhat different vein, I must take exception to the manner in which the draft report treats the issue of the so-called "revolving door" phenomonen and the independence of the NAIC. As far as I can discern, there is not one thread of factual evidence contained in the report to support a contention that a conflict of interest between insurance regulators and the insurance industry exists or that the products and programs produced by the NAIC are designed to benefit the insurance industry at the expense of insurance consumers. Yet, by inference and innuendo, the draft report, clearly attempts to leave the reader with this impression. As a result, the draft report attacks or at least raises questions about, the integrity of every individual insurance regulator and every individual member of the NAIC as well as members of the NAIC staff. If the GAO study revealed specific improprieties they should be disclosed and the information underlying the findings should be furnished the proper authorities in the state or states involved. If the study did not develop such information, the report should not imply that improprieties obviously exist but the GAO simply couldn't cite specific instances.

As an elected state official whose entire business career has been devoted to state insurance regulation and one whose senior staff includes no person with insurance industry experience, I am perhaps more sensitive to this kind of criticism than others. By the same token, however, I have the advantage of

APPENDIX VII

being able to observe my colleagues with a more critical eye. With rare exception, I must tell you that in my twenty two years of insurance regulatory involvement, I have found state insurance regulators to be persons of high moral standards, integrity, impeccably honest, and dedicated to serving the public interest regardless of their background. This is not to say that in my subjective judgment some have not been better regulators than others and that some have contributed more to the insurance welfare of their respective constituencies than others, but as a whole in this span of time they have been dedicated public servants.

Despite the critical nature of my remarks, I have sincerely attempted to be constructive. With equal sincerity, I believe that elimination of the subjective conclusions and the addition of information necessary to more clearly portray reality, will make the GAO report a more valuable and reliable document for use by the state insurance regulatory community, the Congress and others interested in its content.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:cs

APPENDIX VII

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
JAMES J. SHEERAN, COMMISSIONER
201 EAST STATE STREET
POST OFFICE BOX 1810
TRENTON, N. J. 08625
609 292 5363

July 10, 1979

Harry S. Havens, Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Havens:

I thank you for the opportunity to comment on the draft report of your study of insurance regulation by the individual states. I also congratulate you for compiling so voluminous a report on such a complex subject in such a relatively short period of time.

There are a few points in the report on which I would like to comment.

The report does not convey the magnitude of New Jersey's effort to reform the driver classification and territorial rating systems. Moreover, the report seems to overlook the fact that an examination of the territorial rating system is very much a part of our ongoing study.

Our reform effort started to take shape almost a year ago when the Department began the research preparatory to holding a public hearing. The hearing began on January 24, has convened on more than 40 days since then, and is not expected to conclude until sometime in the fall. Consultants hired by the Department, rather than merely reporting to us, have worked closely with us in what has proved to be a productive team effort. When concluded, our study will have been the most comprehensive of any ever made in this country.

I am enclosing a copy of my hearing order so that you may more fully understand exactly what New Jersey is doing in this troublesome area of insurance pricing.

APPENDIX VII

On page 34, Chapter 4, the report asserts that only one state publishes examination reports if the company under examination does not respond to the report within 60 days. It is our practice, if a company does not respond within 40 days of its receipt of the draft report of the market conduct report, to finalize it, file it as a public record, and make it available to the other states.

On page 35 of the same chapter, the report states that there are no formal standards established for judging what constitutes unacceptable behavior by insurance companies. I disagree. New Jersey and other states have adopted Unfair Trade Practices laws, which include the regulation of claim settlement practices. New Jersey also recently adopted a Minimum Standards law for health insurance and I have proposed an implementing regulation that is probably the most stringent in the country.

The desirability of a uniform complaint classification system and the use of the NAIC complaint system, which the report discusses beginning on page 19, Chapter 4, have my endorsement. However, I understand that the implementation of such a system would be very expensive and is not likely to be achieved in New Jersey because of our budgetary restraints.

I am in complete agreement with the argument for indexing and retrieving consumer complaints and the utilization of complaint information. It is my intention to implement a computerized complaint control system, which would permit the Department to develop an extensive data base and a system of tracing complaint patterns and identifying problem companies and agents. Initial work on developing the system will begin in early August.

In general, I would conclude that there are few ills associated with state regulation of insurance that your report points out that would not be cured if adequate funding were provided.

Finally, I would express my disagreement with your conclusion that regulation of auto insurance rates is not justified. It has been my experience that the only competition among auto insurers is for the cream of the crop. The industry is too willing to consign too many people, especially those with good driving records, to the secondary market.

APPENDIX VII

Moreover, I think that New Jersey's rate regulation has made a difference in pricing. We have insurance available in New Jersey at prices that are much lower than the companies would charge if there were no prior approval required.

I thank you again for the opportunity to comment on your draft report.

Yours very truly,

James J. Sheeran

skw

Enc.

APPENDIX VII

DEPARTMENT OF INSURANCE
State of North Carolina
P. O. BOX 26387
RALEIGH N. C. 27611

JOHN RANDOLPH INGRAM
COMMISSIONER OF INSURANCE

919 733 7349

July 17, 1979

Mr. Harry S. Havens
Director, Program Analysis Division
United States General Accounting Division
Washington, D. C. 20548

Dear Mr. Havens:

Concerning the draft report on "State Regulation of the Business of Insurance", which was received in this office on July 2, the Commissioner's Office of North Carolina would like to make several comments.

We have studied the document as thoroughly as time limitations would allow and have developed some six pages of notes as to items which are of concern to us. In keeping with your letter of June 22, a member of our staff contacted Mr. Mark Nadel last week to inform him of our efforts in terms of commenting on the draft of the proposed report.

The following are some highlights from these more extensive notes made by the staff and represent areas of particular concern to the Commissioner's Office:

I Re: Pages 1-3:

"Revolving door Commissioners" is a matter about which North Carolina has expressed concern. Commissioner Ingram, in his testimony before such committees as Senator Metzenbaum's United States Judiciary Subcommittee on Anti-Trust Monopoly and Business Rights, has joined with Senator Metzenbaum in recognizing the problem of having persons going from regulation into the insurance industry with positions whose duties are to lobby in the NAIC for industry points of view. North Carolina is one of a handful of states that have an elected Commissioner. The North Carolina Commissioner's Office has set up a code of ethics which, in fact, prohibits such activities for a period of at least two years following employment with the North Carolina Department of Insurance;

APPENDIX VII

II Re: Pages 2-10:

"Obtuse Legal Language of Policies". North Carolina has held public hearings and worked on this problem during the past two years and promoted a law which was passed in the 1979 session of the General Assembly requiring "readable policies".

III Re: Chapter 4, Page 1:

This section of the draft deals with market conduct examinations. North Carolina has a market conduct unit which has been in effect approximately three years. This examination team is a part of the Consumer Insurance Information Division of the Department. All of the market conduct examiners are chosen from persons who possess undergraduate degrees in the areas of business and economics. Three of its examiners are also law school graduates. A CPA also works as a part of this team, both as an advisor, as well as a participant in the actual examinations;

IV Re: Chapter 4, Page 6:

The McKinsey Study recommended greater reliance on CPA audit and financial examinations. North Carolina has a CPA as its Director of Technical Operations (co-chief administrative officer). North Carolina also has a CPA as the Deputy Commissioner in its Company Admissions Division;

V Re: Chapter 4, Page 7:

North Carolina has a strong history of rehabilitation of domestic insurance companies and the prevention of serious financial problems due to the quality of its constant monitoring process in both the Examination and Admissions areas. North Carolina has both a Life and an A & H Guaranty Fund. These Guaranty Associations are established pursuant to statute and provide excellent consumer protection;

APPENDIX VII

VI Re: Chapter 4, Page 13:

Concerning the authority of the Commissioner's Office, North Carolina established a Consumer Insurance Information Division in 1973. That Division is staffed by approximately thirty persons. It has worked directly on over 135,000 complaint files since its organization in October of 1973. It has been directly responsible for some $17 million dollars being returned to citizens in terms of claims paid, premiums refunded and other consumer services. The Consumer Insurance Information Division has been augmented by the creation of the Consumer Services Section, which includes the placing of seven of the Department's fourteen Divisions under one Director, allowing for a very broad based utilization of Department personnel and resources in order to provide very thorough responses to individual consumer complaints;

VII Re: Chapter 4, Page 27:

It is the intention to eventually examine all companies licensed in North Carolina in terms of their market conduct with priorities given to those companies whose complaint profile illustrates a need for immediate market conduct review;

VIII Re: Chapter 4, Page 34:

North Carolina has begun a consumer review process with questionnaires being sent to policyholders of companies during market conduct examinations;

IX Re: Chapter 5, Page 56:

North Carolina has worked dilligently for the authority of the Insurance Commissioner to properly regulate the insurance industry in the public interest. The lobby power of the insurance industry is tremendous. The Commissioner's Office in North Carolina has developed creative methods of dealing with such areas as automobile insurance rate regulation having, for example, abolished a discriminatory assigned risk mechanism and replaced it with a fair and extremely workable reinsurance facility mechanism;

APPENDIX VII

Mr. Harry S. Havens
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X Re: Chapter 5, Page 59:

North Carolina's Insurance Commissioner has held that investment income should be a part of an appropriate rate review process. In a test of this position by the industry, the State Supreme Court ruled with the Commissioner's Office that investment income should be a factor considered in rate reviews.

The North Carolina Department has made tremendous strides in providing consumers with necessary insurance information. Our review indicates that real competition in the marketplace is minimal and information about possible cost savings and/or the true value of an insurance product is difficult for consumers to obtain. Efforts to make this information available or require the companies to make it available meets with tremendous and often successful lobbying efforts by the insurance industry in the General Assembly;

XI Re: Chapter 6, Page 37:

North Carolina has pioneered in the area of safe driving and merit rating. North Carolina's Commissioner has maintained the point of view that insurance rates should be directly in relationship to the driving record of the insured. Elimination of such discriminatory factors as age and sex (as a matter of law) have been abolished due to the efforts of the Commissioner's Office, often against unrelenting opposition from the insurance industry;

XII Re: Chapter 6, Page 38:

North Carolina developed data and information demonstrating conclusively that age and sex as rate-making factors were not valid, while at the same time, developing a classification scheme that was based on objective criteria;

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XIII Re: Chapter 6, Page 56:

North Carolina has required audited data and absent such data, has disapproved rate filings. The North Carolina Court of Appeals has upheld the Commissioner's position concerning audited data, resulting in a $46 million dollar refund being ordered. That case is now pending before the State Supreme Court due to an appeal by the insurance industry;

XIV Re: Chapter 7, Page 19:

North Carolina's Insurance Commissioner has worked during each session of the General Assembly for the inclusion of collision insurance into the reinsurance facility. Its lack of inclusion in the facility is solely the result of extreme lobbying activities by the insurance industry. Under North Carolina law, persons with good driving records pay a surcharge simply for having been ceded to the facility. The Commissioner's Office has maintained that cession to the facility should not be grounds for surcharge, but surcharges should be based entirely on the individuals driving record;

XV Re: Chapter 7, Page 29:

In North Carolina, liability insurance policies cannot be cancelled for any reason other than such conditions as non-payment of premium. There is no "free underwriting" period for the companies;

XVI Re: Chapter 7, Page 31:

A 1979 law requires insurance companies to notify those who are ceded and give the reason for their having been ceded;

XVII Re: Chapter 7, Page 32:

In North Carolina, non-renewals and cancellations are treated essentially alike, i.e. liability policies;

XVIII Re: Chapter 8, Page 7:

Other areas that have innovative as far as North Carolina is concerned is our Reinsurance Facility, which was the first Reinsurance Facility set up. Our court system has recognized that it was necessary that data submitted on rate filings be audited versus edited. All of this is in addition to the age, sex and marital status abolishment in automobile rating. North Carolina has also been instrumental in the life insurance cost disclosure and replacement area. However, it must be realized that the insurance industry lobby is extremely powerful in the General Assembly. For example, North Carolina's very effective solicitation regulation was replaced by the NAIC's much weaker version due to the General Assembly's passage of the NAIC model;

XIX Re: Chapter 8, Page 9:

North Carolina was able to innovate and respond to local needs in the area of medical malpractice. In fact, the situation is so favorable at this particular time, the medical malpractice rates in North Carolina are well below the average throughout the United States. This is because the Commissioner of Insurance here was able to set up an insurance company run by and for the doctors;

XX Re: Chapter 8, Page 11:

North Carolina has held hearings on, and there will be further hearings on the area of cancer insurance, medi-gap insurance, debit insurance, life insurance cost disclosure, and replacement regulations.

In conclusion, North Carolina has vigorously regulated the insurance industry. It has a reputation for being very responsive to the needs of the consumer and is perhaps the most aggressive state in terms of consumer protection in insurance matters. The North Carolina Commissioner's Office has won many significant firsts, both in the legislative process and in court challenges. For example, the Supreme Court decision that investment income was an appropriate factor in rate considerations, the Court of Appeals decision upholding the Commissioner's requirement of audited data, the elimination of age and sex as ratemaking factors, and the abolishment of a discriminatory assigned risk in auto liability insurance.

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In North Carolina, the Commissioner of Insurance is answerable directly to the people, being subject to statewide election every four years. The Commissioner's Office has established one of the most stringent code of ethics in government today which eliminates potential conflict of interest problems.

Attached is a statement on these general areas by Commissioner Ingram and Deputy Commissioner Brown made before Senator Metzenbaum's Subcommittee on Anti-Trust Monopoly. Also attached is a statement made by Commissioner Ingram at the NAIC Annual Meeting at Chicago in June of 1979. From this last statement, it can be seen that the North Carolina Insurance Commissioner has continuously urged the NAIC to become more responsive to the needs of the consumer and less dominated by the insurance industry.

Sincerely,

W. KENNETH BROWN
Director
Consumer Services

WKB/kmd

Attachments

APPENDIX VII

JAMES A. RHODES
Governor

STATE OF OHIO
DEPARTMENT OF INSURANCE
2100 STELLA COURT
COLUMBUS 43215

HARRY V. JUMP
Director of Insurance

July 3, 1979

Mr. Harry S. Havens
Director
United States General Accounting Office
Washington, D.C. 20548

Re: Draft of Proposed Report, "State Regulation of the Business of Insurance," prepared by the United States General Accounting Office

Dear Mr. Havens:

We would like to take this opportunity to express our complete disagreement with the above-captioned report's comments about this Department's review of automobile insurance rate charges. These comments began on P.10 of Chapter 5, "Price Regulation of Automobile Insurance."

Far from being "largely a formality," this Department's rate reviews include an extensive review of each automobile insurance rate filed with us. The purpose of this review is to make certain that each such filing is in compliance with the statutory standards established by the Ohio legislature in Section 3937.02 of the Ohio Revised Code. We would like to point out that Section 3937.02 (D) prohibits such rates from being excessive, inadequate or unfairly discriminatory; our review encompasses this statutory prohibition.

While it is true that no member of our staff is a Fellow of the Casualty Society of Actuaries, the relevant point is that each member of our staff is thoroughly qualified to review automobile insurance rate filings to determine compliance with Section 3937.02. Far from being "unable to question" automobile insurance rate filings, we subsequently disapproved one hundred forty-three such filings in 1978 alone.

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The report's statement that no rate adjustment has ever been subsequently disapproved is simply not correct. For example, in June, 1975 the Ohio Department of Insurance issued Notices of Hearing to Reserve Insurance Company, Leader National Insurance Company, Globe American Casualty Company, Progressive Casualty Insurance Company, State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company. The reason that the Department issued these Notices of Hearings was that the Department believed these insurers automobile insurance rates filed for Cleveland, Ohio were inadequate, excessive or unfairly discriminatory in violation of Section 3937.02 of the Ohio Revised Code. The hearing process ultimately resulted in enactment of a statute, Section 3901.21 of the Ohio Revised Code, to prohibit automobile insurers from splitting rates within a municipality.

Finally, we agree with the report's last sentence in this paragraph, ending on page 11. The underlying philosophy of a file and use system, such as that enacted by the Ohio legislature in Chapter 3937 of the Ohio Revised Code, is that the principal regulator of rates is competition, not the regulatory authority. This philosophy, inherent in any file and use system, views competitive forces in the marketplace as the preferred regulator of prices.

File and use systems are based on the premise that the most effective way to produce rates which are not excessive, inadequate or unfairly discriminatory is through rate competition among insurers.

Thank you for affording us the opportunity to comment on the GAO's report.

Sincerely,

Harry V. Jump
Superintendent of Insurance

HVJ:JFM:dlh

NONGOVERNMENTAL ORGANIZATIONS CONTACTED BY GAO

Aetna Life and Casualty Co.

Alliance of American Insurers

Allstate Insurance Co.

American Council on Life Insurance

American Insurance Association

Arizona Women's Commission

Automobile Club of Southern California

California Consumers' Action

Conference of Insurance Legislators

Consumers Union

Commercial Union Assurance Companies

Connecticut Commission on Human Rights and Opportunities

Continental Insurance Companies

Crum & Forster Insurance Companies

Farmers Insurance Group

Fireman's Fund Ins. Co.

Griffith Foundation

Hartford Area Rallies Together

Hartford Insurance Co.

Illinois State Insurance Plan

Independent Insurance Agents of America

Independent Insurance Agents of Connecticut

APPENDIX VIII

Independent Insurance Agents of Massachusetts

Indiana Consumer Center

Indiana Public Interest Research Group

Insurance Information Institute

Insurance Services Office

Kemper Insurance

Liberty Mutual

Mercury Casualty Co.

Motorists Mutual Insurance Co.

National Association of Independent Insurance

National Association of Insurance Commissioners

National Consumer Law Center

Nationwide Insurance Co.

North Carolina Independent Agents Association

Ohio Insurance Institute

South Carolina Independent Insurance Agents Association

SRI International

State Farm Insurance Co.

Travelers' Insurance Co.

Twentieth Century Insurance Co.

Western Association of Auto Insurance Plans

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