LIFE INSURANCE (C3) SUBCOMMITTEE

Reference:
1979 Proc. Vol. I p. 553
1978 Proc. Vol. II p. 379

Hon. J. Richard Barnes, Chairman – Colorado
Hon. Herbert W. Anderson, Vice-Chairman – Iowa

AGENDA

1. Report of the Standard Nonforfeiture and Reserve Valuation Laws Task Force.
2. Report of the Life Insurance Cost Disclosure Task Force.
3. Report of the Task Force on Revision of Group Life Insurance Model Law.
4. Report of the Advisory Committee on Policy Lapsation.
5. Any other matters brought before the subcommitree.

CONTENTS

The Life Insurance (C3) Subcommittee convened at 3:30 p.m. in the Red Lacquer Room of the Palmer House in Chicago, Monday, June 4, 1979. All members of the committee or their representatives were present with the exception of Guam.

1. Report of the Life Insurance Cost Disclosure Task Force.

Erma Edwards of the Nevada Insurance Department delivered this report (attached). Commissioner Anderson moved receipt and adoption of the report, and it was unanimously adopted.

It is to be noted that the report calls on the chairman of the (C3) Subcommittee to appoint a task force to evaluate the NAIC's Model Life Insurance Solicitation Regulation.

2. Report of the Task Force on Revision of Group Life Insurance Model Law.

The (C3) chairman reported that the task force chairman has asked to be relieved of that position due to travel problems, and that there would be no written report. A new chairman will be appointed to continue the work.

3. Report of the Advisory Committee on Policy Lapsation.

In view of the fact that this subject is included in and related to item number 2 above, no report was given.

4. Other Matters Discussed.

A. It was reported that Commissioner Shaw of West Virginia had a desire to discuss the matter of deposit term insurance. He was not present but it was noted that this subject is under consideration by another task force in the NAIC.

B. The privacy question in connection with authorizations for attending physicians and similar statements has been brought up by C.N. Burwell of the Rails Company in Maplewood, New Jersey and others. It was pointed out that this too was the work of another task force, namely the Privacy Task Force, and therefore no discussion was held.

C. John K. Booth of ACLI called the committee's attention to the fact that the question of sex and marital discrimination in connection with certain life insurance and health products needs further discussion in light of the work of the (D3) Subcommittee and its proposed revisions to the Unfair Trade Practices Act. He cited the NAIC Model Regulation to Eliminate Unfair Sex Discrimination as stating, under 6, ". . . However, nothing in this regulation shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits . . ."

His suggestion thus is that, under Section 4(7)(D) of the Model Unfair Practice Act, a sentence should be added to the existing wording to read, "However, nothing in this section shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits."

D. Superintendent James Montgomery of the District of Columbia recommended that a task force be appointed by the (C) Committee to look into abuses in the debit insurance field. It was the unanimous vote of the (C3) Committee to approve such a recommendation.

5. Report of the Standard Nonforfeiture and Reserve Valuation Laws Task Force.

Mr. Ted Becker, chairman of the task force, presented his report in the form of a May 2 special report (attached).

Considerable discussion was held with particular emphasis on guideline D of the report concerning single premium deferred annuities. Speaking against the adoption of the guidelines were Gregory I. Carney, ASA actuary for Anchor National Life; Carrol Pritle of the

same company; Richards S. Barger, attorney representing Anchor National Life; Walter Rugland of Milliman & Robertson, Inc., also representing Anchor National Life; and Bill White, associate actuary of the American Council of Life Insurance.

John Montgomery of California Insurance Department indicated that California would not consider the guideline to be "retroactive," because they had always followed the principle of that guideline. *[Underlined material added by the parent (C) Committee. See p. 326 .]*

After considerable discussion back and forth, it was moved by Commissioner Anderson of Iowa that the committee receive the report and adopt it, with the exception of guideline D. The motion was seconded by Commissioner Voorhis, of Texas. Bradford S. Gile, A.S.A., spoke in favor of Guideline D as Wisconsin's representative of the subcommittee and as a member of the technical task force. He stated, however, that the guideline requires amendment for those states which have not enacted the revisions to the Standard Valuation Law adopted by the NAIC in December, 1976. He moved for a substitute amendment to guideline D which would have left the guideline unchanged in those states which have adopted the revisions, but would have stated that methods other than the Commissioners Annuity Reserve Valuation Method might be demonstrated to the Commissioner as meeting the provisions of the Standard Valuation Law in those states which have not enacted the 1976 revisions. The motion was seconded and, after some discussion, failed. The Anderson motion was then unanimously adopted.

The committee interpreted this action as meaning that proposed guideline D will continue to be considered by the task force for further revision along with their other research projects in progress. Some of these are: a new mortality table for individual life insurance; possible revision of the standard valuation and nonforfeiture law; model variable annuity nonforfeiture regulation; and further guidelines.

6. Adjournment.

Having no further business, the subcommittee adjourned at 5:10 p.m., June 4, 1979.

Hon. J. Richard Barnes, Chairman, Colorado; Hon. Herbert W. Anderson, Vice-Chairman, Iowa; Hon. William H. L. Woodyard III, Arkansas; Hon. James Montgomery III, Acting, District of Columbia; Hon. Ignacio C. Broja, Guam; Hon. Edward J. Birrane, Jr., Maryland; Hon. Walter Weaver, Nebraska; Hon. Donald W. Heath, Nevada; Hon. Lowell L. Knutson, South Dakota; Hon. Durwood Manford, Texas; Hon. Susan Mitchell, Wisconsin.

(C3) Life Insurance Cost Disclosure Task Force

Chicago, Illinois
June 2, 1979

The (C3) Life Insurance Cost Disclosure Task Force met on April 1, 1979 at the New Orleans Hilton Hotel in New Orleans and on June 2 at the Palmer House in Chicago. Task force members attending the June 2 meeting were Commissioner William Woodyard III, Arkansas; Commissioner Herbert Anderson, Iowa; Thomas Kelly, New York Department; Larry

Gorski, Illinois Department; Erma Edwards, Nevada Department. James Montgomery III, Commissioner, District of Columbia, was not able to be present. Other persons present at the Executive Session included John Montgomery of the California Department, Ted Becker of the Texas Department, Richard Hemmings, NAIC Milwaukee office, and Brad Gile of the Wisconsin Department.

The task force received the charge at the December NAIC meeting to study the various regulations proposed by the State that differ from the NAIC model. Cathy Hildebrand volunteered at the April meeting to send letters to the various states requesting copies of any proposed regulations that differ essentially from the NAIC model. A compilation of the replies will be distributed to task force members in the near future.

Lapsation Advisory Committee

At both the April and June meetings, there was considerable discussion of the report of the Lapsation Advisory Committee. This report was circulated as an exposure draft at the December NAIC meeting in Las Vegas. The report includes a disclosure statement that could be included in the annual statement to provide regulators with a reasonable indication of the level of a company's persistency.

At the April 1 meeting William White, American Council of Life Insurance, gave a verbal report on the Council's Legislative Committee meeting on lapsation. He said the consensus of the ACLI Committee meeting was that the advisory committee report was a very thorough report. They felt that while the disclosure system would appear to satisfy the requirements imposed by the task force, it was complicated and would not be particularly useful to the regulators. They considered three general alternatives to the proposed disclosure system, including addressing the problem of lapsation through the cost disclosure mechanisms, market conduct examinations or modifying the disclosure form recommended by the advisory committee. Helen Noniewicz, Chairman of the Advisory Committee, reported that one concern expressed to her committee was that the dislcosure of lapsation rates would be used by companies as a competitive tool in their advertising. Other concerns included the cost to companies of completing the form. Bob Carlson,Vice President Research Division, LIMRA, recommended that individual companies should be tested with the proposed disclosure system and that LIMRA could provide the norms for such testing.

At the June 2 meeting, written response to the lapsation study was submitted by John Glover, Travelers Insurance Company; Mel Campbell, Aetna; and the ACLI. The primary objection expressed in their position papers was the inclusion of the disclosure form in the annual statement. Copies of these position papers are attached. The task force reviewed the response to the lapsation disclosure study. It was decided to ask the lapsation advisory committee through LIMRA to collect the required data for the disclosure statement from a broad range of companies and to submit the results to the task force. The task force will circulate the results to the commissioners, along with guidelines for their application in the disclosure statement and will solicit responses from the various state insurance departments as to the usefulness of the information.

Dividend Philosophy, Principles and Practices

Progress reports of the Society of Actuaries Committee on Dividend Philosophy and the American Academy of Actuaries Committee on Dividend Principles and Practices were given by Bart Munson at both meetings and are attached to this report. Mr. Munson explained the two committees were established in order to expedite the work in this area. The Society Committee will work on the development of the final opinion and its supporting recommendation and the Academy will simultaneously consider means of implementing appropriate standards of practice in connection with the allocation and illustration of dividends in life insurance policies. Jack Moorehead referred to the use of the word "nominal" in the last sentence of the introduction of the exposure draft Opinion S7. The task force agreed to write a letter to the Society and ask for clarification of the term. At the June 2 meeting, further definition of the term "nominal" as used in the Opinion was submitted to the task force members and is attached.

Life Solicitation Regulation

At the April meeting the report of the Advisory Committee on monitoring the impact of the NAIC Model Life Solicitation Regulation was given by Charles Greeley, Chairman of the Advisory Committee. An additional report was submitted by Harold Leff at the Chicago meeting. Both reports are attached.

The task force discussed the possible necessity for amending the NAIC Life Insurance Solicitation Regulation. They voted to recommend to the (C3) Subcommittee that it assign to an appropriate task force the charge of evaluating the current NAIC model.

A report by the Special Task Force in Wisconsin to study the proposed Wisconsin Life Solicitation Regulation was given by Bill Snell at both the April 1 meeting and the June 2 meeting. Both reports are attached.

Manipulation Advisory Committee

An oral report for the Manipulation Advisory Committee was given at the April meeting by Julius Vogel. Mr. Vogel stated that at their initial meeting the committee considered the meaning of "manipulation." Although no definition was agreed upon, it was considered to be broad enough to possibly include any elements of the policy's benefits, pricing, method of cost disclosure, advertising or sales promotion which is likely to mislead a consumer to favor a particular policy. The committee agreed their primary purpose is to develop a method which will help regulators identify manipulation tending to produce unrealistic cost indexes. This advisory committee was recently reconstituted and no further meetings have been held. Thomas Kelly of the New York Department has been named chairman of the new committee. A list of members of the new committee is attached.

During the June meeting a draft set of guidelines for deposit term type contracts was distributed to the task force members by the chairman. These guidelines were originally developed in the Valuation and Nonforfeiture Technical Task Force and were referred over to the Cost Disclosure Task Force. The Cost Disclosure Task Force will consider these guidelines at its next meeting. (The draft guidelines are attached to the Valuation and Nonforfeiture Task Force regular June 1979 report. See p. 377 .)

The June 2 meeting adjourned at 6:00 p.m.

Erma Edwards, Chairman, Nevada; James Montgomery III, District of Columbia; Bill Homan, Iowa; Walter Weaver, Nebraska; Frank Howatt, Oregon.

To: Ms. Erma Edwards
Deputy Commissioner
Nevada Department of Insurance

From: John H. Glover
Second Vice President
The Travelers

Date: April 12, 1979

Re: Proposed Life Insurance Lapse Rate Disclosure System

I am sorry I was not able to attend the meeting of your task force hearing on April 1. However, I have heard through Helen Noneweicz and others that there was some support for and some opposition to the proposed reporting system. It concerns me, as I know it concerns Helen, that it seemed to be a concensus of your task force to adopt the proposal without giving sufficient time for the consideration of viable alternatives.

Very quickly, let me state our position:

1. We favor a reporting system which will serve as a useful tool to regulators to monitor and to serve as a basis for taking action against companies (and agents) whose marketing and servicing practices cause inordinately high lapse rates and waste of consumers' money. We think this can best be accomplished as a part of the market conduct portion of the trienniel examination.

2. We believe that such a reporting system must discreetly recognize the different markets served in terms of demographics of consumers (income, age, educational and cultural differences). We know, for instance, that certain companies tend to sell to specifically targeted markets of more affluent people, which, of course, will result in lower lapse rates. Other companies, such as The Travelers, serve very broad markets which include both more and less affluent people. These companies will tend to have somewhat higher lapse rates. This begs the question: shouldn't the reporting system be such that it will not misrepresent to the regulators and our various publics what may become a quantifiable measure of a company's marketing and servicing efficiency? Company A, with a 10% first-year lapse rate, may appear superior to Company B, with a 15% first-year lapse rate, but Company A may be serving a very narrow and affluent market while Company B may be serving a very broad market.

3. We believe that the regulator should be provided with the technology to interpret data reported by the reporting system. By this, we mean that there are statistical tools available which can be applied to the data presently called for in the industry advisory committee report to "normalize" the data for buyer, seller and other characteristics and which would make the interpretation of the data more meaningful to the regulator. I believe you will find LIMRA willing and able to perform such a normalizing process.

4. We do not believe that the data in the presently prescribed form should be allowed in the public domain where the risk of abuse far outweighs any possible usefulness to the customer. I would question the ability of anyone to give a meaningful and consistent interpretation to a first-year lapse rate on nonpension permanent life insurance for a particular company without a considerable amount of digging into the marketing and servicing practices of that company. On the other hand, once such information on a comparative basis is placed in the public domain, it can be readily used and abused for competitive purposes. To illustrate this point, I have enclosed a portion of a sales presentation made here on the premises of The Travelers home office. Please note in Exhibit 1, the use of data taken from "the Hart Committee in Congress" by the highlighted company for its "top competitors." Now, please observe in Exhibit 2 similar data from a recent LOMA report ("The Challenge of Servicing Orphan Policyholders," November 1978 Report No. 46), authored by an official of that same company, which compares what he calls "leading companies." The data are essentially the same but the use and the content differ dramatically and, I think you would agree, are strongly biased in Exhibit 1. It is the similar use of lapse rate comparisons and the context in which they may be made which seems to be such an inordinate risk.

5. Unless the lapse rate data are used with great discretion, we see the probability of marketing and servicing trends which could be both paradoxical and counter-productive to consumers and to our industry, such as: (a) steering away from lower income markets, (b) abandoning new agent development programs, (c) inhibiting EEO Affirmative Action Plans, and (d) inhibiting companies' equitable replacement of their own business.

LIMRA's Quality Business Committee has been continuously engaged in focusing attention on research and the development of practices to improve lapse rates for more than 40 years. I have been priviledged to serve on that committee for the last nine years, two of which I served as its chairman. I know that its membership (which makes it the largest as well as the oldest standing committee of LIMRA) is vitally interested in the proposed disclosure system. At its last semi-annual meeting here in Hartford, we stressed to the members the importance of studying the IAC Report, weighing its implications and providing input to viable solutions through the ACLI Task Force. I believe some viable input will now begin to flow and I would ask that you provide the opportunity for it to be heard.

I would suggest that the IAC Report be allowed an additional six month exposure period.

****

Exhibit I

1976 Million Dollar Round Table Statistics

20 Largest Life Companies Listed by Assets	Number of Agents	1976 Round Table Members	Total % of Agents
Prudential	24,934	298	1.2
Metropolitan Life, NY	31,000	383	1.2
Equitable Society	7,716	341	4.4

20 Largest Life Companies Listed by Assets	Number of Agents	1976 Round Table Members	Total % of Agents
New York Life	10,404	1,155	11.1
John Hancock	10,596	146	1.3
Aetna Life	18,650	183	.9
NORTHWESTERN MUTUAL	3,418	883	25.8
Connecticut General	1,155	150	12.9
Travelers	30,153	44	.15
Massachusetts Mutual	3,465	538	15.5
Mutual of New York	4,000	338	8.4
Sun Life of Canada	3,741	145	3.8
New England Life	2,148	442	20.5
Teachers Ins. & Ann.	–	–	–
Connecticut Mutual	2,143	337	15.7
Bankers Life, IA	1,872	84	4.2
Mutual Benefit	1,747	280	16
Lincoln National, In.	1,380	115	8.3
Manufacturers Life	1,681	151	8.9
Penn Mutual	2,310	198	8.5

Question: Why can or do some companies have more agents reaching this coveted goal? Would policy costs and caliber of agents be contributing factors? Could it be the service provided by agents? When NML has the largest per cent of agents with this "success" pattern (even more than Prudential and Metropolitan combined even though they have over 40,000 more agents) there has to be a reason. Why?

Something else to think about: One very important factor to always consider is SERVICE. What kind of service are you likely to receive in the future? This is something tht can't be measured in dollars and cents and yet it obviously has a value for most people. Part of service is what the agent actually does for you, BUT another facet is what is his likelihood of being in business 5-10-15 years hence. Below are some statistics compiled by the Hart Committee in Congress. In essence this is a study to see what per cent of full time agents hired by a company actually remain with the company – remain to service YOU. The study encompassed 82 companies. Here are statistics on the eight companies normally considered to be NML's top competitors. It is based on full time agents starting in 1962 and still with the company 5 years hence (1967) and 10 years hence (1972).

Company	After 5 Years	After 10 Years
Bankers Life (Iowa)	12%	9%
Connecticut Mutual	18	16
Massachusetts Mutual	22	16
Mutual Benefit	14	11
New England Mutual	16	14
New York Life	11	11
NORTHWESTERN MUTUAL	34	25
Penn Mutual	10	4

Again, the question is why? Can those . . .

****

Exhibit II

The home office sponsors management clinics for field management covering topics on selection and training of new agents, supervision, sevice to policyowners, and other field management areas. Candidates for field management participate in a work-study program and the LIMRA management training course, General agents are evaluated on the number of agents they recruit and retain. The most important factor in a policy staying on the books is whether the agent remains with the company. Service satisfaction depends on policy persistency which in turn depends on agent retention.

In 1975, the Senate Subcommittee on Anti-Trust and Monopoly published figures on agent retention for agents who came under contract in 1962 and 1967 and were still under contract in 1972. The figures for some leading companies are shown in the following tables.

Percentage of Full Time Agents
Contracted in 1962
(still under contract in 1972)

Aetna	33.3%
Bankers Life (Iowa)	7.8%
Conn. Mutual	16.1%
Mass. Mutual	15.8%
Mutual Benefit	11.1%
New York Life	11.3%
New England Life	14.2%
Northwestern Mutual	24.9%
Penn. Mutual	4.0%
Travelers	35.3%

Percentage of Full Time Agents
Contracted in 1967
(still under contract in 1972)

Aetna	33.2%
Bankers Life (Iowa)	12.0%
Conn. Mutual	18.3%
Mass. Mutual	21.8%
Mutual Benefit	13.7%
New England Life	15.5%
New York Life	11.1%
Northwestern Mutual	34.4%
Penn. Mutual	9.5%
Travelers	33.7%

At Northwestern Mutual, persistency of business is measured by agency and by individual agent. First year persistency is especially crucial to agent compensation. Good persistency (i.e., lapses which are less than 40 percent of the company's average first year lapse rate) is rewarded by increasing renewal commissions up to 12 percent. A new determination is made each year . . .

****

To: NAIC Task Force on Lapse Rate Disclosure

From: John H. Glover
The Travelers

Re: Statement on Lapse Rate Disclosure

1. We believe it is in the industry's enlightened self-interest to reduce lapse rates. Out of every $1.00 lost in a 1st duration lapse, we estimate the consumer loses $.35; the company (Travelers) loses $.43 and the agent loses $.22. Therefore, almost 2/3 of the loss is borne by the company and the agent – twice as much as the consumer.

2. We believe the IAC proposed reporting system is incomplete and can be misleading. Our research shows that, of characteristics at point of sale we measured, 5 of the 10 characteristics that explained most of the variability in lapse rates related directly to "market" and explain 30% of the variability that can be "controlled" at point of sale. These facts could steer companies away from markets that have very legitimate needs for coverage.

In addition, of the "reasons for termination" in Table 14 on pages 60 and 61 of the IAC report, about 70% may be beyond the control of the company or the agent. Therefore, we believe both short-term and long-term lapse rates can be subject to misrepresentation.

3. We think it somewhat ironic that the NAIC would entertain a lapse rate disclosure system when it has just recently endorsed a regulation that facilitates replacements. The data supporting Table 14 "reasons for termination" was taken from a 1960-61 study by LIMRA. 24% of the "reasons" shown were replacement related. I would suspect that percentage would be higher today.

For these reasons, we support the proposal of the ACLI. Disclosure is not a proper solution. We believe inter-action between the company and the regulator during the examination process is the right solution.

****

To: Life Insurance Cost Disclosure Task Force

From: Dean E. Wolcott, Senior Vice President
Aetna Life & Casualty

Re: Position Comments on A Lapse Disclosure System Proposed to NAIC
by The Industry Advisory Committee

The charges to the committee from the NAIC were as follows: (1) "The authorities want to be able to identify the companies that have excessive cash value plan lapse rates so that they may challenge those companies to either improve or to explain why the level is justified. The committee's task is to develop a disclosure system that will avoid unfairness and misrepresentation of the data the authorities are seeking. (2) The committee is to develop a report on lapsation in reply to the six global questions posed by the regulators:

1. Is there a lapse problem?
2. Howe extensive is the lapse problem?
3. What are the factors affecting persistency?
4. What effect do lapses have on rates for all other insureds?
5. What is the extent of injury to consumers where a high lapse rate exists?
6. What possible solutions may we find?

The Aetna feels that highly beneficial and excellent work has been done by the committee on the Part 2 of its charge. There is not a great deal new or unusual to its findings, but the compilation of material and observations are accurate and complete.

Unfortunately, the committee has been unable to fulfill the first part of the charge. In fact, the disclosure system recommended is on several points in contradiction with conclusions made in connection with the Part 2 portion of the charge.

While the committee seemed cognizant of the differences in markets and other characteristics which contribute to lapses, its end product – the disclosure system – does not take these obvious differences into anywhere near sufficient consideration. Aetna has severe misgivings about the recommendation for a display in an annual statement of ratios of companies' actual to industry "expected" lapses in 24 different categories. How will "expecteds" gain unanimity of acceptance, or will actuaries rightfully feel they are inadequate to reflect all the influences affecting withdrawal for 1, 2, 3-5, 6-10, and 11+ policy years? How often will the "expecteds" be changed, and how will adjustments be determined?

The Aetna feels that it is improbable, if not impossible, to measure meaningfully the lapse results of many companies with differing markets against an industry "expected" norm which cannot (and does not) take into account all these marketing differences. We feel the most effective way for regulators to monitor this important area is to have each company show trend lines which indicate the bettering or worsening of results relating to that company's marketing operation. This type of system would avoid any forced withdrawal from lower social/economic sale markets as a result of unfavorable comparison with an industry "expected" which does not take into account these important markets to be served.

Industry concerns about the power to produce an effect of "expecteds" will distract company managements from the review of their own lapse trends. Rather, these management talents will be directed into explaining their own result by pointing out the shortcomings of the industry "expecteds."

The Aetna's recommendation is that the NAIC try to improve the excessive poor lapse situations of some companies by means of the regular, normal company examinations. This company feels that the only fair way to display persistency data (if such data is absolutely necessary) is to utilize the "trend line" method. In this fashion, all companies will indicate to any reader what improvements (or negative results) they are experiencing. The Aetna voices strong disapproval of the disclosure system being recommended by the industry advisory committee for the reasons stated above.

****

To: The NAIC Life Insurance (C3) Cost Disclosure Task Force

From: The American Council of Life Insurance

Date: May 25, 1979

Re: The Report of the Industry Advisory Committee on Policy Lapsation

This statement is presented on behalf of the American Council of Life Insurance, whose 484 member companies account for 95 percent of the life insurance in force in the United States.

I. Introduction

After the submission of the draft report by the Industry Advisory Committee on Policy Lapsation to the Life Insurance (C3) Subcommittee in Las Vegas on December 6, 1978, the council appointed a special task force of member companies to review and recommend a position on the draft report. That task force's recommendations have been reviewed and approved by the appropriate committees and the Board of the Council.

The council is in basic agreement with much of the industry advisory committee's report. We feel that it furnishes an excellent analysis of the subject and that it will be a valuable reference work. From a factual standpoint, we have only one concern. Chapter II contains a comparison between lapse rates reported by LIMRA and by the council. In Item 4 on page 32, there is a reference to "the impact of data-related errors on the trend of the ACLI series" that we believe is unfortunate. As mentioned in the report, the lapse studies of the two organizations involve different groups of companies and measure different rates. We feel it is important to emphasize that the dissimilarities between the LIMRA and the council (ACLI) lapse rate trends are due to these differences rather than to suggest that data-related errors in either set of results are responsible for the differences.

II. Industry Motivation to Control Lapses

As pointed out in the industry advisory committee's report, life insurance companies use many means to attempt to control lapses. The greatest incentive for any company to minimize its lapses, especially those occurring in early policy years, is self-interest. Companies operate on the principle that essentially there are three parties whose interests are vitally involved in a contract of insurance: the consumer, the company, and the agency force. Companies realize that if the consumer becomes dissatisfied a lapse is likely, resulting in financial loss to all. The company and the consumer are both in a loss position for several years under a typical permanent insurance contract, and if lapse occurs during this period both will suffer a loss. For the agency force, lapses result at the very least in a loss of future commissions, and in addition most companies have devised commission charge-back systems, persistency penalties or incentives, etc., to ensure that persistent business is pursued vigorously.

III. Regulators' Motivation to Control Lapses

We recognize the regulators' interest in helping companies to achieve the desirable goal of minimizing lapses. They have a duty to alleviate the financial burdens of early lapse on all policyholders, not only those who terminate early but also those who persist but pay a higher cost for their insurance because of early lapses by other policyholders.

Questionable sales practices are one cause of early lapsation. Therefore, it is important that laws and regulations concerning disclosure, deceptive or misleading sales practices, and replacement be enforced.

IV. Disclosure System Proposed by Industry Advisory Committee

The council's recommendations relate primarily to the disclosure system proposed by the industry advisory committee. This system involves a display in the annual statement of ratios of actual to expected lapses in 24 different categories chosen by the committee. It should be noted that the committee in its report specified that it was making this proposal in response to an NAIC request and was "not necessarily advocating such."

The council does not feel that the proposed disclosure system will furnish regulators with meaningful data that will be helpful in attempting to improve company lapse experience. Accordingly, we are recommending an alternate approach, discussed in the next section, that we feel will be considerably more effective in this respect.

We identify a number of problems and concerns with the proposed disclosure system. Some of these were cited in the committee's report and include the following:

1. There are many characteristics not recognized in the proposed disclosure system that are highly influential in determining lapse rate levels. Prominent among these are the socio-economic market of the company, the age distribution of the business, the distribution of the business by mode of premium payment, the company's marketing system (e.g., direct mail, brokers, career agents), and company size.

2. There is a valid concern that companies will be driven out of legitimate and socially desirable markets in order to avoid lapse rates considerably above industry "standards." This concern also had been expressed by an earlier NAIC committee looking into lapses.

3. Smaller companies are concerned that the standards will be based largely on data supplied by large, well-established companies whose lapse rates tend to be lower.

4. There is the problem of credibility of the data for smaller companies. The lapse of one or two large policies can affect the rates disproportionately.

5. Companies are concerned with the burden and cost of producing additional annual statement data that will not be useful in accomplishing the avowed purpose of improving lapse experience. Some regulators feel that the annual statement is already overburdened with data. This consideration argues against adopting a scheme that would be elaborate enough to reflect some of the important factors listed previously.

6. The proposed disclosure in the annual statement makes the data available for public use without appropriate interpretation. This could lead to abuse or misuse of the data.

V. Alternate Approach Recommended by the Council

In lieu of the disclosure of lapse experience proposed by the industry advisory committee, the council recommends that an analysis of lapse performance be made a part of the examination of companies by state insurance departments. This alternate approach will enable regulators to make meaningful analyses of both the level of the company's lapse experience and the effectiveness of its efforts to control this experience. They also will be able to determine whether company sales practices are causing excessive lapses.

To measure the level of the experience, companies would be asked to make available to the examiners their lapse rates for each year covered by the examination. It is recommended that only first year rates be required. The greatest losses to consumers and companies arise from first year lapses, and they are more amenable to company control than lapses occurring in later policy years. Given these considerations, we feel strongly that the development of lapse rates for policy years after the first would add to the complication of the work required of the companies but would not produce comparably valuable information for the regulators.

With the level of the experience influenced by numerous characteristics, we feel that the calculation of actual-to-expected ratios as suggested by the committee would carry with it the strong possibility of producing distorted conclusions about the quality of a company's performance. (Some of these characteristics that are not recognized in the committee's proposed disclosure system were listed in Section IV of this statement.) For this reason, we recommend that companies not be asked to calculate actual-to-expected ratios. Instead, we propose that a table be developed showing appropriate first year lapse rate ranges for the major characteristics that affect policy persistency. This table would be in a form that can be used by regulators in interpreting a company's experience. In this connection, it is our feeling that the general trend of a company's experience should be an important element of this interpretation.

The committee's proposal calls for a subdivision of lapse results into four categories of business. Term insurance and permanent insurance would be reported separately and, within the latter category, there would be a separation between regular, ordinary, debit ordinary, and pension trust business. We generally support this type of classification of first year lapse rates, although there is concern that some companies may have difficulty in segregating their experience into these specific categories. We think that finer subdivisions of the results should not be required, but that companies should be free to develop data for any additional classifications that might facilitate a meaningful analysis of their experience.

Finally, we recommend that companies and regulators study the excellent presentation in Chapter VI of the committee's report regarding techniques that can be effective in improving lapse results. This information can be particularly useful to companies that appear to be experiencing lapse problems.

To summarize the council's recommendations:

1. Lapse performance would be reviewed as part of the examination of companies by state insurance departments instead of through reliance on annual statement disclosure.

2. Companies would make available, for each year covered by the examination, their first year lapse rates subdivided into the type-of-business categories specified in the industry advisory committee's report. Companies would be free to develop data for any additional classifications that might facilitate analysis of their experience.

3. Appropriate first year lapse rate ranges would be developed in a form that can be used by regulators in interpreting company experience. The general trend of a company's experience should be an important element of this interpretation.

4. Companies and regulators should give consideration to the techniques for improving lapse results that are presented in the industry advisory committee's report.

The council feels that this alternate approach to the industry advisory committee's proposal will develop necessary information and provide it to those regulators who should be in the best position to make use of it. This approach should be the most effective way to accomplish the general improvement of lapse experience, which of course is the fundamental goal of all parties involved – the industry, the regulator, and the consumer.

****

To: Life Insurance (C3) Cost Disclosure Task Force

From: Society of Actuaries Committee on Dividend Philosophy

Date: April 1, 1979

Re: Status Report

Since our last written report to you (October 10, 1978 in Indianapolis), you've received the November 29, 1978 letter from Paul Barnhart, President of the Society, commenting upon the developments at the Society meeting last October. As Mr. Barnhart's letter indicated, Ed Lancaster has been named chairman of the committee. He has asked me to share these observations with you on behalf of the committee.

At the conclusion of this report, for your general information, is a listing of the current committee members. Most continue from the membership we had prior to last fall; several new minds have been added, to bring fresh ideas and to give us a more complete complement for the task ahead.

We also view as active participants with us and liaison to others the chairman of the related committee in the American Academy of Actuaries (John Harding, Vice President and Actuary, National Life Insurance Company), the chairman of the related committee in the Canadian Institute of Actuaries (Charles Galloway, President, National Life Assurance Company of Canada), and John Booth, Vice President and Chief Actuary of the American Council of Life Insurance.

We recognize the direction given by the Society's Board of Governors, as reported to you in Mr. Barnhart's November 29 letter. You may wish to know the specific motion adopted by the Board on October 22, 1978:

> The Board of Governors accepts the submitted report of the Society's Committee on Dividend Philosophy;
>
> Authorizes continuation of the Committee on Dividend Philosophy with regard to continued and newly identified research and Society discussion;
>
> Takes the position that any results of the committee's work, as it affects actuarial practice, should take effect as standard practice;
>
> Requests Vice-President Lackie to work with the Presidents of the CIA and AAA and the Chairman of the Society's Committee on Professional Conduct to set in motion implementation of appropriate standards of practice as called for by the Committee on Dividend Philosophy that emerge from the current and future work of this committee as accepted by the Board of Governors.

The profession's reactions to our exposure of an opinion, as found in our report released last October and shared with you in Indianapolis, have been supportive. The general and seemingly widely held belief is that we are on the right track, for a difficult subject; and the profession is eager to wrestle with more details and specifics.

To that end, our committee met last on March 16 in Chicago. All but two members were present, and they each were represented by an associate from their office. In addition, all three liaison persons identified above were present.

As agreed at that March 16 meeting, specific actions we are pursuing, with the intended timetable, include:

1. All committee members are currently wrestling with the specifics of a recommendation which would support the opinion we have exposed. Thoughts are being shared on a very preliminary outline draft of such a recommendation.

2. By the first of May a subcommittee will redraft the outline, and this will be shared with all committee members by mid May.

3. The committee plans to meet next in Kansas City on May 24 to discuss the progress on that drafting.

4. Simultaneously, another subcommittee is attempting to develop a clearer understanding of the practices of stock companies which might relate to our charge. We will then evaluate how those practices relate to our opinion and supporting recommendation. As our draft opinion stated, we intend it should apply to "mutual companies and the participating business of those stock companies which treat such business essentially as though it were a separate mutual company." After our survey we will better be able to see what should fall within our opinion and recommendation and what might more appropriately be addressed elsewhere – for example, by the American Academy of Actuaries committee.

5. It is our intention to have a useful draft of a rather detailed recommendation available to Society members this fall, for discussion at the October 22-24 Society annual meeting.

We recognize this as a rather ambitious schedule, considering the scope and complexity of the subject. We adopted it as a reflection of the importance we place on the matter and our desire to be of service, as a profession, to the regulators, the insurers we serve, and the public who rely on the dividends paid and illustrated.

We are pleased to keep in close contact with you. Don't hesitate to contact Chairman Lancaster or the undersigned when and if you have any questions or desire further information.

Mr. E. B. Lancaster, Chairman, Executive Vice-President, Metropolitan Life Insurance Company; Mr. J. A. Fibiger, Executive Vice-President, Home Office Administration, New England Mutual Life Insurance Co.; Mr. H. D. Garber, Executive Vice-President, Equitable Life Assurance Society of the United States; Mr. R. P. Hill, Vice-President, Prudential Insurance Company of America; Mr. R. R. Jensen, Senior Vice President, Operations, Northwestern Mutual Life Insurance Co.; Mr. R. A. Miller, Vice-President & Corporate Actuary, Aetna Life and Casualty; Mr. D. B. Maier, Acting Secretary, Actuary, Metropolitan Life Insurance Company; Mr. R. S. Miller, Senior Vice-President & Chief Actuary, Southwestern Life Insurance Company; Mr. W. N. Miller, Vice-President and Actuary, New York Life Insurance Company; Mr. B. L. Munson, Vice-President & Actuary, Insurance Products, Aid Association for Lutherans; Mr. D. S. Rudd, Senior Vice-President, London Life Insurance Company; Mr. W. A. Spare, Vice-President and Actuary, Provident Mutual Life Insurance Co.; Mr. T. C. Sutton, Second Vice-President, Individual Actuarial, Pacific Mutual Life Insurance Co.

****

To: Life Insurance (C3) Cost Disclosure Task Force

From: Society of Actuaries Committee on Dividend Philosophy

Date: June 2, 1979

Re: Status Report

This report covers the progress of the committee since our last report to you dated April 1, 1979.

The major work of the committee since that time has been proceeding with the development of a paper presenting "recommendations concerning actuarial principles and practices in connection with dividend determination and illustration." A subcommittee went through several drafts prior to the committee's last meeting in Kansas City on May 24, 1979. At that meeting, the latest draft was reviewed in some detail. It continues to be the goal of the committee to have a useful draft distributed to the Society members at the October 22-24 meeting in Bal Harbour, Florida, for discussion.

A draft questionnaire to be sent to stock companies was also distributed to the members at the May 24th committee meeting. The purpose of this questionnaire is to survey stock company practices with respect to nonguaranteed benefits. This will help the committee consider the extent to which its recommendations should apply to stock companies and what practices of stock companies would not be given separate consideration. It is planned that this questionnaire will be in final shape for distribution this fall.

Once again, we are pleased to have this opportunity to keep you informed of our progress. Of course, Chairman Lancaster or I would be pleased to respond to any further questions you may have.

****

To: Life Insurance (C3) Cost Disclosure Task Force

From: American Academy of Actuaries Committee on Dividend Principles and Practices

Date: April 1, 1979

Re: Status Report

Our committee has been formed since the exposure of the Society of Actuaries drafted Opinion S-7: "Actuarial Principles and Practices in Connection with Dividend Calculation and Illustration." It is our purpose to assist in implementing standards of practice for the actuarial profession in the United States in this subject area.

Our committee's charge, as given by the Academy's Board of Directors, reads:

> The purpoe of this committee is to consider means of implementing appropriate standards of practice in connection with the allocation and illustration of dividends on life insurance policies. The committee shall coordinate its work with the Society of Actuaries' Committee on Dividend Philosophy and with any appropriate committee of the Canadian Institute of Actuaries."

The committee membership, found at the end of this report, includes three members of the Society Committee, for some overlapping membership was felt to be needed to assist in the close coordination between the two committees.

Our committee, it appears, will hold its first meeting in Kansas City on May 23 or 24. As we prepare for that meeting, we are giving particular thought to these three areas related to the actual development of a recommendation by the Society Committee:

1. What type of "Actuarial Certificate on Dividend Computation" (as it was called in last fall's report of the Society Committee) would be appropriate for the annual statement (or elsewhere)? This can be pursued, albeit not fully concluded, while the standards of practice to which it refers are being developed.

2. What, if anything, can or should be done with Schedule M to relate to the developing actuarial standards of practice and to make the schedule more useful?

3. What might be developed as a "consumer impact statement" which would assist the consumer in more clearly understanding the nature of dividends, paid and, particularly, illustrated, consistent with the developing actuarial standards of practice? This is related to the variety of caveats used, or not used, by insurers today to describe to the buying and insured public the nature of dividends.

These are particular areas which our Academy Committee appropriately can pursue while we also attempt to assist the Society Committee in its simultaneous development of the final opinion and its detailed supporting recommendation.

At the risk of oversimplification, perhaps a word about the nature of both the Academy and the Society would assist in understanding how these two committees view their roles. The Society is more the scientific body. It is engaged heavily in research and in the education and examination of its members. It is international in scope, covering both the United States and Canada. The Academy, on the other hand, is a US-only body. (Its US-only nature explains the creation of a similar committee in the Canadian Institute of Actuaries.) It has the function of interfacing more directly and frequently with government. Thus, it is a logical and practical division of effort in this large and complex task that the Society Committee develop the specifics of the standards of actuarial practice and the Academy Committee "consider the means of implementing" them.

You might also find useful a brief outline of the mechanics we envision for stating our standards of actuarial practice on this subject. There are precedents which serve to illuminate the path we're on, and a structure is in place for our use.

There are four levels of stated principles and practices. From the more general to the more specific, they are: Guides to Professional Conduct, Opinions as to Professional Conduct, Recommendations, and Interpretations. Each level serves to support and amplify the more general level(s) above it. Both the Society and the Academy have adopted essentially identical guides, seven in number. They are general and brief, varying from one to four paragraphs each. Similarly, both the Society and Academy have adopted six essentially identical opinions. These are of somewhat greater detail and length, averaging three pages each in our Year Books. It is such an opinion that the Society Committee exposed last fall.

What is being pursued now by the Society Committee, and which our Academy Committee would help implement, is a supporting recommendation, perhaps with interpretations. There are two such detailed documents currently in place to guide actuarial conduct. Both are Academy adoptions. One is "Financial Reporting Recommendations and Interpretations." The other is "Pension Plan Recommendations and Interpretations." While length per se is no criterion, you may wish to know that these number 44 and 21 pages, respectively, in the 1978 Academy Year Book. It is our best guess that the "Dividend Recommendations and Interpretations" (or whatever it will be named) that is currently being pursued also probably will run many pages.

The Academy Committee is pleased to be in place and looks forward to assisting both our profession and its publics, including specifically the NAIC, as this matter is pursued over the coming months.

John Harding, Chairman, Vice-President and Actuary, National Life Insurance Company; Jon Christopherson, Assistant Actuary, Woodmen of the World; J. Jacques Deschenes, Vice President and Actuary, Sun Life Assurance Company; James Kambla, Towers, Parrin, Forester and Crosby; William Krisher, Senior Vice-President, Connecticut Mutual Life Insurance Co.; Walter Miller, Vice-President and Actuary, New York Life Insurance Company; Bartley Munson, Vice-President and Actuary, Insurance Products, Aid Association for Lutherans; Paul Overberg, Senior Vice-President and Chief Actuary, Allstate; Michael Ristau, Associate Actuary, CNA Insurance Company; John Roberts, Senior Vice-President, Cororate Services, Pan-American; Richard Robertson, Vice-President, Lincoln National Corporation; Richard Stenson, Vice-President and Associate Actuary, Equitable Life Assurance Society; Thomas Sutton, Second Vice-President, Pacific Mutual Life Insurance Co.

****

To: Erma Edwards, Chairman
Life Insurance (C3) Cost Disclosure Task Force

From: John H. Harding, Chairman
American Academy of Actuaries Committee on Dividend Principles and Practices

Date: May 29, 1979

Re: Update on Committee Activity

This committee met in Kansas City on May 23 and 24, to explore in detail the nature of the problem we are trying to solve and to agree on a course of action.

The problem is the scope of practices with regard to dividend allocation and illustration has been expanding significantly in the past decade. This expansion has occurred as a result of two primary factors. First, consumer and regulatory interest in cost disclosure has made companies more concerned with the illustration of low-cost products. Second, advances in computer technology have made it possible for companies of all sizes to adopt far more elaborate methods to allocate and illustrate dividends.

The Society of Actuaries Committee on Dividend Philosophy is defining appropriate standards of practice for dividend allocation and defining the relationship between dividend allocation and dividend illustration. These standards of practice will necessarily and properly give the actuaries and companies broad scope in the allocation process, but at the same time, they will force consistency between allocation and illustration.

While these standards of practice will limit the range of permissible dividend illustrations, there will still exist dividend illustrations which are not truly comparable. The pattern of the solution to this problem is expected to be the following nature:

This Academy Committee will use the work of the Society Committee as the basis for establishment of a proper framework to:

A. Provide full disclosure to company management with regard to the method of dividend allocation and its consistency with actuarial standards of practice and the relationship between allocation and illustration; and

B. Inform and disclose to the insurance commissioners and the informed public that the standards for allocation and illustration have been met, with full disclosure of any exceptions. This will include a certification by the responsible actuary in the annual statement. It may also include a revision of Schedule M to provide more information relevant to the company's practices of allocation and illustration; and

C. Inform the prospective buyer of the nature of the dividend illustration presented and its impact upon cost comparisons.

Drafts of items B and C are being prepared and distributed within the committee. It is expected that substantial progress can be made with these drafts through the use of telephone and mail. The date of the next meeting will depend upon the rate of this progress.

****

To: Erma Edwards, CLU, FLMI
Chairman, Cost Disclosure Task Force

From: Edwin B. Lancaster
Society of Actuaries' Committee on Dividend Philosophy

Date: April 23, 1979

Re: Draft Opinion S-7

Your letter of April 9, 1979 indicates that Jack Moorhead raised a question as to the interpretation the Dividend Philosophy Committee had in mind for the word "nominal" when its draft opinion stated that it related primarily to mutual life insurance companies and that participating business of stock life insurance companies which "except for a nominal contribution to shareholder interests, is conducted as though it constitutes a separate mutual company."

Section 216 of New York's Insurance Law provides that no company can issue both participating and nonparticipating business in New York unless it agrees that no profits on participating business shall inure to the benefit of stockholders "in excess of the larger of (a) ten percent of such profits, or (b) fifty cents per year per one thousand dollars of participating life insurance. . ." This is what we had in mind when we referred to a "nominal" contribution to shareholder interests.

As indicated in Bart Munson's report to you, we are planning a survey to determine the range of practices of stock companies writing participating business. When this survey is completed, we will be in a better position to more specifically define the kinds of participating business of stock companies to which the mutual company opinion should apply and then to consider just what approach we or the Academy of Actuaries' Committee might take with respect to other participating business of stock companies.

I hope that this note satisfactorily responds to your question. While it is not likely that we can respond much more specifically at this time, please feel free to call me (212-578-3181) or Don Maier (212-578-2955) if you wish to discuss this further.

****

To: Erma Edwards, Chairman
Cost Disclosure Task Force

From: Charles Greeley, Chairman
Advisory Committee on Monitoring the Impact of the
NAIC Model Life Insurance Solicitation Regulation

Date: March 15, 1979

Re: The Activity and Current Status of the Advisory Committee

The first meeting of the committee was held on January 31, 1979. It was recognized that considerable research has already been done in the area of public attitudes toward the purchase of life insurance. As an initial step, we felt it essential to review and codify the existing material – not only to avoid duplication of effort but, more importantly, to document the trend of public attitudes and industry responses over the years.

Accordingly, we asked that the ACLI staff develop a bibliography of relevant existing materials, the result of which is attached to this letter. The bibliography has been annotated to indicate the nature and major findings of each of the studies. Of course, we intend to expand this bibliography as additional information becomes available. For example, the study by Professor Formisano is now underway and its results will obviously be taken into account in the committee's considerations.

The committee also reached agreement as to certain fundamentals which would apply to any method for monitoring the impact of the NAIC Model Life Insurance Solicitation Regulation – as follows.

1. Comparative Trends

A major purpose of the NAIC Model is to educate the insurance-buying public, both with respect to types of insurance which can meet individual needs and methods for evaluating the relative costs of similar policies. Education by its nature is a continuing process, and the cumulative impact over a period of years is probably more significant than the results of a study made at any given point in time.

Various industry market surveys in past years can serve to provide a starting base of the general level of public understanding that existed prior to the introduction of the NAIC Model. However, surveys conducted currently and in the recent past would indicate only the initial impact of the educational process. Time will be needed to measure a full impact – as the NAIC model becomes more widely distributed, and as the public becomes increasingly familiar with its contents. Thus, the committee believes than an effective monitoring system must be an on-going process which focuses on the trend of public attitudes over a number of years.

2. Objectivity

As a second fundamental consideration, the committee believes that the broadest possible parameters must be used to obtain an accurate and objective picture of consumer understanding and educational trends. Surveys should cover representative areas throughout the United States, rather than a limited area within one state. They should look at reactions from different segments of the broad market – i.e., from those who purchase small versus large insurance amounts, and from the young to the old insuring ages.

In this connection, attached is a copy of a letter sent by Mr. Albus, Associate General Counsel of the National Association of Life Underwriters. The letter is addressed to Professor Formisano and sets forth general concerns as to possible areas of bias which would affect the objectivity of survey results.

The committee also believes that a monitoring system should not be limited to a survey of recent purchasers of life insurance, but should be comprehensive and cover the impact of changing demands on companies and agents, as well as the general public.

****

Consumer Reaction to Cost Disclosure:
An Annotated Bibliography of Studies

1. "Life Insurance Consumers: A Review of the Literature," Life Insurance Agency Management Association and the Institute of Life Insurance, LIAMA Research Report 1973-10, Hartford, Connecticut, 1973.

   First of a series of three joint reports prepared at the request of the NAIC Life Insurance Cost Comparisons (3) Task Force. A review of the literature of information on what consumers know about life insurance and want to know at the point of sale. Most of the information is taken from nationwide surveys. A bibliography is also included.

2. "Life Insurance Consumers: An Exploratory Study of Attitudes and Expectations Regarding Cost Comparison," Institute of Life Insurance and Life Insurance Marketing and Research Association, New York, May 1974.

   Second of three reports prepared at request of the NAIC Task Force. Findings from an exploratory study in which 300 respondents were interviewed in depth about the meaning of life insurance costs, the role of cost information in the purchase decision, and receptivity to various cost information sources and methods.

3. "Life Insurance Consumers: A National Survey of Cost Comparison Attitudes and Experience," Institute of Life Insurance and Life Insurance Marketing and Research Association, August 1975.

   Third and last in a series of reports prepared at request of the NAIC Task Force. Describes the findings of a nationwide survey of 2,036 adult household heads interviewed in Fall 1974. Based on the exploratory research described in the prior report, this survey dealt with the meaning of the cost of life insurance to consumers, saliency of cost, experiences in comparing cost, and reactions to specific cost comparison methods.

4. "A study of Consumer Reaction to and Comprehension of a Life Insurance Buyer's Guide" prepared by Actionfacts for the NAIC, May 28, 1976.

   This report, prepared for the NAIC, surveyed consumer reaction to an NAIC Buyer's Guide. Interviews were conducted in March 1976 by telephone with 326 respondents. Respondents were promised a silver dollar if they completed the interview. The study found that consumers displayed little interest in the Buyer's Guide. Those who did read the guide found it understandable, informative and helpful. Recall of the main topics covered was good. However, the cost section appears to have been confusing to many respondents.

5. "Impact Among Policyowners of the New Business Booklet 3," Prudential Life Insurance Company, 1976.

   A survey of policyowners, who received the NAIC Buyer's Guide, conducted in Summer 1976 showed that about two in three recalled receiving the guide. Four in five who recalled receiving the guide stated that the document was helpful. However, ability to understand the surrender cost index was very low.

6. "Life Insurance Policy Selection, Monitoring the Impact of Product Beliefs, Affect Toward Agent, and External Memory," R. W. Chestnut, unpublished Ph.D. Dissertation, Purdue University, 1977.

   A study of life insurance decision-making based on an experimental study of 96 college undergraduates. The relative importance of beliefs about such values, beliefs about life insurance protection and attitudes toward the agent were measured as respondents chose between hypothetical term and whole life insurance products. A principal finding was that attitudes toward the agent are highly related to the amount of information acquired.

7. "Consumer Accessing and Use of Information in Making Life Insurance Purchase Decisions," Technical Report submitted to the Life Insurance Task Force of the Federal Trade Commission under contract No. L0226, J. Jacoby, D. A. Sheluga, W. D. Hoyer and R. W. Chestnut, August, 1978.

   Reports on an experimental study (involving 238 respondents) designed to test the extent to which consumers use cost information when making a life insurance purchase, the extent to which consumers utilize other information, and how different types of cost disclosure information affect consumer demands for information. Of special interest was the importance of premiums on purchase decisions and the relationship of cost information received to cost of policy selected. Another major goal of the study was to compare five cost "yardsticks" in terms of how much they helped respondents choose policies, which yardstick led to the fastest decisions, and which yardsticks respondents preferred most.

8. "Effectiveness of the Proposed FTC, NAIC and Belth Cost Disclosure Systems," A Technical Report Submitted to the Life Insurance Task Force of the FTC under contract No. L0226, J. Jacoby, D. A. Sheluga, W. D. Hoyer and M. C. Nelson, August, 1978.

   A presentation of the results of an experimental study of the effectiveness of five disclosure systems. A control group that received neither buyer's guide nor yardstick was also included in the study. Experimental subjects were asked to select the lowest "cost" of eight policies, given a test of knowledge of life insurance and asked to choose whether term or whole life insurance was appropriate for various hypothetical individuals. The performance of experimental subjects given different cost disclosure information was compared.

9. "Life Insurance Marketing and Cost Disclosure Report Together With Dissenting Views" by the Subcommittee on Oversight and Investigation of the Committee on Interstate and Foreign Commerce. House of Representatives, December, 1978.

   An evaluation of state regulation of life insurance marketing and cost disclosure. Specific issues addressed were does the life insurance market operate smoothly to provide consumers the products they need, what are indicants, causes, consequences and remedies of any market shortcomings, what is appropriate role of the FTC, and what does the experience of the NAIC cost disclosure role indicate about state regulation. Among the witnesses who testified were Albert Kramer, Director of the FTC's Bureau of Consumer Protection and Julius Vogel of the Prudential Insurance Company.

10. "Approaches to Complying with Disclosure Regulations: A LOMA/LIMRA Joint Study," LIMRA Research Report 1978-8, Hartford, Connecticut, 1978.

This report described the results of a survey of the membership of LOMA and LIMRA dealing with the practices of companies in meeting the cost disclosure regulations in the various states. It also covered voluntary practices in states that had not, at the date of the survey, adopted such regulations. The amount of business sold under disclosure procedures is described, as are special assistance and training procedures provided by companies to the field. The survey was conducted in October 1977 among 232 companies.

****

To: Professor Roger A. Formisano
Assistant Professor of Risk and Insurance
University to Wisconsin

From: William N. Albus, Associate General Counsel
National Association of Life Underwriters

Date: November 2, 1978

Re: Questionnaire Objectivity

On behalf of Jim Douds and myself, let me say that it was a distinct pleasure meeting you last week and having the opportunity of discussing your projected survey to determine the effectiveness of the New Jersey Life Insurance Solicitation Regulation.

As I believe we indicated at that time, NALU has no serious objection against the attempt to assemble accurate statistical information regarding the effectivity of the subject regulation. As I mentioned to you, I am not personally knowledgable in the methods and procedures for obtaining such data. I do, however, realize that objectivity should, at least logically, be the basic criterion for eliciting responses which will comprise the material upon which your analysis will be based. I also know both from my courtroom experiences as a trial attorney as well as common sense that many sought-after answers can be obtained by the form and direction of the questions. For these reasons and without delving into the complexities of market research, NALU strongly objects to the lack of objective balance in your questionnaire.

I appreciate your candor at the meeting whereby you indicated some of the individual issues were inserted at the insistence of the FTC and I understood that you did not necessarily agree with them. This, however, does not alleviate the problem of questionable questions. Certainly, if the study is directed toward equating whole life insurance purchases with other forms of investment and emphasizing, however subconsciously, the advantages of term insurance over permanent and the disadvantages of whole life without concomitant comments regarding the weaknesses of investments and term insurance, it seems, to me at least, that the results will be immediately suspect. If the FTC would only consult its own sister federal agencies such as the Veteran's Administration, they would be able to learn that term insurance is not in many instances a particularly good buy. NALU has attempted to demonstrate this point philosophically, but the Veteran's Administration has learned empirically of the inherent problems regarding NSLI purchases during the Second World War.

We feel, Professor Formisano, that the investigation is intended to engender a particular result. We are in no way accusing you of deliberately attempting to do this but I believe if you detachedly examined the questions, you would discover that such is the case. Although we appreciate the limitations which have been placed upon you by your employer, we cannot accept the premise that the perlustration as presently constituted will develop as unbiased, factual, unprejudiced and valid conclusion.

At the meeting, I believe you indicated a willingness to amend at least some of the material before using it. Perhaps the revision will give the process more objectivity. In any event, may we have a copy of the revised material when it becomes available?

Once again, Professor, it was a pleasure meeting with you and we appreciate the opportunity to comment upon your project.

****

Advisory Committee Reporting to the
Life Insurance (C3) Cost Disclosure Task Froce

Chairman: Charles Greeley, Vice-President and Actuary, Metropolitan Life, One Madison Avenue, New York, N.Y. 10010 (212/578-2903)

Members:

Douglas Broome, Chief Actuary, Life and Health, Insurance Department, South Carolina, P.O. Box 4067, Columbia, South Carolina 29240 (803/758-2313)

Dr. Roger A. Formisano, Graduate School of Business, University of Wisconsin, 1155 Observatory Drive, Madison, Wisconsin 53706 (608/263-3922)

Robert L. Hill, Counsel, Law Department, Aetna Life & Casualty, 151 Farmington Avenue, Hartford, Connecticut 06156 (203/273-6652)

Harold G. Ingraham, Jr., Senior Vice President & Chief Actuary, New England Mutual Life, 501 Boylston Street, Boston, Massachusetts 02117 (617/266-2831)

Seth C. Macon, Senior Vice President, Agency, Jefferson Standard Life, P.O. Box 21008, Greensboro, North Carolina 27420 (919/378-2011)

Dr. Robert I. Mehr, Department of Finance, College of Commerce & Business Administration, Box 106 Commerce West, University of Illinois, Urbana, Illinois 61801 (217/333-7185)

Richard S. Miller, Vice President & Chief Actuary, Southwestern Life Ins. Co., P.O. Box 2699, Dallas, Texas 75221 (214/655-5233)

I. Edward Price, Vice President & Associate Actuary, Prudential Life Ins. Co., Prudential Plaza, Newark, New Jersey 07101 (201/877-6654)

The following individuals, while not members of the advisory committee, are planning to work with the committee:

William N. Albus, Associate General Counsel, National Assoc. of Life Underwriters, 1922 F Street, N.W., Washington, D.C. 20006 (202/331-6000)

John K. Booth, Vice President & Chief Actuary, American Council of Life Insurance, 1850 K Street, N.W., Washington, D.C. 20006 (202/862-4160)

Dr. Robert Carlson, Vice President, Research Dept., Life Ins. Marketing & Research Association, 170 Sigourney Street, Hartford, Connecticut 06105 (203/525-0881)

Miss Jeanne R. Corbett, Vice-President, Metropolitan Life, One Madison Avenue, New York, N.Y. 10010 (212/578-6088)

Dr. Mathew Greenwald, Director, Social Research Services, American Council of Life Insurance, 1850 K Street, N.W., Washington, D.C. 20006 (202/862-4132)

William A. White, Associate Actuary, American Council of Life Insurance, 1850 K Street, N.W., Washington, D.C. 20006 (202/862-4162)

****

To: Erma Edwards, CLU, FLMI
Chairman, Cost Disclosure Task Force

From: Charles Greeley, Chairman
Advisory Committee on Monitoring the Impact of the
NAIC Model Life Insurance Solicitation Regulation

Date: May 11, 1979

Re: An Updated Report on the Activity and Current Status of the Committee

In my first report I indicated the committee's belief that a major purpose of the NAIC model is to educate the insurance-buying public; and that education is necessarily a continuing process which must be measured on a cumulative basis over a period of years. The public education goal is really at the end of a chain of steps – through state requirements, company compliance and voluntary actions, agent training, and finally consumer understanding and response. Our committee feels that this long-term nature must be emphasized in order to avoid raising unrealistic expectations.

However, certain intermediate steps can be taken very soon. For example, the question of whether the NAIC model can work might be addressed; e.g., are companies delivering the Buyer's Guide and Policy Summary; are agents being trained to explain this material and to use cost comparison indexes; and do agents discuss disclosure information with their customers. Other steps aiming at a longer-range study might be started, building upon ongoing industry research in the areas of agent and public attitudes.

The necessary work to implement both short- and long-range projects was discussed at the second meeting of the advisory committee held on April 1, 1979, following the meeting of the NAIC Life Insurance (C3) Cost Disclosure Task Force. The following five projects were then outlined, with any necessary decisions to be reached at the committee's next meeting:

1. State Requirements – Information will soon be available as to the number of states that have adopted the NAIC model; the number of companies voluntarily complying on a nationwide basis; and the percentage or purchasers who are receiving the disclosure material called for by the NAIC model. A survey was conducted by LIMRA in October 1977 and it is now being updated.

2. Impact on Companies – The committee is considering a survey of life insurance companies to determine: agents' training programs; measures to ensure delivery of Buyer's Guides and Policy Summaries; and the extent of feedback (complaints or questions) from purchasers.

3. Impact on Agents – Information will be sought through the NALU and LIMRA to determine if agents' opinions and sales experience are being changed as a result of cost disclosure. LIMRA has for some time been producing a "Survey of Agency Opinion"; specific questions on the NAIC model will be included in the next survey scheduled for release in the fall of this year.

4. Impact on Consumers – Since 1968 ACLI has conducted nationwide surveys of public attitudes toward life insurance (called "Monitoring Attitudes of the Public"). The 1979 version is being released in May and includes questions developed and reviewed by committee members, directed at the importance consumers attach to cost comparison information and whether they feel they are now getting sufficient information. Also under consideration is a joint ACLI/LIMRA project to survey recent purchasers and consumers who were recently contacted by agents but did not buy.

5. Statistical Information – The committee is considering the gathering of statistical information from companies in an attempt to measure the extent to which competition has intensified and buying patterns have changed – e.g., sales volume trends; any change in the number of policies returned under a "free look" provision; and the split between term and permanent insurance sales.

In addition to the above the committee will continue to review and analyze the results of other activities which bear upon our charge – such as, the Purdue University study, Dr. Formisano's study, and the recent hearings in Wisconsin.

It is possible that the above projects will not only measure the general effectiveness of the NAIC model, but may reveal certain particular areas of deficiency. While we understand that the present charge to your task force and our committee is not to consider amendments to the model, we will, of course, inform you if our research suggests that certain changes would be appropriate.

****

Report to the (C3) Task Force on Cost Comparisons
by the Special Task Force in Wisconsin

April 1979

At the public hearings held in Wisconsin on a proposed solicitation regulation, Ins. 2.14, the industry requested that the rate of return be eliminated from the regulation, and instead a special task force be formed to further study the matter. One of the reasons for the suggestion was that in no event would rate of return information be required before January 1, 1980.

The suggestion was adopted by former Commissioner Harold Wilde, Jr.

A task force was appointed in October, 1978 consisting of the following members: William A. White, Associate Actuary, American Council of Life Insurance; William M. White, Jr., Director of Government Relations, Connecticut General; Bradford S. Gile, Actuary, State of Wisconsin Insurance Department; Donald B. Maier, Actuary, Metropolitan Life Insurance Company; Stephen M. Rieth, Assistant Actuary, Aid Association For Lutherans; and William M. Snell, Associate Actuary, Northwestern Mutual Life, as Chairman.

Our charge was as follows:

1. What is the relationship between the Linton yield and the surrender cost index and what are the unique values of each for purposes of understanding and comparing the costs of life insurance products?

2. Can additional meaning and context be given to the surrender cost index which would provide it with independent significance and make it unnecessary to use a rate of return index?

3. What assumptions and context should be prescribed for all insurers to follow if a rate of return index is to be used, either for cost comparison purposes, or to provide a measure of investment "yield" which is not subject to misrepresentation?

Our first meeting was in November 1978, and we have met monthly since then. Total meetings to date number five. Our accomplishments to date are:

1. A conclusion that for the limited use of Linton yield now required by Ins. 2.14, there is no need to establish new YRT rates. We do not endorse the rates set forth in the regulation, but the cost/benefit ratio does not justify further work at this time.

   (2.14 provides: "Any sales presentation which repeatedly refers to an insurance premium or element of the insurance premium as a deposit, an investment, a savings or in any other phrase of similar impact, and does not disclose the Average Annual Rate of Return Index for 10 and 20 years is an unfair marketing practice . . .")

2. We are in our penultimate draft of guidelines for providing policy summaries for in force policies. These guidelines will be sent to all life insurance companies operating in Wisconsin, and hopefully decrease the number of questions now being received by the Wisconsin Insurance Department.

   (2.14 requires: "For policies already issued and paying premiums on the effective date of this rule, policyholders shall have the right to obtain a Policy Summary at cost. The company may charge a reasonable fee for preparing this Summary, not to exceed $5, and may utilize reasonable assumptions in providing the cost disclosure information, so long as they are clearly disclosed.")

3. We have requested data from companies writing in Wisconsin in order to carry out the first charge given to us by the Commissioner. Approximately 100 questionnaires have been received so far, and the programming is being checked out. The work will be done at NML, but the questionnaires will be coded when we receive them for processing so that the identity of individual companies will be preserved.

4. A qualitative analysis fo the Linton Yield method is also being drafted.

We will have another meeting before June 1979, and if the task force meets in Chicago, an additional progress report could be made at that time.

We hope to be able to answer our charge by late 1979.

****

Report to the (C3) Task Force on Cost Comparisons
by the Special Task Force in Wisconsin

Chicago, Illinois
June 2, 1979

This report supplements that given to the task force on April 1, 1979 in New Orleans.

Data from approximately 180 companies has been coded, checked, and is available from our data base.

Currently, Linton Yield percentages and Interest Adjusted Cost figures are being calculated. The raw data will be available for the next meeting of the special task force later this month.

In addition a report is being written on all of the facets of the Linton Yield Method. Each member was assigned a specific portion to write. First draft will be discussed at our meeting in late June 1979.

We are still aiming for a fall report on the viability of the Linton Yield Method.

****

Manipulation Advisory Committee (Reconstituted)

Mr. E. J. Moorhead, F.S.A.
2594 Woodberry Drive
Winston-Salem, North Carolina 27106

Professor Harold Skipper, Jr.
Assistant Professor of Insurance
Georgia State University
University Plaza
Atlanta, Georgia 30303

Professor Joseph Belth
Indiana University
School of Business Building
Graduate School of Business
Bloomington, Indiana 47405

Mr. Thomas J. Kelly, Chairman
Chief Actuary
State of New York
Department of Insurance
Two World Trade Center
New York, New York 10047

Mr. Paul Overberg
Allstate Life Insurance Company
Allstate Plaza
Northbrook, Illinois 60062

Mr. Walter Miller
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

Mr. Norman Peacor
Chief Actuary
Massachusetts Mutual Life Insurance Company
1285 State Street
Springfield, Massachusetts 01111

Dr. Brenda Roberts
Firemans Fund Life Insurance Company
1600 Los Gamos
San Rafael, California 94911

Mr. Julius Vogel
Senior Vice President and Chief Actuary
Prudential Insurance Company of America
Prudential Plaza
Newark, New Jersey 07101

****

(C) Committee Technical Task Force on
Valuation and Nonforfeiture Value Regulation

SPECIAL REPORT

Life Insurance

May 1979

CONTENTS

Actuarial Guidelines

The (C) Committee Technical Task Force on Valuation and Nonforfeiture Value Regulation recommends that the (C3) Life Insurance Subcommittee adopt the four additional actuarial guidelines proposed in this special report and that these actuarial guidelines be recommended to the (A5) Financial Condition Examination Subcommittee for inclusion in the actuarial section of the Financial Condition Examiners Handbook. The four additional actuarial guidelines recommended are:

A. Acceptable Approximations for Continuous Functions,
B. Interpretation Regarding Use of Joint Life Mortality Tables,
C. Interpretation Regarding Calculation of Equivalent Level Amounts, and
D. Interpretation Regarding Reserves for Single Premium Deferred Annuities.

These four actuarial guidelines were taken from a list of interpretations entitled "Interpretations of the California Insurance Code with Respect to Valuation and Nonforfeiture Requirements Applicable to Life and Annuity Products." This list of interpretations was originally prepared within the California Department of Insurance. The interpretations in the list are concerned with the Standard Valuation Law and the Standard Nonforfeiture Law, and they are of general interest in all states which have passed these model laws. The Technical Task Force has been considering the interpretations in the list on an individual basis.

Only the four actuarial guidelines identified above are being recommended at this time, but a number of other interpretations in the list are still being reviewed. Some of these other interpretations may be recommended in the future.

The text of each of the four recommended actuarial guidelines is given below, along with a brief description of the background material and the purpose and essential features.

A. Interpretation Regarding Acceptable Approximations for Continuous Functions

Text:

For reserves and values using continuous functions:

(a) $\bar{D}_x = {}_0\int^1 D_{x+t}\,dt$

By assuming that D_{x+t} is linear for $0 \leqslant t \leqslant 1$

$\bar{D}_x \doteqdot 1/2\,(D_x + D_{x+1})$.

By assuming that the deaths in the year of age x to x+1 are uniformly distributed over that year of age,

$\bar{D}_x \doteqdot [(\delta - d)/\delta^2]\,D_x + [(i - \delta)/\delta^2]\,D_{x+1}$

where: $d = iv = i/(1+i)$
δ = force of interest
i = interest rate.

(b) $\bar{C}_x = {}_0\int^1 D_{x+t}\mu_{x+t}\,dt$

By assuming that deaths in the year of age x to x+1 are uniformly distributed over that year of age,
$\bar{C}_x \doteqdot (i/\delta)\,C_x$.

By assuming that the total deaths are concentrated at the middle of the year of age,
$\bar{C}_x \doteqdot (1+i)^{1/2}C_x$ or $(1+i/2)C_x$.

Background Material

The actuarial mathematics used in calculating net premiums, reserves and nonforfeiture values for life insurance policies was first developed using two basic assumptions. These basic assumptions are: (1) that all death benefits are payable at the end of the policy year of death and (2) that all gross premiums due under the policy are payable annually at the beginning of the policy year. Actuarial values which are calculated under these two basic assumptions are described as being calculated using curtate functions. For any specific mortality table and interest rate, all the necessary actuarial values are uniquely defined for a policy using curtate functions.

The Standard Valuation Law and the Standard Nonforfeiture Law define minimum reserves and minimum nonforfeiture values, respectively, for life insurance policies using curtate functions. These two model laws originated in the early 1940's when almost all insurance companies were using the two basic assumptions inherent in the curtate functions. However, the wording of the model laws does not prohibit insurance companies from using other assumptions if the resulting reserves and nonforfeiture values will always be at least as large as the minimum amounts defined in these laws.

Nowadays, many insurance companies do prefer to use alternative assumptions in computing the reserves and nonforfeiture values for their life insurance policies. These companies consider the alternative assumptions more appropriate for their policies. These alternative assumptions are: (1) that all death benefits are payable immediately upon death and (2) that all gross premiums due under the policy are payable continuously throughout the policy year.

Actuarial values which are calculated under both of the alternative assumptions, pertaining to death benefits and gross premiums, are described as being calculated using continuous functions. However, the underlying mathematics for continuous functions involves two integrals, representing the actuarial functions $\bar{C}_x$ and $\bar{D}_x$, which must be approximated. In the past, there has been some disagreement among actuaries as to which approximations for the two integrals are the most suitable. Because of the use of different approximations for these two integrals, actuaries have obtained different numerical amounts for the necessary actuarial values using continuous functions even though these actuaries were working with the same mortality table and interest rate.

Some insurance companies prefer to calculate their reserves and nonforfeiture values assuming: (1) that death benefits are payable immediately upon death and (2) that all gross premiums due under the policy are payable annually at the beginning of the policy year. Thus, these companies are using the alternative assumption pertaining to death benefits and the basic assumption pertaining to gross premiums. The underlying mathematics for the combination of these two assumptions involves the integral $\overline{C}_x$, which must be approximated. Thus, the use of these two assumptions together gives rise to essentially the same problem as using continuous functions.

Purpose and Essential Features

This actuarial guideline lists the approximations for each of the integrals, representing $\overline{D}_x$ and $\overline{C}_x$, which are considered acceptable for use by actuaries.

Once $\overline{D}_x$ and $\overline{C}_x$ have been determined, all the other necessary actuarial values will be uniquely defined for a policy using continuous functions. Any two actuaries working with the same mortality table and interest rate would then obtain exactly the same numbers for all these other actuarial values, at least if we assume that no errors in arithmetic will be made.

The policies which assume: (1) that death benefits are payable immediately upon death and (2) that all gross premiums due under the policy are payable annually at the beginning of the policy year do not present any special mathematical problems. The approximations in this actuarial guideline are all that an actuary needs to calculate net premiums, reserves and nonforfeiture values.

This actuarial guideline would be helpful to state insurance departments in specifically listing those approximations which can be accepted. This actuarial guideline may be helpful to insurance companies in advising their actuaries which approximations for $\overline{D}_x$ and $\overline{C}_x$ are acceptable, possibly before any great amount of time or money is used in making calculations of net premiums, reserves and nonforfeiture values on the basis of some other approximation. It is hoped that this actuarial guideline will result in a uniform interpretation in most or all states, so that insurance companies can use a single set of such calculations in most or all of the jurisdictions in which they operate.

B. Interpretation Regarding Use of Joint Life Mortality Tables Text:

Reserves and nonforfeiture values for joint life insurance benefits may be calculated by treating the joint life table as a single life table and applying the Standard Laws accordingly.

Background Material

The great majority of life insurance policies provide single life insurance benefits. These policies identify one specific individual as the named insured. A death benefit under the basic policy is payable if this named insured dies while the policy is in force. Usually, there are no further gross premiums due on and after the death of this named insured. The basic policy may provide endowment benefits which are conditional on the survival of this named insured. The policy does not contain any provisions whereby the amount of the death benefits, endowment benefits or gross premiums are affected by the survival or nonsurvival of any other persons besides the insured, except possibly in the settlement option provisions or in the provisions of an attached term insurance rider which requires an extra premium.

In contrast to policies which provide single life insurance benefits, policies which provide joint life insurance benefits depend on the survival or nonsurvival of two or more named insureds. Until quite recently, virtually all policies which provided joint life insurance benefits were written on the whole life insurance plan. Such policies paid the face amount as a death benefit on the death of the first of the named insureds to die, provided that the policy was then in full force. No further gross premiums were due after the first death, and the policy terminated upon payment of the death benefit.

Recently there has been increasing interest in plans providing joint life insurance benefits, and insurance companies have developed a variety of new life insurance plans. For example, some policies provide for payment of a death benefit only on the death of the last to die of the named insureds.

The Standard Valuation Law and the Standard Nonforfeiture Law clearly apply to policies which provide joint life insurance benefits as well as to policies which provide single life insurance benefits. Both of these model laws define as "expense allowance" which is added to the present value of the future guaranteed insurance benefits under the policy, and which

affects the modified premiums used for computing minimum reserves and the adjusted premiums used for computing minimum nonforfeiture values. A different amount of "expense allowance" is defined for nonforfeiture values than that defined for reserves, but the principle is much the same.

Insurance companies are allowed to select "expense allowances" for use in computing their reserves and nonforfeiture values up to the level of the "expense allowances" defined in these model laws. A higher "expense allowance" would produce reserves or nonforfeiture values which are less than the minimum defined in the model laws, and therefore state insurance departments can not permit companies to use a higher amount as an "expense allowance."

The wording of these model laws is generally clear and precise in defining the "expense allowances" which are permitted for policies which provide single life benefits. However, the proper level of the "expense allowances" for policies providing joint life insurance benefits is not so clear. The "expense allowance" defined in the Standard Valuation Law depends on the modified net premium for a policy on the 20 payment whole life insurance plan, and the "expense allowance" defined in the Standard Nonforfeiture Law depends on the adjusted premium for a policy on the ordinary life plan.

Actuaries have had different opinions as to how to apply the joint life insurance mortality tables in order to obtain the modified net premium and the adjusted premium required by model laws, so as to calculate the "expense allowances" which are appropriate under those laws. The question has become increasingly important with the development of the new plans providing joint life insurance benefits.

Purpose and Essential Features

This actuarial guideline specifically states that insurance companies may treat the joint life mortality table as a single life table, for the purpose of applying the Standard Valuation Law and the Standard Nonforfeiture Law.

This was the interpretation most commonly used for the original type of policy with joint life insurance benefits, written on the whole life insurance plan with a death benefit of the face amount payable on the first death. The actuarial guideline permits this interpretation to be used for all life insurance policies which provide joint life insurance benefits.

The purpose of this actuarial guideline is to assist state insurance departments, and insurance companies and their actuaries, by setting forth one acceptable manner of treating policies which provide joint life insurance benefits. Again, it is hoped that this actuarial guideline will result in a uniform interpretation of what is acceptable in most or all states.

C. Interpretation Regarding Calculation of Equivalent Level Amounts Text:

Pure Endowments will not be considered in the determination of equivalent level amounts for valuation and nonforfeiture purposes.

Background Material

The "Background Material" section relating to the previous actuarial guideline went into some detail concerning the "expense allowances" defined in the Standard Valuation Law and the Standard Nonforfeiture Law. (See Actuarial Guideline B: "Interpretation Regarding Use of Joint Life Mortality Tables.")

This Actuarial Guideline C is also concerned with the level of these "expense allowances" defined in these model laws. The most common plans of life insurance provide a level face amount as the death benefit, during the period the policy is in full force. These plans do not provide for any benefit which is payable as a pure endowment. (A pure endowment benefit pays a specified amount of pure endowment to the policyholder if the insured is still alive on the specified maturity date and if the policy is still in full force on this maturity date.) However, policies which provide for a death benefit which varies with the duration and policies which provide one or more pure endowment benefits can be legally written in most states.

The Standard Valuation Law and the Standard Nonforfeiture Law do apply to such policies with varying death benefits or pure endowment benefits. In fact, the wording of the model laws shows that considerable thought was given to the treatment of these kinds of policies. In the case of both model laws, the present value of future guaranteed benefits under the policy clearly includes both the death benefits and the pure endowment benefits provided. A more difficult question is involved in the calculation of the "expense allowances" defined under these model laws.

The Standard Nonforfeiture Law includes a paragraph which reads as follows:

> In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this Section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten."

While the wording of the above paragraph is rather complex, the meaning seems to be actuarially precise. The paragraph defines an "equivalent uniform amount" which affects the "expense allowance" defined in the law. The phrase "containing the same endowment benefit or benefits, if any" effectively means that pure endowment benefits are to be ignored in computing this "equivalent uniform amount." This "equivalent uniform amount" is often described informally as the "equivalent level amount." This "equivalent uniform amount" or "equivalent level amount" becomes a sort of weighted average of the death benefits provided by the policy, an average which is not affected in any way by the pure endowment benefits which may be provided by the policy.

The Standard Valuation Law is not nearly so clear on this point. It contains wording as follows:

> Reserves according to the commissioners reserve valuation method for (1) life insurance policies providing for a varying amount of insurance---- shall be calculated by a method consistent with the principles of the preceding paragraph----."

(Note that the quoted wording refers back to the preceding paragraph in the Standard Valuation Law. It does not intend to refer to the paragraph quoted from the Standard Nonforfeiture Law.)

Most actuaries have interpreted the Standard Valuation Law so as to use an "equivalent level amount" which is not affected by any pure endowments included in the policy. They would then use this "equivalent level amount" to calculate the "expense allowance" defined in the model law. This "equivalent level amount" is also a weighted average of the death benefits provided by the policy, in the same fashion as the "equivalent uniform amount" used in applying the Standard Nonforfeiture Law. Some insurance companies use the same "equivalent level amount," for the purpose of the Standard Valuation Law, as the "equivalent uniform amount" defined in the Standard Nonforfeiture Law. Other companies use a very similar calculation to obtain a special "equivalent level amount," for the purpose of the Standard Valuation Law, based only on the death benefits provided on and after the first policy anniversary.

Some actuaries have felt that the wording of the Standard Valuation Law permits an alternate calculation of the "equivalent level amount" which would be affected by pure endowment benefits. Such an "equivalent level amount" would be used to calculate an "expense allowance" under the Standard Valuation Law, even though the "equivalent level amount" no longer has the character of a weighted average of the death benefits provided by the policy.

The inclusion of the pure endowment benefits in the calculation of the "equivalent level amount" would affect the level of the "expense allowance" defined in the Standard Valuation Law, and therefore it would affect the level of the minimum reserves required by the policy. Typically, the denominator of the fraction used in calculating the "equivalent level amount" would remain the same, but the numerator of this fraction would be increased because of this inclusion. Thus, the "equivalent level amount" itself and the resulting "expense allowance" defined in the Standard Valuation Law would also be increased with the inclusion. The end result of the inclusion would be lower minimum reserves at every duration.

Purpose and Essential Features

The chief objection to the inclusion of pure endowment benefits into the "equivalent level amount" is that such inclusion was not clearly intended by the Standard Valuation Law. The inclusion would generally act to lower the level of minimum reserves required in policies which do contain pure endowment benefits.

If the inclusion were expressly permitted, some insurance companies who wished to do so might be able to engage in manipulation to lower the reserves on their new policies. Such companies would accomplish this by revising their current policy forms so as to add pure endowment benefits to the current forms, or to increase the pure endowment benefits already included in the current forms.

If the amounts and maturity dates of the new pure endowment benefits were carefully selected, a considerable degree of reduction in the reserve factors would probably be possible.

This actuarial guideline would expressly prohibit including the pure endowment benefits in determining the "equivalent level amount" for either valuation or nonforfeiture purposes. As explained under "Background," the need for this actuarial guideline arises primarily for valuation purposes under the Standard Valuation Law. The wording of the Standard Nonforfeiture Law is sufficiently precise that this actuarial guideline is virtually a truism for the purpose of calculating nonforfeiture values.

The purpose of this actuarial guideline is to assist state insurance departments and insurance company actuaries by identifying a method of calculating "equivalent uniform amounts" and "expense allowances" which is not considered proper and which will not be accepted.

D. Interpretation Regarding Reserves for Single Premium Deferred Annuities Text:

Individual single premium deferred annuity reserves shall at least equal the greatest of any of the discounted values of cash surrender values available after the date of valuation, such cash values discounted to the valuation date at the maximum permissible statutory interest rate.

Background

This actuarial guideline relates to the calculation of reserves for annuities. It is especially concerned with adequate reserves for single premium deferred annuities having high cash surrender values. There is no future premium income to the insurance company on single premium annuities, and the growth in cash surrender values from one contract year to the next year is effectively limited to the interest earnings on the net single premium. (The net single premium is the balance of the gross single premium which remains after deductions for the insurance company's expenses.)

Most of the state insurance departments do not feel that they have the authority to disapprove a single premium deferred annuity contract, because its schedule of guaranteed cash surrender values is such that the insurance company must earn an interest rate higher than the maximum interest rate allowed for calculating its reserve for such contracts. However, the hazard inherent in guaranteeing such high interest rates must be recognized. If an insurance company chooses to sell such single premium deferred annuities, it must set up reserves on the basis that it may not be able to earn interest in the future at a rate higher than the statutory basis.

The Standard Valuation Law defines minimum reserves for annuity contracts as well as for life insurance contracts. Some states have already passed the most recent version of the Standard Valuation Law. It contains a paragraph which reads as follows:

> Reserves according to the commissioners annuity reserve valuation method for benefits under annuity and pure endowment contracts, excluding any disability and accidential death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

This actuarial guideline becomes a truism in these states. It should be noted that the wording of this paragraph distinguishes carefully between "present values," which are calculated at the maximum rate of interest allowed for company reserves, and "future guaranteed benefits," which are computed at the interest rate or rates specified in the contract for determining guaranteed benefits. In the case of single premium deferred annuities, there are no future valuation considerations and the "future guaranteed benefits" are the cash surrender values at the various durations.

The real need for this actuarial guideline arises in the remaining states, which have not yet passed this most recent version of the Standard Valuation Law. In most of these remaining states, the applicable portion of the Standard Valuation Law reads as follows: "Reserves according to the commissioners reserve valuation method for ---- (2) annuity and pure endowment contracts ---- shall be calculated by a method consistent with the principles of the preceding paragraph ----."

However, the preceding paragraph of text in the Standard Valuation Law does not lend itself to the calculation of reserves for these types of single premium deferred annuities. The wording is somewhat ambiguous as it relates to annuities in general, and it gives no guidance whatever to state insurance departments in providing for the special hazards of a high guaranteed interest rate in the cash surrender values for these single premium deferred annuities.

Purpose and Essential Features

The most recent version of the Standard Valuation Law was adopted by the NAIC in December 1976. While some state legislatures have already considered and passed it since that time, other state legislatures have not yet done so. Some of the remaining states may pass this version later, when they have had more time to review and consider it.

In the meantime, there is a continuing trend toward high interest rates throughout the marketplace. Single premium annuities with relatively high cash surrender values are becoming increasingly attractive to the public, especially if the increase in the guaranteed cash surrender values from one policy year to the next is reasonably competitive with interest rates available elsewhere such as the rates paid by banks or savings and loan institutions. More and more insurance companies are offering such annuity products.

The problem of determining proper reserves for these single premium annuities can not be postponed indefinitely. It has generally been settled in those states which have adopted the December 1976 version of the Standard Valuation Law. However, it does not seem prudent for the insurance departments in the other remaining states to wait for legislative action. The annuity contracts in question are subject to a recognized hazard, unless they are properly reserved; and the solution to the problem will have to be fairly prompt in order to adequately protect the policyholders in these states from the distress of a possible insolvency.

The actuarial guideline would adopt the same method described in the December 1976 version of the Standard Valuation Law as the proper method of reserving these single premium deferred annuities. There does not appear to be any conflict with the version of the Standard Valuation Law currently in effect in these other states. Rather, this actuarial guideline fills in a "gap" where the law is ambiguous and unclear.

Like other actuarial guidelines in this group, this actuarial guideline will assist state insurance departments, and insurance companies and their actuaries, by identifying the proper reserve method for these single premium deferred annuities. It is also hoped that this actuarial guideline will result in a uniform interpretation of reserve requirements for these annuities in most or all states.

(C) Committee Technical Task Force to
Review Valuation and Nonforfeiture Value Regulation

Life Insurance

June 1979

CONTENTS

A. Proceedings of the NAIC Technical Task Force

This report concerns only the proceedings of the NAIC Technical Task Force To Review Valuation and Nonforfeiture Value Regulation since the December 1978 meeting. Recommendations for approval of four guidelines, which are intended to be sent on to the (A5) Financial Condition Examination Subcommittee for inclusion in the Financial Condition Examiners Handbook, were made in a Special Report dated May 2, 1979, and sent to all members of the NAIC.

The report includes the minues of the meeting held on December 2 and 3, 1978, (Attachment A); a mailing to the NAIC Technical Task Force members dated April 20, 1979, which contained an instrument entitled "Disclosure Guidelines for Partial-Endowment-Type ("Deposit-Term-Type") Insurance" and which requested that the members vote on these guidelines (Attachment B); a letter from Arthur C. Cragoe of Franklin Life Insurance Company to John K. Booth of the American Council Life Insurance dated January 25, 1978, pertaining to the definition of an annuity, along with a transmittal letter from Larry M. Gorski of the Technical Task Force dated December 14, 1978 (Attachment C). Also included is a letter from Ronald L. Benedict of Ohio National Life Insurance Company dated April 3, 1979, relating to single premium

immediate annuities (Attachment D); a letter from Earl E. McCann of the Connecticut Insurance Department dated May 3, 1979, relating to the practice of using gross premium sufficiencies as an offset against deficiency reserves (Attachment E); an exposure draft of a report from the Society of Actuaries Committee To Recommend New Mortality Tables for Valuation to the Board of Governors of the Society *[Society will publish; not reprinted here]*, along with a transmittal memorandum from Committee Chairman C. A. Ormsby dated January 25, 1979 (Attachment F); a revised draft of the proposed variable annuity nonforfeiture regulation, along with a transmittal memorandum from Jerome S. Golden, Chairman of the Variable Products Advisory Committee, dated March 1, 1979, and other related information (Attachment G); and a letter from John K. Booth dated May 11, 1979, relating to reserve strengthening for insurance companies earning lower interest rates than the rates assumed in their reserves (Attachment H).

In the past it has been customary for the NAIC Technical Task Force to meet twice during each semi-annual period from December 1 to May 31, and June 1 to November 30. However, a meeting which was planned for April 10 and 11, 1979, had to be cancelled because it became apparent that a quorum of the members could not be present. In response to the mailing of April 20, 1979, identified above as Attachment B, the NAIC Technical Task Force members voted in favor of referring the guidelines to the NAIC Life Insurance Cost Disclosure Task Force, with the recommendation that these guidelines be approved by the task force. The NAIC Technical Task Force did not take any other official action after the December 1978 meeting.

Items 1 through 6 below relate to topics which have been listed on the agenda of the NAIC Technical Task Force.

1. Actuarial Guidelines

   a. Four actuarial guidelines are recommended at this time. (See the Special Report dated May 2, 1979, which immediately preceeded this report.)

   b. One additional set of guidelines entitled "Disclosure Guidelines for Partial-Endowment-Type ("Deposit-Term-Type") Insurance" is being referred to the NAIC Life Insurance Cost Disclosure Task Force, with the recommendation that these guidelines be approved by that task force. (See Attachment B.)

      These guidelines would apply to the types of life insurance policies which are commonly described as "deposit term plans" or "modified premium whole life plans." These guidelines are concerned specifically with disclosure, and they do not include any special reserve or nonforfeiture value requirements for these types of policies.

   c. The NAIC Technical Task Force is now working on three actuarial guidelines relating to annuities.

      (a) Definition of an Annuity: Annuities need to be precisely defined so that they can be distinguished from life insurance contracts. The problem manifests itself in contracts were the insurance company's risk in providing a death benefit is relatively small, in relation to the other benefits under the contract. The minimum standards for reserves described in the Standard Valuation Law will be quite different, depending on whether or not such a contract is classified as an annuity. Also, in those states which have passed the Standard Nonforfeiture Law for Individual Deferred Annuities, the minimum nonforfeiture values will also be quite different. Generally, the minimum nonforfeiture values would be higher in these states if the contract is considered as an annuity. Because these laws themselves do not define an annuity, state insurance departments need an appropriate definition to apply to contracts which have some of the aspects of an annuity. It should not be necessary for a state insurance department to have to rely entirely on the title given to the contract by the insurance company which offers it.

      Attachment C describes three alternative definitions for an annuity. The NAIC Technical Task Force will discuss these three definitions at its June 1979 meeting, and attempt to develop a suitable actuarial guideline.

      (b) Definition of a Group Annuity: For similar reasons, group annuities need to be distinguished from individual annuities. The minimum standards for reserves described in the Standard Valuation Law are different for group annuities than for individual annuities, because a different mortality table and interest rate are used in the computation. Generally, an insurance company would have to hold higher

reserves for the same type of obligation to provide income benefits if the contract is considered as an individual annuity. Also, the Standard Nonforfeiture Law for Individual Deferred Annuities defines and requires minimum nonforfeiture benefits for the typical individual annuity, but this law applies to group annuities only to a very limited extent.

The major question before the NAIC Technical Task Force is to determine the extent to which a group annuity can properly allocate benefits to specific individuals, other than the benefits which become payable at death, termination of employment or retirement. Many contracts which are labeled as group annuities have some of the aspects of individual annuities. For example, the contract terms may allow individuals to withdraw from the annuity at any time they choose in exchange for a specified cash surrender value. A guideline which defines group annuities would assist state insurance departments in defining and identifying group annuities for the purpose of the two laws described above.

The NAIC Technical Task Force discussed this subject in December 1978, and it will be considered further at the June 1979 meeting.

(c) Definition of an Individual Single Premium Immediate Annuity: Still another question involves the definition of individual single premium immediate annuities;which also needs to be considered by the NAIC Technical Task Force. Here the problem lies in distinguishing individual single premium immediate annuities from other individual single premium annuities. The Standard Valuation Law allows a higher interest rate to be used in calculating minimum reserves for individual single premium immediate annuities than for any other types of individual annuities. A guideline which defines individual single premium immediate annuities would assist state insurance departments in defining and identifying the annuities which can properly be reserved at these higher interest rates. This question was presented to the NAIC Technical Task Force very recently and it will be discussed for the first time at the June 1979 meeting. Attachment D is a letter related to this question.

d. The NAIC Technical Task Force is also working on other possible actuarial guidelines, in connection with a list of interpretations of the California Insurance Department. (Please see the 1978 NAIC Proceedings, V. II, pp. 452-3 for the original list of these interpretations.) The four actuarial guidelines now being recommended were developed from interpretations in the original list, and eight other interpretations in the list are still under consideration for development into actuarial guidelines. Attachment E is a letter which relates to one of these eight remaining interpretations.

It has also been suggested that the NAIC Technical Task Force should develop a guideline for calculating nonforfeiture values for life insurance policies with varying gross premiums, under existing laws, with a target date of December 1979 for completion of the project. This suggestion is a new proposal, and it has not yet been discussed at any of the NAIC Technical Task Force meetings.

2. New Mortality Tables for Individual Life Insurance

The Society of Actuaries Committee To Recommend New Mortality Tables for Valuation has now prepared its report to the Board of Governors of the Society. The Board of Governors has received this report, and it has authorized release of the report for exposure to members of the Society. The board had a number of comments and points, which it has asked the committee to consider and then report back on. It is expected that the further exposure may raise additional points for consideration by the committee in the future. The proposed new mortality tables are expected to be discussed in detail at the annual meeting of the Society of Actuaries in October 1979.

A copy of the report of the committee is included as Attachment F *[not reprinted here]*. However, it should be understood that exposure within the Society will not be completed for several months.

One significant difference between the recommendations in Attachment F and the mortality tables now in use is that the recommended mortality tables were developed separately for males and females, with each table being derived from groups of insured lives which were confined to that sex. The mortality tables currently in use make

use of essentially the same table of mortality rates, but these rates are intended to reflect male mortality. Insurance companies are permitted to use an age setback of a specified number of years in applying these tables to female lives. The most recent versions of the Standard Valuation Law and the Standard Nonforfeiture Law allow companies to assume that a female insured is as much as six years younger than her actual age.

It should be noted that the charge of the Society of Actuaries Committee which produced Attachment F is directed toward valuation, the computation of reserves for life insurance policies. Considerable work is necessary in order to determine the suitability of these mortality tables for the computation of cash surrender values and other nonforfeiture values. This question will involve the testing of various assumptions for "expense allowances." These trial "expense allowances" would be used in computing "adjusted premiums" and then applied prospectively to obtain minimum cash surrender values.

The NAIC Technical Task Force can make only limited progress on this topic at its June 1979 meeting, since the Society of Actuaries has not yet completed its recommendations. The NAIC Technical Task Force expects to discuss the material contained in Attachment F, the "expense allowances" which might be used with the proposed tables, and the procedures for performing tests in connection with this general subject. The NAIC Technical Task Force is also concerned with the question of whether the new mortality tables should be expressed in a formula suitable for convenient use in computer operations.

3. Revision of the Standard Nonforfeiture Law and the Standard Valuation Law

a. The introduction of new mortality tables for individual life insurance would require changes in the wording of both of these model laws. Also, the "expense allowance" used in computing "adjusted premiums" is defined in the Standard Nonforfeiture Law, and a change in the method of determining the "expense allowance" would require a change in the wording of that law. The preceding section of the report discusses these two potential changes.

b. The NAIC Technical Task Force is also considering a revision of these two laws, so that the interest rates used for computing minimum reserves and minimum nonforfeiture values would be changed at regular intervals (probably at the beginning of each calendar year) in accordance with the current economic conditions prevailing at a reference date shortly before the beginning date of each interval. Thus, all life insurance policies written in the calendar year 1989, for example, would have minimum reserves and minimum nonforfeiture values based on a specially calculated interest rate determined perhaps on October 1, 1988. This same interest rate would continue to be used for determining minimum reserves and minimum nonforfeiture values for these policies issued in 1989, no matter how long those policies remained in force. However, a new interest rate would be calculated on October 1, 1989, to apply to all life insurance policies issued in the calendar year 1990, no matter how long they remained in force. Similarly, new interest rates would be calculated on October 1, 1990, and each year thereafter, for use with life insurance policies issued during the appropriate calendar year.

   The above procedure can be described informally as a "floating" interest rate assumption. It would have an advantage over the current wording of the model laws in that specific action by state legislatures would no longer be necessary, every time that economic conditions suggest that a change in the interest rate for new policies is in order.

   It should be noted that the "floating" interest rate is for the purpose of computing minimum reserves and minimum nonforfeiture values, so as to effectively define the maximum interest rate which insurance companies can use if they wish to do so. Insurance companies which preferred to use a lower, more conservative interest rate to compute the actual reserves and the actual nonforfeiture values for their policies would be free to do this. It should also be noted that a type of "floating" interest rate is defined in the Actuarial Guideline entitled "Reserve Requirements with Respect to Interest Rate Guarantees on Active Life Funds Held Relative to Group Annuity Contracts." This actuarial guideline was previously developed by the NAIC Technical Task Force, and this guideline is now included in the current NAIC Financial Examiners Handbook.

c. It has also been suggested that the NAIC Technical Task Force should consider possible revisions to the Standard Nonforfeiture Law which would affect the calculation of minimum cash values for varying gross premium plans. This is a new proposal, and it has not yet been discussed at any of the NAIC Technical Task Force Meetings.

4. Variable Annuity Nonforfeiture Regulation

The Variable Products Technical Committee has reviewed the previous draft of this regulation, and has presented a new draft for consideration by the NAIC Technical Task Force. Attachment G includes the current draft of the proposed regulation, as well as some pertinent explanatory material. The transmittal letter from Jerome S. Golden endeavors to show how this material relates to the specific requests which the NAIC Technical Task Force had made to the Variable Products Technical Committee on October 26, 1978, and which were described in the minutes for the NAIC Technical Task Force meeting held on that date.

The NAIC Technical Task Force will consider this new draft of the regulations at its June 1979 meeting.

5. Problem Plans

No such plans have been submitted to the NAIC Technical Task Force during the period covered by this report.

6. Companies Earning Lower Interest Rates Than the Rate Assumed in Their Reserves

This is a joint topic which involves credit insurance and accident and health insurance in addition to life insurance.

There are two separate aspects within this topic. One of these is in better identification of those insurance companies for which a problem does exist, and the other is in establishing the proper remedy for the problem once such a company has been identified.

With regard to identification of insurance companies, the NAIC Technical Task Force has discussed certain proposed changes in the Annual Statement blank at its December 1978 meeting. However, no specific recommendations were made. It should be noted that certain revisions in Page 6 of the Annual Statement blank (Analysis of Increase in Reserves During the Year), which had been proposed by the (A3) Subcommittee Task Force on Life and Health Insurance Early Warning System Tests, were not actually adopted.

These proposed revisions were current at the time of the December 1978 meeting, and the NAIC Technical Task Force did not wish to make any alternative proposals for revising Page 6 at that time.

With regard to a remedy for such a problem, the NAIC Technical Task Force discussed reserve strengthening at its December 1978 meeting as one possible solution but did not reach any specific decision. John K. Booth's letter of May 11, 1979, (Attachment H) states his conclusion that there are a number of other remedies which might be suggested, and that reserve strengthening is an inappropriate remedy in some circumstances where the problem exists.

The NAIC Technical Task Force expects to consider both aspects of this topic again at its June 1979 meeting.

B. Recommendations

See the Special Report dated May 2, 1978, for recommendations to the (C3) Life Insurance Subcommittee.

See Part A, Section 1b, and Attachment B elsewhere in this June 1979 report for comments concerning a recommendation to the NAIC Life Insurance Cost Disclosure Task Force.

No other recommendations are made with this report.

Ted Becker, Chairman, Texas; John O. Montgomery, California; James Montgomery III, District of Columbia; Larry Gorski, Illinois; Erma Edwards, Nevada; Thomas J. Kelly, New York; Thomas A. Bickerstaff, Pennsylvania; Bradford S. Gile, Wisconsin.

ATTACHMENT A

(C) Committee Technical Task Force to
Review Valuation and Nonforfeiture Value Regulation

Las Vegas, Nevada

December 2-3, 1978

The NAIC (C) Committee Technical Task Force to Review Valuation and Nonforfeiture Value Regulation met from 9 a.m. to 3:30 p.m. on Saturday, December 2, 1978, in Conference Rooms 1 and 2 of the Las Vegas Hilton Hotel in Las Vegas, Nevada. The Technical Task Force met again on Sunday, December 3, 1978, in Conference Rooms 4 and 5 in the same hotel. There were separate morning and afternoon sessions at the December 3 meeting. The morning session began at 9 a.m. and continued until 12 noon. The afternoon session began at 2:30 p.m. and continued until 5 p.m.

Because of unfavorable weather and difficult travel conditions, certain individuals were not able to attend the December 2 meeting. It was necessary to depart from the prepared agenda, and to rearrange the order in which the various topics were considered. Some of the topics had to be postponed from December 2 until December 3.

Thus, the Technical Task Force considered topics pertaining to the (C1) Accident and Health Subcommittee on December 2, and again at the morning session on December 3. The Technical Task Force considered topics pertaining to the (C2) Credit Insurance Subcommittee at the morning session on December 3. The Technical Task Force considered topics pertaining to the (C3) Life Insurance Subcommittee on December 2, and again at the afternoon session on December 3. The Technical Task Force considered one joint topic pertaining to all three subcommittees on December 2.

The following Technical Task Force members were present on both December 2 and December 3: Ted Becker, Chairman, Texas; John Montgomery, Vice Chairman, California; Erma Edwards, Nevada; Larry M. Gorski, Illinois; James R. Montgomery III, District of Columbia.

Another Technical Task Force member was present on December 3: Thomas J. Kelly, New York.

Other State Insurance Department representatives were also present on both December 2 and December 3: Douglas A. Broome, South Carolina; N. Barry Greenhouse, New York; Jay Koleski, Minnesota.

One State Insurance Commisssioner was present on December 2 only: E. V. "Sonny" Omholt, Montana.

The following persons were present on both December 2 and December 3: Wilbur M. Bolton, Occidental of California; John K. Booth, American Council of Life Insurance; David M. Holland, Munich American Reassurance; Anthony J. Houghton, Tillinghast, Nelson and Warren; Ken Jones, Cuna Mutual; Richard S. Miller, Southwestern Life; William A. White, American Council of Life Insurance.

Another person was present only on December 2: Mike Medland, Cuna Mutual.

The following additional persons were present on December 3 only: James F. Allen, Kemper Life Insurance Company; J. Stephen Beckman, United Investors Life; Will Burgess, Bankers Life and Casualty; Gregg Carney, Anchor National Life; Carroll Dietele, Anchor National Life; Ann B. Enarson, Kemper Life Insurance Company; W. J. Fitzgibbon, Aetna Life and Casualty; Harvey Galloway, Nationwide Corporation; Burnett A. Halstead, Kemper Life Insurance Company; George Harding, University Life; H. C. Jaros, United Investors Life; Howard Kayton, Security First Group; Harold Leff, Metropolitan Life; R. A. Miller III, Aetna Life and Casualty; Robert Sable, National Consumer Law Center; Robert Shapland, Mutual of Omaha; Anthony T. Spano, Equitable, New York; Peter Thexton, Health Insurance Association of America; William S. Timmons, Blue Cross-Blue Shield; Eugene R. Volpi, Aetna Life and Casualty.

Mr. John Montgomery, Vice Chairman of the Technical Task Force, presided at the December 2 meeting and at both sessions of the December 3 meeting. Mr. Becker, Chairman of the Technical Task Force, acted as secretary.

(C3) Life Insurance Subcommittee

December 2-3, 1978

Construction of New Mortality Tables

Mr. Bolton, a member of the Society of Actuaries Special Committee to Recommend New Mortality Tables for Valuation, gave an interim report on this topic on December 2, 1978. This committee has not yet completed work on its report to the Board of Governors of the Society, but this report is expected to be submitted to the board in January or February, 1979. The Board of Governors of the Society may wish to take additional time to consider the report after it has been submitted by the committee.

Mr. Bolton noted that the proposed new tables would be entirely distinct for males and females. (Thus, it would not be possible to obtain female mortality rates by merely applying an age setback to the rates for males.) Both the male table and the female table would terminate at age 100. He also noted that net premiums under the proposed new tables would tend to be slightly less than net premiums under the Modern C.S.O. Table (described in Transactions of the Society of Actuaries, Vol. XXVII, 1975, p. 624).

In response to a question from Mr. Booth, Mr. John Montgomery stated that he felt the earliest possible date on which these proposed new tables could be adopted by the NAIC would be June 1980.

These proposed new tables are being developed for computing reserves. There was some discussion as to how these tables might be tested to see if they would also be suitable for computing nonforfeiture values.

The Technical Task Force decided to consider this question further in Executive Session. Please see the section of these minutes entitled "Executive Session."

Definition of An Annuity

The Technical Task Force proceeded to discuss the question of distinguishing an annuity from a life insurance policy on December 2. This question had not been resolved at previous meetings. The Technical Task Force also discussed the related question of distinguishing a group annuity from an individual annuity.

Mr. Booth mentioned that the American Council of Life Insurance has a committee which is working on matters involving annuities. This committee might be able to suggest possible answers to these questions, for subsequent consideration by the Technical Task Force. Mr. Booth felt that the proper answers should be based on what the contract actually does, not merely on how it labels itself.

It was generally agreed that the degree of allocation of funds is critical in any attempt to distinguish individual annuities from group annuities. In response to a request from Mr. Miller, Mr. Becker agreed to circulate a report from an Advisory Committee to the Texas Commissioner of Insurance which is pertinent to this topic.

Mr. Miller mentioned that the Internal Revenue Service definition of an annuity might be considered by the Technical Task Force. This definition refers to "incidental" life insurance, and under this definition the typical retirement income policy would be classified as an annuity.

The Technical Task Force deferred any decision on these questions until Executive Session. Please see the section of these minutes entitled "Executive Session."

Guideline on Deposit Term Insurance

On December 3, Mr. Booth reported on the most recent draft of proposed guidelines, which he had prepared in a letter dated November 8, 1978. There are now two separate proposed guidelines. One of these proposed guidelines relates to disclosure and the other to minimum nonforfeiture values. The titles and the text of these proposed guidelines now refer to "partial endowment" type policies, rather than to "deposit term" type policies. The titles to the proposed guidelines are "Disclosure Guidelines for Approval of Partial Endowment Type Insurance" and "Minimum Nonforfeiture Guideline Requirements for Approval of Partial Endowment Products."

Mr. Harding commented on the proposed disclosure guidelines. He was especially concerned about the first item in the list of minimum disclosure requirements. Requirement 1 specifies that all advertisements for these products must fully and fairly inform the applicant as to future premium, benefits and related options. Mr. Harding felt that this language could be used to prohibit any sort of advertising which attempts to generally describe these products, and he noted that such restrictions would not be applicable to any other plans of life insurance policies. He suggested that the words "fully and fairly" be replaced by the word "adequately." Mr. Harding also had suggestions for changing the wording of Requirement 5, which relates to sales material for policies containing a voluntary deposit provision, and of Requirement 6, which now requires a separate explanation sheet.

Mr. Holland noted that the title of the proposed disclosure guideline uses the word "approval," but the guidelines go beyond mere policy approval since they impose requirements on advertising and sales materials that would be used after the policy form has already been approved.

The Technical Task Force agreed to delete the words "approval of" from the title of these proposed disclosure guideline. However, the Technical Task Force decided not to make any of the changes in the wording of the proposed guidelines that Mr. Harding had suggested.

At the suggestion of Mr. James Montgomery of the Technical Task Force, the minutes of the Technical Task Force will state that a form which simply invites a prospect to request information is not intended to be considered as "advertising, sales material or sales presentation" within the meaning of Requirement 1. The critical factor would be whether or not the form makes any attempt at a partial description of the policy. If there is an attempt at partial description, the form would have to be considered as advertising. No change in the wording of the proposed guideline was deemed necessary in connection with this interpretation.

The Technical Task Force agreed to make a number of technical changes in the wording of the proposed disclosure guidelines that were suggested by its members. Requirement 5 was revised so as to substitute the words "excess of the first year premium over the renewal premiums" for the words "additional first year premium." Requirement 6 was changed so as to make the explanation sheet a requirement rather than a recommendation. Also, in the ninth line of Requirement 6, the words "of the contract" will be added between the words "the first twenty policy years" and "and representative policy years."

It was pointed out that the rules of the NAIC appeared to effectively prohibit any further action on the proposed disclosure guidelines at the NAIC annual meeting of December 3-8, 1978. The (C3) Life Insurance Subcommittee can only consider material which is prepared and circulated among its members thirty days in advance of its meeting. The Technical Task Force also discussed the possibility of referring the proposed disclosure guideline to the (C3) Life Insurance Cost Disclosure Task Force.

The Technical Task Force did not reach a decision as to how to proceed with the proposed disclosure guidelines at this meeting. The Technical Task Force did not discuss or take any action on the other proposed guidelines, relating to minimum nonforfeiture values.

Revision of Standard Nonforfeiture Law and Standard Valuation Law

On December 3, the Technical Task Force also discussed a proposed revision of the Standard Nonforfeiture Law, which had been presented by Mr. E. James Morton in a letter dated October 13, 1978. This proposed revision would affect minimum nonforfeiture values only for those plans of life insurance with premiums that decrease the first ten years. The revision would apply a method for computing minimum values similar to the method used in computing reserves for annuities, under the Model NAIC Amendments to the Standard Valuation Law previously recommended by the Technical Task Force.

The Technical Task Force agreed not to take any action on Mr. Morton's proposed revision at this meeting. It was felt that this proposal could not be recommended as an isolated piece of legislation, but that the proposal might be given further consideration when the Technical Task Force proceeds to recommend a general revision of the Standard Nonforfeiture Law.

There was some discussion of the goals of the Technical Task Force in the next general revision of the Standard Nonforfeiture Law and the Standard Valuation Law. It was agreed that there should be some type of "floating" maximum interest basis. The maximum interest rate under the "floating" basis would be the same for all life insurance policies sold in

a given year; this interest rate would be determined from current economic conditions on a reference date shortly before the beginning of that particular year. The maximum interest rate would be adjusted annually in succeeding years, and the adjusted interest rate would apply to new life insurance policies sold during the one year period following each adjustment. However, once a policy was issued, the same interest assumptions would continue to apply to that partucular policy just as long as it remained in force. Thus, a change in the maximum interest after the date of issue of a policy would have no effect whatever on its cash values, nor would there be any effect on the reserves attributable to that policy.

It was suggested that the mortality rates might also be allowed to operate on a "floating " basis in the same manner. However, the Technical Task Force did not reach any definite conclusions with respect to these proposed interest rates and mortality rates under the "floating" basis.

Relationship of Successive Cash Values

The Technical Task Force discussed this topic on December 3. It was noted that the present wording of the Standard Nonforfeiture Law defines minimum cash values at all durations for life insurance policies, but that it apparently does not require any relationship between the cash values which are actually provided in successive policy years.

Mr. Allen had suggested a possible test for the relationship of cash values in successive years in his letter to Mr. Booth dated September 6, 1978, which had previously been distributed to the Technical Task Force. Under this test, the cash value at the end of a specific policy year would be discounted at the loan interest rate; the gross annual premium for that policy year would then be deducted, and the result would be compared to the cash value for the previous policy year.

Mr. Leff pointed out that the report of the Special Committee on Valuation and Nonforfeiture Laws of the Society of Actuaries had recommended a single set of minimum cash values, in the same manner as the present Standard Nonforfeiture Law. This committee did not recommend any tie-in of successive cash values. (Transactions of the Society of Actuaries, Vol. XXVII, 1975, pp. 549-633.)

The Technical Task Force decided not to take any action on this subject at this meeting. There was some feeling that problems relating to the subject could be considered by the (C3) Life Insurance Cost Disclosure Task Force in its review of manipulation of cash values.

Other Guidelines for Life Insurance and Annuities

The Technical Task Force considered this topic on December 3, 1978. They proceeded to review the second exposure draft of "Interpretations of the California Insurance Code with Respect to Valuation and Nonforfeiture Requirements Applicable to Life and Annuity Products." The twelve numbered interpretations in this draft were presented as possible actuarial guidelines, which might be suitable for inclusion in the NAIC Examiners Handbook.

Mr. Kayton and Mr. Carney stated that there was a possible conflict between Interpretation 10 and 11 and between Interpretations 10 and 12. Mr. John Montgomery indicated that Interpretation 10 was intended to apply to annual premium life insurance policies only, whereas Interpretations 11 and 12 related only to annuities.

Mr. John Montgomery also suggested that the Technical Task Force review the interpretations on an individual basis at this meeting. Some of these interpretations could possibly be recommended as guidelines right away. The remaining interpretations could be considered at subsequent meetings, so that there might be a second set of recommended guidelines resulting from these interpretations later.

The Technical Task Force agreed to go ahead on this basis. The interpretations were then considered individually, and in numerical order.

There was considerable discussion of Interpretation 1, dealing with group permanent life insurance. It was agreed that it would be desirable for the next general revision of the Standard Nonforfeiture Law and the Standard Valuation Law to specifically address group permanent coverage. At the suggestion of Mr. Kelly of the Technical Task Force, the words "the Standard Valuation Law and the Standard Nonforfeiture Law" were substituted for the words "valuation and nonforfeiture provisions of the California Insurance Code."

In response to a question from Mr. Minck, Mr. John Montgomery stated that Interpretation 1 was intended to apply only to group permanent coverage purchased by employee considerations. It was not intended to apply to the type of group permanent coverage paid for by employer considerations. Mr. Kelly suggested that the wording of Interpretation 1 be changed to specifically restrict it to those group permanent plans which are based on employee considerations.

Mr. White mentioned that the New Jersey Department is requiring the minimum cash value under a group permanent plan to be calculated on an asset share basis. Thus, cash values would always be at least as large as the corresponding asset shares.

The Technical Task Force agreed that more research was needed in connection with Interpretation 1. Mr. Minck was requested to gather information on this subject; he was asked to work with the Group Insurance Committee of the American Council of Life Insurance, if this is feasible.

In response to a question from Mr. Booth, Mr. John Montgomery stated that Interpretation 2 was intended to apply to individual annuities only. It was not intended to have any effect on group deposit administration contracts. Mr. Gorski of the Technical Task Force suggested that the approach in Interpretation 2 was satisfactory for interest rate purposes, but that the method of computing reserves would have to be the same as for a flexible premium annuity.

The Technical Task Force decided to defer action on both Interpretations 2 and 3.

Several changes in the wording of Interpretation 4 were made. The first line was expanded so as to read, "For reserves and values using continuous functions, any of these assumptions are acceptable." Also, a technical error in part (b) was corrected by changing "C_x" to "$\bar{C}_x$" on the left hand side of all three equations.

The Technical Task Force proceeded to discuss Interpretation 5. Mr. Becker felt that the wording of the first sentence might allow the insurance company to use either age last birthday or age nearest birthday assumptions at its discretion, regardless of how the age of the insured is determined when the company considers the application for insurance and issues a policy.

It was also noted that the wording of Interpretation 5 seems to require the company to actually show the nonforfeiture factors necessary to determine any cash values after the twentieth policy year. The Technical Task Force deferred action on Interpretation 5 for the Executive Session.

There was some discussion of Interpretations 6, 8, 10 and 12 ;but the Technical Task Force agreed that they need further work.

A change was made in the wording of Interpretation 7. The Technical Task Force agreed to introduce the words "at the joint equal age" between the words "single life table" and the words "and applying."

The Technical Task Force then agreed to recommend Interpretations 4, 7, 9 and 11 as guidelines, without any further changes in wording.

The Technical Task Force decided to consider Interpretation 5 further in Executive Session. Please see the section of these minutes entitled "Executive Session."

Other Matters

There was no report from the Variable Products Advisory Committee at this meeting. This committee had previously submitted a proposed Variable Annuity Nonforfeiture Regulation. At its October 1978 Meeting, the Technical Task Force had asked this committee to do some additional research and to consider certain specific questions. It is understood that the committee is now working on these matters, and the Technical Task Force expects to have a report from the committee in the near future.

On December 3, Mr. Booth mentioned a life insurance policy form, which purports to be a whole life insurance plan, but this policy has a schedule of increasing gross premium rates somewhat like a one year renewable term plan.

The gross premium rates are extremely low and increase annually up to about age 70. There is a steep increase in the gross premium rate at that age, and the premiums remain level thereafter. The gross premium rates in the early policy years are such, that if a one year renewable term policy had been offered at the same premium rates, then the guideline developed by the Technical Task Force would have required a special reserve for the low guaranteed rates. However, the company offering this policy considers it to be a whole life policy; the company allegedly calculates net premiums as proportional to corresponding annual gross premiums with no deficiency reserve or special reserve for the low guaranteed rates being set up.

Several of the Technical Task Force members commented that this policy should require reserves at least as high as a one year renewable term policy with the same gross premium rates. However, no action was taken at this meeting.

Please see the section of these minutes entitled "Joint Topic for (C1) Accident and Health Subcommittee Report, (C2) Credit Insurance Subcommittee Report, and (C3) Life Insurance Subcommittee Report" for a report on the topic "Companies Earning Lower Rates Than the Interest Rate Assumed in Their Reserves." This topic was considered by the Technical Task Force on December 2, 1978. The topic relates to accident and health insurance and to credit insurance, as well as to life insurance.

Please note also that the "Executive Session" section of the minutes contains additional material on certain life insurance topics described above.

Joint Topic for – (C1) Accident and Health Subcommittee Report, (C2) Credit Insurance Subcommittee Report, and (C3) Life Insurance Subcommittee Report

December 2, 1978

Companies Earning Lower Interest Rates Than the Rate Assumed in Their Reserves

The Technical Task Force began consideration of this topic by discussing possible changes in the Annual Statement blank, which might help to identify this problem.

Mr. John Montgomery noted that the (A3) Subcommittee Task Force on Life and Health Insurance Early Warning System Tests had already proposed certain revisions in page 6 of the Annual Statement blank. (Analysis of Increase in Reserves During the Year.) He questioned whether the Technical Task Force should come up with any additional suggestions for revision of page 6 at this time. However, he stated that it would be desirable for this page to show information on reinsurance.

Mr. White suggested that the Annual Statement blank might be revised to show additional information on investment income. He felt that page 4 (Summary of Operations) could be revised for this purpose. Mr. Miller mentioned page 14b (Five-Year Historical Data) as an alternative place for the revision.

Mr. John Montgomery pointed out Exhibit 9 (Aggregate Reserve for Accident and Health Policies) as another part of the Annual Statement blank which needs consideration by the Technical Task Force.

Several alternative methods for amending Exhibit 9 were discussed, including expanding Exhibit 9 to make it more similar to Exhibit 8 or adding a line to Exhibit 9 calling for required interest. It was felt that any revision of Exhibit 9 should not make this exhibit too complex, and that the instructions for filling in the revised Exhibit 9 would have to be very precise in order to avoid ambiguity.

The Technical Task Force voted to recommend adding a new Part C to Exhibit 9, which would include additional information such as interest on claim reserves. However, a definite format for this revision will have to be worked out after the meeting. The Technical Task Force decided not to recommend any changes in page 4, page 6, or page 14b of the Annual Statement blank at this meeting.

Mr. Gorski of the Technical Task Force pointed out that the general problem of insurance companies which earn low rates of interest had not been resolved at the October 1978 meeting, and that the proposed change in Exhibit 9 of the Annual Statement blank would help to identify the problem but would not correct it.

Mr. Booth suggested that once an insurance company has been identified as earning interest at a lower interest rate than the rate assumed in its reserves, then that company should be required to strengthen its reserves. The recalculated reserves would be calculated at a lower interest rate which the company is actually able to earn.

There was considerable discussion on this suggestion. It was generally agreed that any such reserve strengthening should be mandatory, so that the Insurance Commissioner of the domiciliary state for the company would be required to order an increase in its reserves. It was felt that an additional amount of mandatory securities valuation reserve would not be an acceptable substitute for the strengthened reserves. The problems involved in the reserve strengthening were recognized as very complex; one problem is that various blocks of business may generate quite different needs for reserve.

The Technical Task Force asked Mr. Booth to develop proposed guidelines for such reserve strengthening. It was recommended that the proposed guidelines include suggestions for state insurance departments. For example, the guidelines might seek to identify policy forms which are hazardous to the company and which need to be removed from the market.

Executive Session

The Technical Task Force adjourned and convened in Executive Session on the afternoon of December 2, 1978, immediately following the meeting in open session. The Technical Task Force convened again in Executive Session on both the morning and the afternoon of December 3, 1978, immediately following the meetings in open session.

Two topics pertaining to the (C3) Life Insurance Subcommittee were considered in the Executive Session held on December 2, and one additional topic pertaining to the (C3) Life Insurance Subcommittee was considered in the Executive Session held on the afternoon of December.

(C3) Life Insurance Subcommittee – Executive Session
Construction of New Mortality Tables

In Executive Session on December 2, the Technical Task Force discussed the testing of the proposed new tables for nonforfeiture purposes in more detail. Mr. John Montgomery stated that he felt the state insurance departments would need to do at least some of the testing for themselves. He hoped to be able to make certain computations to check out the expense loadings described in Charles Richardson's recent paper (Transactions of the Society of Actuaries, Volume XXIX, 1977, p. 209). Mr. Gorski said that he might also be able to make some computations.

Definition of an Annuity

The Technical Task Force also discussed the problem of defining an "annuity" and a "group annuity" again in Executive Session on December 2. It was pointed out that the next general revision of the Standard Valuation Law and the Standard Nonforfeiture Law needs to be entirely clear and unambiguous as to what is meant by an "annuity" and by a "group annuity." The Technical Task Force asked Mr. Gorski to work with Mr. Arthur Cragoe of Franklin Life Insurance Company to develop a suggested method for distinguishing an individual annuity from an individual life insurance contract. The Technical Task Force did not take any action on the question of distinguishing group and individual annuities.

Other Guidelines for Life Insurance and Annuities

In the Executive Session on December 3, the Technical Task Force gave further consideration to Interpretation 5 of the "Interpretations of the California Insurance Code with Respect to Valuation and Nonforfeiture Requirements Applicable to Life and Annuity Products." The Technical Task Force was in general agreement with the underlying philosophy of Interpretation 5. However, no alternate wording was decided upon; and work on this Interpretation was deferred until the next meeting, along with Interpretations 1, 2, 3, 6, 8, 10 and 12.

Ted Becker, Chairman, Texas; John O. Montgomery, California; James Montgomery III, District of Columbia; Larry Gorski, Illinois; Thomas J. Kelly, New York; Erma Edwards, Nevada ;Thomas A. Bickerstaff, Pennsylvania; Bradford S. Gile, Wisconsin.

****

ATTACHMENT B

To: Members of the NAIC Technical Task Force to Review Valuation and Nonforfeiture Value Regulation

From: Ted Becker, Texas, Chairman

Date: April 20, 1979

Re: Deposit Term Insurance

PLEASE NOTE THAT AN IMMEDIATE RESPONSE TO THIS MEMORANDUM IS REQUESTED!

For various reasons, it appears that it is feasible for our Technical Task Force to vote on only one matter prior to our June 2 and 3 meeting in Chicago. This is in connection with the Disclosure Guidelines for Partial-Endowment-Type ("Deposit-Term-Type") Insurance.

I have enclosed the December 1978 draft of these guidelines. This is the most recent version; and it incorporates certain changes made in the October 2, 1978, draft at the December 3, 1978, meeting of the Technical Task Force. (Those changes were confined to pages 1 and 5 of the October 2, 1978 draft.)

I have provided a short ballot and a self-addressed envelope. The ballot solicits your decision as to whether or not our Technical Task Force should refer these guidelines to Erma Edwards' NAIC Task Force on Life Insurance Cost Disclosure, with a recommendation that these guidelines be approved by that task force.

Please mail in your completed ballot to me next week, so that all ballots will be received in Austin by Monday, April 30, 1979. Thank you for your consideration and assistance on these guidelines.

I plan to get out a general mailing to our Technical Task Force and to other persons on our mailing list in the next few days. This mailing will cover a variety of other topics which our Technical Task Force is now studying.

****

Disclosure Guidelines for
Partial-Endowment-Type ("Deposit-Term-Type") Insurance

(Draft of 12/3/78)

Scope

These guidelines deal with those annual premium individual insurance products which require the payment of a premium in the first contract year higher than a level series of premium in the renewal contract years. The excess of the first year premium over the renewal year premiums is sometimes described as a "deposit." "Deposit term insurance," "deposit whole life insurance" and "modified premium whole life insurance" are names which are typically given to these products, but these guidelines apply to all products of the type described irrespective of the name given to the coverage.

Description of Partial-Endowment-Type Products

Partial endowment insurance generally involves the payment of a relatively higher first year premium as compared to renewal year premiums. The excess of the first year premium over renewal year premiums is often mistakenly characterized as an initial "deposit" which is returned to the policyholder at the end of a selected period of years, usually eight or ten, increased by what is often alleged to be interest.

"Modified premium whole life" is similar at the outset, except that there is an "automatic attained age conversion" to a whole life plan at the end of the initial period. The maturity value that is normally payable at the end of a partial endowment contract may or may not be payable at the time of automatic conversion.

After the conversion, if the maturity value of the "precursory contract" is not payable at the time of automatic conversion, the nonforfeiture values of the whole life policy may or may not be augmented by the value of the maturity value. Some converted policies provide nonforfeiture values which progress so that the maturity value gradually disappears over the life of the whole life policy. Modified premium whole life policies generally offer the policyholder the option to "roll over" the maturity value and start a new modified premium whole life policy instead of continuing on the automatic track. In this case the maturity value from the precursory coverage is used as the "additional first year premium" for the new coverage. Thus, it is possible for a modified premium whole life insurance policy to be rolled over several times so that it in effect becomes a series of renewable partial endowment insurance coverages.

The nature of partial-endowment-type products is such as to enhance the possibilities of misunderstanding unless such products are carefully sold and fully explained. For this reason, these guidelines set forth minimum disclosure requirements for partial-endowment-type products.

Minimum Disclosure Requirements for Partial-Endowment-Type Products

1. All advertisements, sales materials and sales presentations of partial-endowment-type products which fail to fully and fairly inform an applicant or prospective insured as to future premium changes, benefits and related options constitute a misrepresentation as to material facts.

2. The use of any statement or illustration in any advertisement, sales material, or sales presentation which makes reference to such terms as "deposit," "accumulation," "interest at x%," and all similar terms associated with fund accumulations and investment contracts where life contingencies are involved constitutes a misrepresentation of material facts.

3. The name given to partial-endowment-type products shall not include any term that implies a "deposit" or any similar term associated with fund accumulations and investment contracts.

4. Any statement or illustration showing a comparison between the endowment value or any specific cash value and the excess of the first year's premium over the renewal premium which implies that such endowment or cash value arises solely from such excess constitutes a misrepresentation as to material facts.

5. If the policy contains a provision permitting the making of voluntary deposits which will accumulate at interest, the nature thereof shall be disclosed, and such disclosure shall distinguish such deposit provision and the insured's rights thereunder from the excess of the first year premium over the renewal premiums.

6. It is a requirement that an "explanation" sheet be given to every applicant or propsective insured with pertinent figures inserted for the specific case showing the following amounts for each of the first twenty policy years of the contract and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns:

   a. The amount of the premium payable for the year for the basic policy.

   b. The amount of the premium payable for the year for each optional rider. Any life insurance, annuity or deposit fund rider will be subject to the requirements for disclosure for life insurance, annuities, or deposit funds.

   c. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

   d. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

   e. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

   f. Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

Various options should be explained, with premium rates shown. The explanation sheet should set forth a reasonably complete picture of the plan. It would be advisable to have the applicant acknowledge receipt of the explanation sheet on a copy which would be kept by the insurer or its agent.

7. In the case of replacement situations, the required replacement disclosure statement must be filled out so that premium changes and/or options at the end of the partial endowment period are fully and fairly disclosed to the applicant. This may be done on the replacement disclosure statement itself, in the "premiums" section, for example, or may be shown on a supplemental section attached to the statement.

8. It is the responsibility of the insurance company to see that the public is given a true and complete disclosure of partial-endowment-type plans in clear and unambiguous terms. Each company should examine its own particular products to determine how it can most effectively meet its responsibility.

****

ATTACHMENT C

To: Mr. Ted Becker, Chairman
(C) Committee Technical Task Force
Texas Insurance Department

From: Larry M. Gorski, A.S.A., Life Actuary
State of Illinois Department of Insurance

Date: December 14, 1978

Re: Cragoe Letter on Classifying Annuities

I wrote to Mr. Art Cargoe of Franklin Life insurance Company with a request for his thoughts on criteria for classifying contracts as either life insurance contracts or annuity contracts. He responded to me with a copy of a letter that he had sent to Mr. John Booth of the ACLI on this subject. This letter to Mr. Booth contained three proposals on a classification rule. The third proposal was actually a variation of the second, so I will only discuss the first two proposals. The first proposal dealt with a decomposition of the net level premium for the contract into a protection premium and a savings premium with the rule being based on a relationship between a protection premium and the total net level premium. The second proposal dealt with the so-called 100 times rule. The contract was considered an insurance contract if the death benefit at all durations exceeded the monthly income purchased with the guaranteed cash value at maturity by at least 100 times. This proposal contained guidelines for the application to flexible premium plans and for contracts with unspecified maturity dates.

I think from an administrative standpoint the second proposal is more acceptable to myself. It would be rather easily applied and understood by Insurance Department Personnel. I suggest that we circulate this proposal amongst the task force members to gather their opinions on the proposal. At the same time, we might be looking at contracts which we subjectably feel are either life insurance or annuity contracts and see how they are classified by this rule.

One person we should definitely contact is Brad Gile from the Wisconsin Department since he was the first person interested in developing such a rule.

****

To: Mr. John K. Booth, Associate Actuary
American Council on Life Insurance
Washington, D.C.

From: Art Cragoe
Franklin Life Insurance Company

Date: January 4, 1978

Re: Classifying Policies as Life Insurance or Annuities

Here is another approach to the problem Mr. Richard Miller brought up on December 2. The problem has to do with when to treat a product under life insurance nonforfeiture laws and when to use the new annuity nonforfeiture laws. I have been in written conversation with an insurance department who asked for similar mathematical tests. They wanted the "protection" and "savings" elements of a product expressed as net level premiums. For an n pay, m year endowment.

$$\text{Protection} = \frac{\sum_{t=1}^{m} C_{x+t-1} (DB_t - CV_t) \text{ if positive}}{N_x - N_{x+n}}$$

$$\text{Savings} = \frac{\sum_{1}^{m} D_{x+t-1} [\sqrt{CV_t} - CV_{t-1}]}{N_x - N_{x+n}}$$

After doing this for several common plans, at various ages, the department still could not settle on a proper percentage relationship between the protection and total net level premium. I had written a program and tested many varieties of income endowments and other plans. As you know there are $10.00 income endowments at 55 and $15.00 or $20.00 income endowments at 65 that are very heavy in savings element.

As an alternative I have suggested a paraphase of the "100 times" rule which the Federal Government uses in establishing the presence of incidential life insurance features under qualified pension plans. Thus to be automatically considered a life plan, the death benefit of the plan at all durations must equal or exceed 100 times the monthly income derived from the guaranteed cash value of the plan at its maturity date, or at age 75 if earlier. The last phrase is to cover plans with no maturity date such as ordinary life.

For plans with optional maturity dates, the last such date would be used to determine the monthly income, or age 55 if earlier. This would prevent an artificial early date to be inserted merely for nonforfeiture qualification purposes yet would permit income endowment plans to be approved which are designed by several companies with optional retirement dates and larger than $10 monthly retirement income at the later dates such as age 65.

This rule would be consistent and fair for all n pay, m year plans. It works on a 10 year endowment, an 18 year endowment, a 20 year endowment, an endowment at (any age), a 20 pay endowment at (any age), in that they would be considered life insurance at all ages under the guaranteed settlement options I know about. A flexible premium plan could be considered to be a level premium to maturity plan for the purpose of determining 100 times the monthly income produced from maturity cash value. Thus the typical flexible annuity and retirement annuity would fail the test even if a one or two year higher death benefit were inserted.

Another way to consider which plans would qualify and which would not under the suggested rule would be to consider the guaranteed income factors per $1,000 proceeds. For a $1,000 endowment amount, the monthly income factor per $1,000 would have to exceed $10 to cause a problem with a 100 times rule. We use the 1937 Standard (–1, –6) at 2½% and our largest factor is $9 at ages 85 and over. Also there may be companies that have a regular income endowment at age 65 that provides $15 or $20 of monthly income and we may want such plans to be considered under the life laws. There are plans that mature for $10 per month at ages under 65. They may or may not allow later optional maturity ages. Thus the 100 times could be modified to 75 or 66 times to give a bit of margin or perhaps even 50 times. This would be a matter of how close we wish to stick to the $10 monthly income at maturity per $1,000 initial face as a dividing line between life and annuity plans. Perhaps the dividing line should be $12.50 per $1,000 or $15 per $1,000 to give a margin. This would be a matter of judgment for the Insurance Departments.

In words we could say nonforfeiture values according to the annuity nonforfeiture law shall be required for any contract or rider which calls itself an annuity. For contracts or riders which call themselves life insurance, minimum nonforfeiture values shall nonetheless be required according to the annuity nonforfeiture law if the death benefit of the contract or rider does not, at all policy durations, exceed 50 times the monthly income derived from the guaranteed cash value of the contract or rider at its maturity date, or at age 75 if earlier.

For plans with optional maturity dates, the last such date would be used to determine the monthly income, or age 55 if earlier.

Perhaps some of these thoughts may be of use to you.

****

ATTACHMENT D

To: Mr. John O. Montgomery, Chief Actuary
California Department of Insurance

From: Ronald L. Benedict, Assistant General Counsel
The Ohio National Life Insurance Company
Cincinnati, Ohio

Date: April 3, 1979

Re: Single Premium Immediate Annuities

We have recently received a number of inquiries and requests for quotes on our single premium immediate annuities for purposes other than the typical retirement annuity situation. Such requests are made by casualty insurance companies for the purpose of funding settlements on personal injury claims where the terms of the settlement call for payments to be made to the claimant for a specified number of years or for life.

Evidently, our rates for single premium immediate annuities are very competitive at younger ages, so several casualty companies have sought us out for such products. Such companies are, of course, interested in obtaining annuities for this purpose at the lowest available premium. For that reason, they have no desire to purchase any annuity which might generate cash values or nonforfeiture rights prior to commencement of annuity payments.

Examples of the kinds of benefit configurations for which we have received inquiries, or for which inquiries might be contemplated, include the following:

1. Annuity payments increase annually or at some other specified interval in order to provide for anticipated inflation.

2. Annuity payments increase at a specified future date and then later reduce, such as in a case where a child is awarded monthly income for life with balloon payments during the anticipated college years, such as from age 18 to 22.

3. Annuity payments commence at a later date, such as one year from the date of settlement of judgment, because the personal injury settlement also provides for an immediate lump sum payment to meet accumulated and current needs.

4. Annuity payments commence when the child claimant reaches the age of majority. (In such cases there is often a separate award to the child's parent or guardian to provide for the child's needs during the continuance of his or her minority.)

5. Annuity payments commence at a later date and then reduce, such as a situation where payments are to commence in August of the year a child is scheduled to enter college, then discontinue or reduce to some specified lesser amount in June of the anticipated year of graduation.

We believe that single premium immediate annuities are appropriate in each of the above situations because, at the time such contracts are purchased by the casualty company, the mode of settlement is fixed and cash values cannot be reached or withdrawn by the annuitant or beneficiary except as payments come due. The funds are thus locked in and cannot be withdrawn prematurely, as could be done if deferred annuities were to be used for such purposes. Thus, we believe it is appropriate that contracts such as those described above should be reserved for as SPIA's. We trust that you concur with this conclusion. Please let me know at your earliest convenience if such is not the case.

****

ATTACHMENT E

To: Mr. John O. Montgomery
State of California
Chief Actuary and Department Deputy Commissioner

From: Earl E. McCann, Chief Examiner
Connecticut Division of Insurance

Date: March 28, 1979

Re: Offsets Against Deficiency Reserves

The state of Connecticut adopted and voted into law the NAIC sponsored nonforfeiture and valuation law effective as of October 1, 1978.

Since the law has gone into effect, we have had two problems arise, both in relation to the valuation portion, with our domestic companies asking for a clarification. Both problems concern deficiency reserves.

The first question concerned the "most recent minimum standard." This question was answered by the latest correspondence from the most recent NAIC meeting held in December 1978. The NAIC directive in this case was the same as that taken by our state and we were gratified by your decision.

The second question concerned the use of sufficiencies to offset deficiencies. As you might imagine, our life companies' deficiency reserves are now growing to good size and are becoming increasingly unpopular.

Our stand on sufficiencies has been to let the company apply a sufficiency on one policy to offset a deficiency on that same policy, but we do not allow sufficiencies to be applied by bulk – that is, on valuation cells or blocks of business, etc.

We are wondering if your committee has discussed this problem and if you have made any ruling and, if not, do you have any feelings on this problem?

I look forward to your reply. Thank you very much for your time and effort. This problem is of considerable magnitude to us and we are most anxious to resolve it.

****

ATTACHMENT F

To: Members of the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation

(N. M. Anderson, W. M. Bolton, W. J. Davidson, Jr., K. P. Hinsdale, H. L. Jones, Jr., J. C. F. McKibbon, W. K. Nicol, G. N. See, Sibigtroth, Vice Chairman, C. D. Silletto, J. G. Stewart, and W. A. White)

From: Charles A. Ormsby, Senior Vice President
John Hancock Mutual Insurance Company
Boston, Massachusetts

Date: January 25, 1979

Re: Our Report to the Board of Governors Recommending a New Minimum Standard for the Valuation of Individual Ordinary

You will recall that two weeks ago we sent to all members of our committee for final review the fourth draft of our proposed report to the Board. You will be interested in knowing that further suggestions have been made for improving the fourth draft, resulting in a retyping of Pages 1, 2, 10, 15, 16, 20, and 41.

Our fifth draft, which is now ready, will be considered final unless we receive word before February 1 that one or more members of the committee believe further revision is necessary or justified. In the absence of such communication, I shall request that Vice President Leckie submit a copy of the report to the Board of Governors. *[The report, which will be published in full by the Society of Actuaries, is not reprinted here.]*

Obviously, when our report is prepared for publication, additional editorial changes (uniformity of typeface, spacing for readability, etc.) will be made in the Exhibits.

As Francis Bacon has said, we each owe a debt to our profession. You will no doubt agree that one of the best ways for us to honor that indebtedness is to participate in carrying out a professional assignment of this nature. I enjoyed working with you over the past two years and thank you for your splendid cooperation.

****

ATTACHMENT G

To: Members of Technical Task Force on Valuation and Nonforfeiture Value Regulation

From: Jerome S. Gordon, Chairman
Variable Products Advisory Committee
The Equitable Life Assurance Society of the United States
New York, New York

Date: March 1, 1979

Re: Variable Annuity Nonforfeiture Regulation

During the Executive Session on October 26, 1978, the task force developed several new assignments for our committee. You asked us to review the regulation, analyzing the impact of inflation on expenses and the offsetting effect of asset charges. In addition, you asked us to consider the question of providing for a specific charge for transfers in the regulation.

Because of this broad charge, our committee decided to review the regulation from first principles. Based on that review and analysis we are now proposing several changes to the regulation included in the report to the (C3) Subcommittee dated June 1978. Attached is a retyped version of the regulation containing various proposed amendments. New material is underscored and deleted material indicated by brackets. Preceding it is a summary which shows the reasoning behind each of the specific changes.

A few general principles underly the new set of recommendations.

1. Although consistency with the fixed annuity nonforfeiture law is an important objective, it is not achievable in every instance.

2. The regulation should not provide for expense charges which may increase after the issue of the contract. A portion of the asset charge should be adequate to cover the risk that the charges determined at issue become inadequate because of the impact of inflation.

3. The regulation should not have to be revised every few years and should be "dynamic" in its provision for certain expense allowances. The proposed changes in the regulation would permit – for new contract filings only – (a) contract charges to be adjusted to reflect inflation after June, 1979, and (b) premium tax charges to reflect changing tax rates.

4. The regulation should be limited to contracts which are funded solely by separate accounts. It would cover, therefore, contracts permitting transfers between one or more separate accounts or investment divisions within a separate account, but would not cover combination contracts which provide for transfers between fixed and variable (separate) accounts.

5. The regulation should make clear that demonstration of compliance involves an aggregate test based on the total charges under the contract.

6. The regulation should provide expense allowances for a limited number of transactions. Changes for relatively infrequent transactions, e.g., partial withdrawals or partial surrenders, preparation of tax reports, etc., must be covered by the overall margins.

We did not complete a detailed study of variable annuity expenses primarily because the business is still relatively immature for most companies. Operating expenses are running ahead of expectations, and because of the large overhead expenses associated with variable annuity processing and disappointing sales results, expense rates have not reached their "ultimate" levels. Income from asset charges is still not significant, particularly since it may be needed to offset higher than anticipated investment management and accounting expenses, and is further offset in most companies by federal income taxes.

As you may remember, we proposed that the nonforfeiture regulation be included as a new Article VII in the NAIC Model Variable Annuity Regulation. That regulation is limited to contracts which provide for annuity benefits which vary according to the investment experience of a separate account. Our proposed variable annuity regulation, therefore, does not address combination contracts. If the task force feels it appropriate, our committee would be willing to address the question of designing rules applicable to combination contracts.

As we agreed, I have sent this material to John Booth of ACLI. If there is any additional information you will need before the Austin meeting, please drop me a line.

****

Summary of Suggested Changes to
Variable Annuity Nonforfeiture Regulation

1. Paragraph 4 – Line 8

   Suggestion: Delete phrase "allocated to the account or accounts funding the contract."

   Reason: Deletion of this phrase is necessary to reinforce notion that minimum nonforfeiture amounts are based on allowances in regulation rather than on actual contract charges.

2. Paragraph 4 – After Item (iii)

   Suggestion: Add new item (iv) as follows: "A transaction charge of ten dollars ($10.00) for each transfer to another separate account or to another investment division within the same separate account."

   Reason: Provision for a transfer charge should permit greater equity. Companies will be able to allocate charges to specific transactions (e.g., premium collection and transfers) rather than including average costs in a single annual contract charge.

3. Paragraph 4 – New last paragraph

   Suggestion: Add following language: "The annual contract charge of thirty dollars ($30.00) and the transaction charge of ten dollars ($10.00) referred to above will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph 6."

   Reason: This new paragraph provides a cross-reference to the adjustment for inflation in Paragraph 6.

4. Paragraph 5 – Items (a) and (b)

   Suggestion: Add phrase "less any charges for premium taxes."

Reason: By providing for a specific allowance for premium taxes, the regulation should provide for greater equity. In addition, it will make the regulation "dynamic" in that changes in premium tax rates will not require changes in the regulation.

5. Paragraph 5 -- New last paragraph

Suggestion: Add the following language: "The annual contract charge of thirty dollars ($30.00), the collection charge of one dollar and twenty-five cents ($1.25) per collection, and the single consideration contract charge of seventy-five dollars ($75.00) referred to above will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph 6."

Reason: This new paragraph provides cross-reference to adjustment for inflation in Paragraph 6.

6. New Paragraph

Suggestion: Add paragraph on demonstration of compliance, see draft following item #8 of this summary.

Reason: This paragraph presents specific assumptions to be used in demonstrating compliance with regulation. It is designed to take into account various transaction charges and, thus, for example, assumes monthly premium mode for the periodic payment contract to test premium collection charges. By spelling out specific assumptions to be used, the compliance test will be uniform among the various states.

Adjustment of contract charges to reflect increases in the Consumer Price Index after June 30, 1979 will keep the regulation "dynamic," eliminating the need for frequent updating. This proposed change in the regulation does not, however, permit charges which increase after issue of the contract.

7. Renumber paragraph 6, 7, 8, 9, and 10

8. Paragraph 10

Suggestion: Replace "and the total consideration paid prior to such period amounted to less than $2,000" with "and both (i) the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and (ii) the accumulated value, amount to less than $2,000."

Reason: The proposed change recognizes that a test (to determine the right to cancel small annuities) based only on premiums ignores the fact that partial withdrawals or surrenders are in a sense negative premiums. The proposed change does limit the insurer's right to cancel even if the premium/withdrawal test is met and requires that the accumulation value must be less than $2,000.

Paragraph on Demonstration of Compliance

6. Demonstrate that a contract's nonforfeiture amounts comply with this Article shall be based on the following assumptions:

(a) Values should be tested at the ends of each of the first twenty (20) contract years;

(b) A net investment return of 7% per year should be used;

(c) If the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

(d) In determining the state premium tax applicable to the contract, the state of residence should be assumed to equal the state of delivery ;

(e) With respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

(f) With respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

(g) The following contract charges should be used:

1. For contracts filed in 1980 or earlier, the annual contract charge of thirty dollars ($30.00) referred to in paragraphs 4 and 5, the charge of ten dollars ($10.00) per transfer referred to in paragraph 4, the collection charge of one dollar and twenty-five cents ($1.25) per consideration referred to in paragraph 5, and the contract charge of seventy-five dollars ($75.00) referred to in paragraph 5(b).

2. For contracts filed in 1981 or later, the above contract charges multiplied by the ratio of (i) the Consumer Price Index for June of the calendar year preceding the date of filings, to (ii) the Consumer Price Index for June 1979.

As used herein, the Consumer Price Index means such Index for all urban consumers for all items as published by the Bureau of Labor Statistics of the United Stated Department of Labor or its successor.

If publication of the Consumer Price Index ceases, or if such Index otherwise becomes unavailable or is altered in such a way as to be unusable, the Commissioner will substitute an index he deems to be suitable.

****

ARTICLE VII: NONFORFEITURE BENEFITS

(Note: This section should be included only if the Standard Nonforfeiture Law for Individual Deferred Annuities has been adopted in the particular state.)

1. This article shall not apply to any (i) reinsurance, (ii) group annuity contract purchased in connection with one or more retirement plans or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, (iii) premium deposit fund, (iv) investment annuity, (v) immediate annuity, (vi) deferred annuity contract after annuity payments have commenced, (vii) reversionary annuity, or to any (viii) contract which is to be delivered outside this state through an agent or other representative of the company issuing the contract.

2. To the extent that any variable annuity contract provides benefits which do not vary in accordance with the investment performance of a separate account before the annuity commencement date, such contract shall contain provisions which satisfy the requirements of (the Standard Nonforfeiture Law for Deferred Annuities – insert appropriate statutory citation for this law) and shall not otherwise be subject to this article.

3. In the case of contract issued on or after (insert operative date of this article, which should be at least 18 months after adoption), no variable annuity contract, except as stated in Paragraphs 1 and 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(a) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan described in the contract that complies with Paragraph 7. Such description will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(b) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit as described in the contract that complies with Paragraph 3. The contract may provide that the company reserves the right, at its option, to defer the determination and payment of any cash surrender benefit for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

(c) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

4. The minimum values as specified in this Article of any paid-up annuity, cash surrender or death benefits available under a variable annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this paragraph.

The minimum nonforfeiture amount on any date prior to the annuity commencement date shall be an amount equal to the percentages of net considerations (as specified in Paragraph 5) [allocated to the account or accounts funding the contract] increased (or decreased) by the net investment return allocated to the percentages of net considerations, which amount shall be reduced to reflect the effect of:

(i) any partial withdrawals from or partial surrenders of the contract;

(ii) the amount of any indebtedness on the contract, including interest due and accrued;

(iii) an annual contract charge not less than zero and equal to (a) the lesser of thirty dollars ($30.00) and 2% of the end of year contract value less (b) the amount of any annual contract charge deducted from any gross considerations credited to the contract during such contract year; and

(iv) a transaction charge of ten dollars ($10.00) for each transfer to another separate account or to another investment division within the same separate account.

"Net investment return" means the rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in the contract, or in the case of a contract issued by a nonprofit corporation under which the contractholder participates fully in the investment, mortality and expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract shall be determined at least monthly.

The annual contract charge of thirty dollars ($30.00) and the transaction charge of ten dollars ($10.00) referred to above will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph 6.

5. The percentages of net considerations used to define the minimum nonforfeiture amount in Paragraph 4 shall meet the requirements of this paragraph.

(a) With respect to contracts providing for periodic considerations, the net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars ($30.00) and less a collection charge of one dollar and twenty-five cents ($1.25) per consideration credited to the contract during that contract year less any charges for premium taxes. The percentages of net considerations shall be sixty-five percent (65%) for the first contract year and eighty-seven and one-half percent (87½%) for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(b) With respect to contracts providing for a single consideration, the net consideration used to define the minimum nonforfeiture amount shall be the gross consideration less a contract charge of seventy-five dollars ($75.00) and less any charge for premium taxes. The percentage of the net consideration shall be ninety percent (90%).

The annual contract charge of thirty dollars ($30.00), the collection charge of one dollar and twenty-five cents ($1.25) per collection, and the single consideration contract charge of seventy-five dollars ($75.00) referred to above will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph 6.

6. Demonstration that a contract's nonforfeiture amounts comply with this Article shall be based on the following assumptions:

(a) Values should be tested at the ends of each of the first twenty (20) contract years;

(b) A net investment return of 7% per year should be used;

(c) If the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

(d) In determining the state premium tax applicable to the contract, the state of residence should be assumed to equal the state of delivery;

(e) With respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

(f) With respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

(g) The following contract charges should be used:

1. For contracts filed in 1980 or earlier, the annual contract charge of thirty dollars ($30.00) referred to in paragraphs 4 and 5, the charge of ten dollars ($10.00) per transfer referred to in paragraph 4, the collection charge of one dollar and twenty-five cents ($1.25) per consideration referred to in paragraph 5, and the contract charge of seventy-five dollars ($75.00) referred to in paragraph 5(b).

2. For contracts filed in 1981 or later, the above contract charges multiplied by the ratio of (i) the Consumer Price Index for June of the calendar year preceding the date of filing, to (ii) the Consumer Price Index for June, 1979.

   As used herein, the Consumer Price Index means such Index for all urban consumers for all items as published by the Bureau of Labor Statistics of the United States Department of Labor or its successor.

   If publication of the Consumer Price Index ceases, or if such Index otherwise becomes unavailable or is altered in such a way as to be unusable, the Commissioner will substitute an index he deems to be suitable.

[6.] 7. Any paid-up annuity benefit available under a variable annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

[7.] 8. For variable annuity contracts which provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount next computed after the request for surrender is received by the company. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

[8.] 9. Any variable annuity contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the annuity commencement date shall include a statement in a prominent place in the contract that such benefits are not provided.

[9.] 10. Notwithstanding the requirements of this Article, a variable annuity contract may provide under the situations specified in (a) or (b) below that the company, at its option, may cancel the annuity and pay the contractholder its accumulated value and by such payment be released of any further obligation under such contract;

(a) if at the time the annuity becomes payable the accumulated value is less than $2,000, or would provide an income the initial amount of which is less than $20 per month; or

(b) if prior to the time the annuity becomes payable under a periodic payment variable annuity contract no considerations have been received under the contract for a period of two (2) full years [and the total consideration paid prior to such period amounted to less than $2,000] and both (i) the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and (ii) the accumulated value, amount to less than $2,000.

[10.] 11. For any variable annuity contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Paragraph 4, additional benefits payable (a) in the event of total and permanent disability, (b) as reversionary annuity or deferred reversionary annuity benefits, or (c) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Article. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

****

ATTACHMENT H

To: Mr. Ted E. Becker, Life Actuary
Texas State Board of Insurance

From: John K. Booth, Chief Actuary
American Council of Life Insurance
Washington, D.C.

Date: May 11, 1979

Re: Companies Earning Lower Interest Rates Than the Rate Assumed in Their Reserves

In the minutes of the December 1978 meeting of the NAIC (C3) Committee Technical Task Force To Review Valuation and Nonforfeiture Value Regulation, there is a discussion of companies that earn lower interest rates than the rate assumed in their reserves. In that discussion, it is mentioned that I suggested that such companies should be required to strengthen reserves.

The purpose of this letter is to put this remark in the proper context and to indicate that this was only one of a number of things that might be appropriate when a company is unable to earn the interest required to maintain its reserves. The problems of companies in such situations are not necessarily improved by the mechanical application of a reserve strengthening formula, whatever that formula may be. Minimum Valuation Standards are designed to establish a conservative measure of expected life insurance company experience with respect to interest and mortality for the industry but not to take care of all the aberrations of particular companies. The fact that a company's earnings are below those that are required for its reserves may have nothing to do with the particular policy forms or insurance products that it offers but may be related to other factors which may or may not indicate a serious financial problem.

To require an individual company to automatically strengthen reserves when its earnings rate drops below the interest required to maintain reserves might arbitrarily force that company into insolvency and liquidation when there may be other more satisfactory ways to handle the situation. For example, an increase in premium scales, a reduction in policyholders' or stockholders' dividends, a slowdown in the rate of expansion, an expense reduction program, a turnover of part of the asset portfolio, or an increase of capital through the sale of stock might provide means of strengthening the company and restoring higher yields. Therefore, I hope that the Technical Task Force will avoid any arbitrary measure which may not fit the particular circumstances of those companies that fail to meet a test based on a comparison between actual interest earned and interest required to maintain reserves.

The point I was attempting to make at the December meeting is that many of these situations of low interest earnings call for the seasoned judgment of an insurance regulator unhampered by a rigid mechanical formula.

PROPERTY AND CASUALTY (D) COMMITTEE

Reference:
1978 Proc. II p. 464
1979 Proc. I p. 717

Hon. Bill Gunter, Chairman – Florida
Hon. Edward J. Birrane, Jr., Vice-Chairman – Maryland

AGENDA

1. Report of the Redlining Task Force.

2. Report of the Task Force on Property and Liability Policy Readability.

3. Receive report of Property Insurance (D1) Subcommittee.

4. Receive report of Liability Insurance Other Than Automobile (D2) Subcommittee.

5. Receive report of Automobile Insurance (D3) Subcommittee.

6. Receive report of Surety, Mortgage Guaranty and Miscellaneous (D4) Subcommittee.

7. Receive report of Reinsurance, Syndicates and Pools (D5) Subcommittee.

8. Receive report of Workers' Compensation (D6) Subcommittee.

9. Any other matters brought before the committee.

CONTENTS

The meeting of the Property and Casualty (D) Committee was called to order on June 7, 1979 in the Grand Ballroom of the Palmer House Hotel, Chicago, Illinois at 1:30 p.m. Commissioner Bill Gunter of Florida presided with all members of the committee or their representatives present.

1. Atlanta Minutes

The minutes of the (D) Committee meeting held in Atlanta, Georgia on April 30, 1979 were received by the committee (attached).

2. Redlining Task Force

Commissioner Susan Mitchell of Wisconsin presented the report of the NAIC Redlining Task Force and recommended the adoption of the report by the (D) Committee. Ms. Laura Sullivan of State Farm Insurance, Chairman of the Advisory Committee to the NAIC Redlining Task Force, then presented comments on the report. Ms. Sullivan noted the unanimous opposition of the Advisory Committee for the proposed general amendment to the NAIC Unfair Trade Practices Act. However, Ms. Sullivan stated that the Advisory Committee supported the Model Declination, Termination, and Disclosure Act being proposed.

The (D) Committee received written statements on the recommendations of the NAIC Redlining Task Force from the following:

a. Alliance of American Insurers (attached).
b. Independent Insurance Agents of America (attached).
c. U.S. Commission on Civil Rights (attached).

There was considerable discussion and debate on the recommendations of the Redlining Task Force. Several amendments to the task force report were considered by the (D) Committee, and the following amendments to the report of the Redlining Task Force were adopted:

a. The words "agent or broker" in the first and fourth lines of Section VIC(1) of the April 30, 1979 draft of the proposed Property Insurance Declination, Termination, and Disclosure Model Act were deleted.

b. A substitute specific amendment to the NAIC Model Unfair Trade Practices Act was adopted in lieu of the proposed general amendment of the Redlining Task Force (attached). Because of the inclusion of the substance of the task force's proposed model regulation within the substitute specific amendment, the need for a separate model regulation was obviated.

The chairman of the (D) Committee then instructed the Redlining Task Force to consider developing a model Automobile Declination, Termination, and Disclosure Law, with the target date for the completion of this project of December 1979.

A motion to adopt the report of the Redlining Task Force, as amended, was made, seconded and passed.

3. Readability Task Force

Commissioner William H. Woodyard of Arkansas, chairman of the Task Force on Property and Liability Policy Readability, presented an oral report to the committee on the activities of the task force. Mr. Woodyard indicated that the task force was working on a model bill and would develop a final draft for consideration by the (D) Committee at the December 1979 meeting. The report was received and unanimously adopted.

4. Property Insurance (D1) Subcommittee

Ms. Angela Ables, Deputy Insurance Commissioner of Oklahoma, presented the report of the Property Insurance (D1) Subcommittee. The report was received and adopted.

5. Liability Insurance Other Than Automobile (D2) Subcommittee

Director John Trimble of Arizona presented the report of the Liability Insurance Other Than Automobile (D2) Subcommittee. The report was received and adopted.

6. Automobile Insurance (D3) Subcommittee

Commissioner Fletcher Bell of Kansas presented the report of the Automobile Insurance (D3) Subcommittee. Director John Trimble of Arizona then moved to amend the (D3) Subcommittee report by deleting the "Resolution on Insurance Classifications" attached to the report of the Rates and Rating Procedures Task Force. In lieu thereof, Director Trimble proposed a "Substitute Resolution on Automobile Classifications" (attached). After considering and adopting several amendments to the "substitute" resolution, the "substitute" was adopted as amended. Thereafter, a motion to adopt the report of the (D3) Subcommittee, as amended, was made, seconded and passed.

7. Surety, Mortgage Guaranty and Miscellaneous (D4) Subcommittee

Commissioner Edward Birrane of Maryland presented the report of the Surety, Mortgage Guaranty and Miscellaneous (D4) Subcommittee. The report was received and adopted.

8. Reinsurance, Syndicates and Pools (D5) Subcommittee

Commissioner Wesley Kinder of California presented the report of the Reinsurance, Syndicates and Pools (D5) Subcommittee. The report was received and adopted.

9. Workers' Compensation (D6) Subcommittee

Deputy Don Gabay of New York presented the Workers' Compensation (D6) Subcommittee Report. The following amendments were then made to the report:

a. The second paragraph of the (D6) Subcommittee report was deleted and the following paragraph substituted:

> The subcommittee voted to receive the report of the Loss and Expense Measurement Task Force presented by R. Michael Lamb. A motion to adopt the "Resolu-

tion Calling for a Joint Analysis of the Workers' Compensation System" in the task force report was made but failed. A motion to adopt a "substitute resolution" was made and unanimously approved. A motion by Director Trimble to adopt the second item of the "Summary of Recommendations" of the task force report was also unanimously approved.

b. The original resolution was then deleted.

c. "Whereas" was substituted for "Be It Further Resolved That" in the ninth paragraph of the "substitute" resolution and that entire paragraph was made the "substitute" resolution's fourth paragraph.

d. "George Reall" was substituted for "David Hannum" in the third paragraph of the report.

~~In addition, the (D) Committee agreed at the request of Director Trimble to suggest to the (D6) Subcommittee that the (D6) Subcommittee seek technical assistance from the insurance industry through a formal technical advisory committee.~~ In addition, the (D) Committee voted on a motion by Director Trimble to instruct the (D6) Subcommittee to seek technical assistance from the insurance industry by appointing a formal technical advisory committee to the Loss Expense Task Force. *[Material lined through was deleted, and material underlined was added, by the Executive Committee. See p.37 .]*

A motion to adopt the report of the Workers' Compensation (D6) Subcommittee, as amended, was then made, seconded and unanimously approved.

10. Other matters

Commissioner Birrane of Maryland distributed to members of the (D) Committee copies of a "Consumer Statement" from Mr. Hans Dieter Meyer (attached).

No further business coming before the Property and Casualty (D) Committee, the committee adjourned at 6:10 p.m.

Hon. Bill Gunter, Chairman, Florida; Hon. Edward J. Birrane, Jr., Vice-Chairman, Maryland; Hon. John N. Trimble, Arizona; Hon. Wesley J. Kinder, California; Hon. Fletcher Bell, Kansas; Hon. Michael D. Markman, Minnesota; Hon. Donald W. Heath, Nevada; Hon. James J. Sheeran, New Jersey; Hon. Albert B. Lewis, New York; Hon. Gerald Grimes, Oklahoma; Hon. William P. Daves, Jr., Texas.

Property and Casualty (D) Committee
Atlanta, Georgia
April 30, 1979

Commissioner Bill Gunter opened the meeting with a brief discussion of the objectives and goals of the Property and Casualty (D) Committee, its six subcommittees and task forces.

He announced that any suggestions or ideas could easily be incorporated into the work goals already named and stressed the importance of the subcommittees and task forces being ready for the June 1979 meeting.

Mr. Dick Keintz was asked for a report by the Redlining Task Force. A brief history of the organization and work of the task force was given. Mr. Keintz discussed exhibits which had been prepared: Exhibit A which is a proposed general amendment to Section 4(7) of the Unfair Trade Practices Act and Exhibit D which contains a proposed Property Insurance Declination and Termination model act. (These are attached to the June 1979 report of the Redlining Task Force.) A meeting of that task force had already been held on March 21 in Chicago, and another earlier in the day on April 30, in Atlanta. Additional changes in the two models were being made. Suggestions were heard from the Industry Advisory Committee.

It was suggested by Commissioner Gunter that a final draft of the amended Unfair Trade Practices Act be furnished well in advance of the June 1979 meeting. Mr. Keintz asked if the task force should consider the Holtzman Amendment. He asked also if the task force should be disbanded following the June 1979 meeting. These questions were left open.

Ms. Sullivan, Chairperson for the Advisory Committee, stated that they would be reporting in June on depopulation and underwriting rules and guidelines in a homeowners program, as well as on amendments to the Unfair Trade Practices Act. She feels all these issues need to be reviewed by the (D) Committee in June 1979.

An oral progress report by the Task Force on Property and Liability Policy Readability was presented by Ms. Reva Fletcher, Assistant Commissioner of the Arkansas Department. A meeting of the task force was held April 11 in Phoenix, Arizona, and a session with its Advisory Committee was conducted during the Zone V meeting in Santa Fe. Proposals are to be presented to the task force at a meeting tentatively scheduled for May 15 in St. Louis. A preliminary report will be presented in June, but it was felt that December 1979 would be realistic timing for the final draft of a proposed statute and regulation.

Ms. J. Angela Ables, Associate Counsel with the Oklahoma Insurance Department, represented the Property Insurance (D1) Subcommittee at a meeting with the Inland Marine Definition Advisory Committee on Interpretation. She stated that a report from that Advisory Committee would be made in June.

The (D1) Subcommittee requested Mr. John Wrend, acting as secretary of the All Industry Committee on Arson, to provide information to them. Ms. Gloria Jiminez, the Federal Insurance Administrator, has also been contacted to discuss arson, the recent nuclear accident and FAIR plans.

NAIC President Hudson announced that during the Zone V meeting in Santa Fe, it was suggested that the (D1) Subcommittee address the question of excess nuclear losses, building on previous efforts in this area. Mr. Ralph Nader is accusing the NAIC of being unresponsive to this type of problem. Commissioner Hudson believes it is urgent that the (D1) Subcommittee address this issue in spite of the predicability question in nuclear losses being quite elusive.

Commissioner Gunter requested Ms. Ables to notify Commissioner Grimes, Chairman of (D1), that his subcommittee is to address this problem and it should be made a part of the agenda for the June 1979 meeting.

Mr. Dick Brock, representing Commissioner Fletcher Bell as Chairman of the (D3) Automobile Insurance Subcommittee, provided an update on its progress. The Rates and Rating Procedures Task Force is to offer final recommendations regarding the use of sex and marital status in automobile insurance classification systems for action by the NAIC in June. The Automobile Cost Containment Task Force is considering recommendations regarding duplication of benefits in auto insurance. Mandatory preinspection of motor vehicles prior to issuing or continuing auto physical damage comprehensive, fire and/or theft coverage and a post-crash reinspection program are also being reviewed. The Automobile Insurance Availability Task Force will review the results of a questionnaire which was distributed to all commissioners and decide on a possible direction to pursue. Finally, a review and consideration of the development of model no-fault guidelines and/or alternatives will be undertaken.

As Mr. Brock stated, the subcommittee was continuing its comprehensive study of auto insurance. The (D3) will meet again in Kansas City on May 22. Commissioner J. W. Newman felt that the performance standards residual market mechanism could best be handled by the NAIC, not just An all-industry committee. He asked if Commissioner Bell's subcommittee could make an in-depth study.

Commissioner Gunter suggested that the item be placed on the May 22 agenda. Commissioner Newman is to write Commissioner Bell, and Mr. Brock stated that the letter would be placed on the May 22 agenda.

Under the Surety, Mortgage Guaranty and Miscellaneous (D4) Subcommittee, Commissioner Donald Heath announced that the Service Contracts Task Force has scheduled a conference with its Advisory Committee for May 24 and 25 to discuss auto warranties and home service contracts. Unfortunately, the Title Insurance Task Force has not met since 1976.

Commissioner Gunter next read from a report furnished by Commissioner Kinder who chairs the Reinsurance, Syndicates and Pools (D5) Subcommittee. (It currently has no task forces.) The subcommittee will be reviewing the problems relating to "fronting." The biggest hurdle facing the subcommittee is to define fronting and identify those aspects which need NAIC attention.

The report from the Workers' Compensation (D6) Subcommittee by Mr. Hank Lauer of the New York department was an announcement that the Legal Marketing and Rating Task Force has not met and that a meeting of the Loss and Expense Measurement Task Force was held in Las Vegas last month, but due to weather conditions, no one from the New York Department could attend.

Commissioner Gunter presented a report of the recent Las Vegas meeting of the Loss and Expense Measurement Task Force which included discussions of the present classification system utilized by the National Council on Compensation Insurance as well as a discussion of the National Council's statistical data committee. The task force had voted to place a resolution before the (D6) Subcommittee which suggests to the National Council that they review the entire classification system now used, and place before the NAIC's task force suggestions for technical improvements.

Commissioner Hudson announced he had made a statement to Congress in behalf of the NAIC concerning federal regulation of workers' compensation.

Commissioner Gunter expressed appreciation to those providing subcommittee and task force updates, and stressed again the importance of being well prepared for the June 1979 meeting in Chicago.

Meeting adjourned.

Hon. Bill Gunter, Chairman, Florida; Hon. Edward J. Birrane, Vice-Chairman, Maryland; Hon. John N. Trimble, Arizona; Hon. Wesley J. Kinder, California; Hon. Fletcher Bell, Kansas; Hon. Michael D. Markman, Minnesota; Hon. Donald W. Heath, Nevada; Hon. James J. Sheeran, New Jersey; Hon. Albert B. Lewis, New York; Hon. Gerald Grimes, Oklahoma; Hon. William P. Daves, Jr., Texas.

Substitute Specific Amendment to Section 4(7) of the NAIC Unfair Trade Practices Act

[Editor's Note: The Executive Committee authorized the Central Office to renumber sections and otherwise see to it that these amendments conform to the existing text. Consequently, the final version of the amendments passed appears as an attachment to the Executive Committee report. See p.39 for this final form.]

The following subsections (c) and (d) are hereby added to section 4(7) of the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance:

(c) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

(d) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

Substitute Resolution on Automobile Insurance Classifications

[As amended by the Plenary Session. See p. 31 .]

WHEREAS, the Rates and Rating Procedures Task Force of the Automobile Insurance (D3) Subcommittee presented recommendations at the December 1978 NAIC national meeting calling for the elimination of automobile insurance classifications based on sex or marital status characteristics; and

WHEREAS, consideration of these recommendations was postponed until the June 1979 NAIC meeting because of the concerns of several members about the effects of such classification changes on premiums for individual policyholders; and

WHEREAS, the advisory committee to the Automobile Insurance (D3) Subcommittee was directed to undertake an immediate study of alternative recommendations and implementation procedures, including the development of substitute classification variables; and

WHEREAS, the Advisory Committee has completed its study and has recommended that no action be taken by the NAIC regarding the elimination of sex and marital status classifications; and

WHEREAS, some individual automobile insurers, including Commercial Union Assurance and Motorists Mutual, are experimenting with alternative classification systems and are to be commended for their enlightened and innovative competitive vigor; and

WHEREAS, such experimentation demonstrates that the conclusion of the Advisory Committee is not universally accepted by all automobile insurers; and

WHEREAS, the two aforementioned insurance companies, as well as the states of North Carolina, Massachusetts and Hawaii, provide a readily accessible laboratory for experimentation; and

WHEREAS, the Rates and Rating Procedures Task Force does not accept the conclusions of the Advisory Committee, and believes that the information in the advisory report suggests the feasibility of developing alternative classification variables which would continue to provide effective rating classifications; and

WHEREAS, the task force further believes that the introduction of expanded use of these alternative classification variables will substantially reduce the effects of price changes which would otherwise be associated with the elimination of present [sex and marital status] classifications; and

WHEREAS, the insurance industry has consistently maintained that such changes should occur only through the process of competition; and

WHEREAS, regulation should rely wherever possible on effective competition to encourage meaningful experimentation and refinement of classification systems in order to attain greater pricing equity for consumers and more accurate risk assessment for insurers and to bring about differences in classification systems that inure to the benefit of consumers.

[NOW, THEREFORE, BE IT RESOLVED, that the NAIC adopts the position that automobile insurance classifications based on sex or marital status may be inconsistent with sound regulatory policy, and if so, should through competitive evolution and with appropriate transitional protections to the premium paying public be eliminated from use in private passenger automobile insurance as soon as appropriate substitute alternative classifications are developed;]

NOW, THEREFORE, BE IT [FURTHER] RESOLVED, that the NAIC [also] adopts the position that all [other] rating classifications should be subject to minimum regulatory standards which 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, reasonably anticipated loss experience;

BE IT FURTHER RESOLVED, that to encourage the pursuit of a more equitable automobile insurance pricing structure and the development of alternative rating factors which will contribute to meaningful competition and to more effective classification systems, the Rates and Rating Procedures Task Force be directed to continue study of these issues, and in doing so, to provide adequate opportunity for input from the Automobile Insurance (D3) Advisory Committee and other sources;

BE IT FINALLY RESOLVED, that the NAIC calls on the industry to work with NAIC and participate in a program to monitor, evaluate and reassess traditional and experimental classification plans with particular emphasis on the impact of sex and marital status as rating criteria. Such program is to be developed and implemented as follows:

1) The Rates and Rating Procedures Task Force of the Automobile Insurance (D3) Subcommittee with the assistance of other NAIC members and the NAIC Central Office is to develop a theoretical model classification plan designed to include alternatives to sex and marital status as rating factors.

2) Following development of such model, the Rates and Rating Procedures Task Force will specify the statistical data and other informational requirements necessary to pilot test the program.

3) The Insurance Services Office and/or other statistical agencies will be called on to assit NAIC in accumulating and compiling the necessary information received from the participating insurers and will assist the NAIC in analyzing and evaluating such information.

4) The model classification plan is to be developed on or before September 1, 1979 by the Rates and Rating Procedures Task Force.

5) The statistical agencies are to be advised of the informational requirements by the Rates and Rating Procedures Task Force and such requirements are to be transmitted to the participating insurers on or before December 1, 1979.

6) An interim report on the status of the pilot test program is to be presented to the Automobile Insurance (D3) Subcommittee by the Rates and Rating Procedures Task Force at the December 1979 meeting with subsequent progress reports at each following regular and annual meeting of the NAIC until conclusion of the program.

7) The pilot test program shall be completed and a final report shall be presented to the NAIC at its June 1981 meeting.

Redlining (D) Task Force

Chicago, Illinois
June 3, 1979

A meeting was held on June 3, 1979, at the Palmer House in Chicago, Illinois at 1:10 p.m. The following states were represented: Illinois, Michigan, Nevada, North Carolina, Washington, West Virginia and Wisconsin. Dave Brummond of the NAIC staff also attended.

1. Report to (D) Committee and Earlier Reports

Commissioner Mitchell asked for comments on the oral report to (D) Committee and the attached written minutes of January 25, March 21 and April 30, 1979. Ms. Sullivan indicated a presentation concerning the amendment to the Unfair Trade Practices Act and accompanying regulation would be made on Thursday, June 7, 1979, to the (D) Committee. All reports were then received.

2. Advisory Committee Report

Laura Sullivan of the Advisory Committee submitted the attached written report summarizing the activity of the Advisory Committee since December 1978. The report included suggested underwriting guidelines and comments on FAIR Plans for those states that feel a need for such a mechanism. In conclusion Ms. Sullivan asked for further direction from the task force.

3. Model Delination and Termination Act for Automobile Insurance

The task force tabled the proposal to develop a model auto declination law and decided to await direction from the parent (D) Committee.

4. Future of the Task Force

The following resolution was unanimously adopted:

> WHEREAS, the Redlining Task Force has responded to the charges given the task force by the parent (D) Committee; be it resolved, that the task force remain intact for six months to respond to any additional charges given the task force.

The meeting was adjourned at 1:25 p.m.

Hon. Susan Mitchell, Chairman, Wisconsin; Hon. Wesley Kinder, California; Hon. Richard Mathias, Illinois; Hon. Jean Carlson, Acting, Michigan; Hon. Jerry Buxton, Missouri; Hon. Donald W. Heath, Nevada; Hon. James Sheeran, New Jersey; Hon. Albert Lewis, New York; Hon. John Ingram, North Carolina; Hon. Dick Marquardt, Washington; Hon. Richard Shaw, West Virginia.

(D) Redlining Task Force
Milwaukee, Wisconsin
January 25, 1979

The task force met at the Marc Plaza Hotel, Milwaukee, Wisconsin, January 25, 1979, at 9:40 a.m. The Honorable Harold R. Wilde, Jr., of Wisconsin, chaired the meeting, with representatives of the following states present: California, Illinois, Nevada, Washington and Wisconsin. Also present were representatives of the Advisory Committee and Dave Brummond of the NAIC staff.

1. Federal Riot Reinsurance Program

Dave Brummond reported briefly on materials received from the FIA and a study the Central Office had done concerning applications of the Federal Riot Reinsurance Program and what affect it would have on selected states. It was also indicated that a written report would be sent to all interested states as soon as the NAIC staff has it prepared.

2. Model Law for Disclosure of Reasons for Cancellation and Declination

There was a general discussion of the provisions of the draft and how it relates to the Amendment of the NAIC Model Unfair Trade Practices Act and accompanying regulation. Commissioner Wilde suggested that Dave Brummond attend the next meeting of the legal subcommittee of the Advisory Committee to reconcile the provisions of the advisory draft to the amendment and the accompanying regulation. It was agreed that this would be accomplished by February 16,

1979 with copies of the reconciliation being sent to all members of the task force on that date. *[The reconciliation follows this report.]* It was further agreed that a meeting of the task force would take place prior to February 28, 1979 to finalize the amendment and accompanying regulation which would then be submitted to the parent (D) Committee.

3. Response of the Advisory Committee to the "Twelve Challenges"

A discussion followed on how all the information gathered by the Advisory Committee could be sent to all property and casualty companies. Commissioner Wilde suggested that the insurance trade associations copy and send to all members the material contained in the written response distributed at the NAIC December meeting in Las Vegas. Ms. Sullivan agreed to meet with the appropriate offices of the major trade associations and work out a distribution program which would be discussed with the task force at the next meeting.

4. Future Challenge of the Advisory Committee

It was suggested that the Advisory Committee would be the proper forum to present responsible alternatives and suggested changes to recent federal legislation (Holtzman Amendment). The legal subcommittee indicated that there was interest in pursuing the suggestion and it would be discussed at the next meeting.

There being no additional business, the task force adjourned at 1:30 p.m.

Hon. Susan Mitchell, Chairman, Wisconsin; Hon. Wesley Kinder, California; Hon. Richard Mathias, Illinois; Hon. Jean Carlson, Acting, Michigan; Hon. Jerry Buxton, Missouri; Hon. Donald W. Heath, Nevada; Hon. James Sheeran, New Jersey; Hon. Albert Lewis, New York; Hon. John Ingram, North Carolina; Hon. Dick Marquardt, Washington, Hon. Richard Shaw, West Virginia.

To: All Members of the NAIC Redlining Task Force and its Advisory Committee

From: David J. Brummond

Re: Distribution of Model Law Drafting Alternatives

Date: February 16, 1979

You will recall that at the January 25, 1979 meeting of the NAIC Redlining Task Force, Commissioner Harold R. Wilde suggested that I attend the next meeting of the legal subcommittee of the Redlining Advisory Committee "to reconcile the provisions of the advisory draft to the amendment and the accompanying regulation." Commissioner Wilde further suggested that copies of various drafting alternatives be distributed to all members of the NAIC Redlining Task Force by February 16, 1979. Pursuant to Commissioner Wilde's suggestion, I met with the legal subcommittee on February 8-9, 1979 in Boston, Massachusetts to develop appropriate language for NAIC model laws which address the redlining problem. The results of our work are attached to this memorandum as exhibits A-D.

Although there are numerous combinations of approaches which can be taken to address insurance redlining problems, the legal subcommittee and myself concur in presenting five drafting alternatives for consideration by the NAIC Redlining Task Force. These alternatives, in no particular order of preference, are as follows:

Alternative One: A general amendment to section 4(7) of the NAIC Unfair Trade Practices Act with an accompanying model regulation specifically aimed at insurance redlining (Exhibit A).

Alternative Two: A specific amendment to section 4(7) of the NAIC Model Unfair Trade Practices prohibiting general business practices which constitute insurance redlining (Exhibit B).

Alternative Three: A specific amendment to section 4(7) of the NAIC Unfair Trade Practices Act prohibiting individual acts which constitute insurance redlining (Exhibit C).

Alternative Four: A model property insurance termination, declination and disclosure act (Exhibit D).

Alternative Five: A model law "package" consisting of a specific amendment to section 4(7) of the NAIC Unfair Trade Practices Act in conjunction with a property insurance termination, declination and disclosure model act (Exhibits B & D).

It should be noted that amendments were made to the previous drafts of each of these alternatives in such a way that each alternative now constitutes a different drafting approach than has been considered in the past by the Redlining Task Force. While none of these amendments represent a drastic deviation from previous drafts, they are nevertheless significant and should be reviewed carefully by the task force before the task force adopts one or more of the alternatives.

****

EXHIBIT A

Proposed General Amendment to Section 4(7)
of the NAIC Unfair Trade Practices Act

February 16, 1979 Draft

(c) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards in the issuance, renewal or cancellation of any insurance coverage intended primarily for personal, family or household needs rather than for business or professional needs.

****

Proposed Model Regulation to Interpret the Proposed
General Amendment to Section 4(7) of the
NAIC Unfair Trade Practices Act

February 16, 1979 Draft

SECTION 1: AUTHORITY. This regulation is promulgated pursuant to the authority granted under section 12 of the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.

SECTION 2: PURPOSE. The purpose of this regulation is to identify specific acts or practices of unfair discrimination under section 4(7)(c) of the NAIC Unfair Trade Practices Act. This regulation is not exclusive and other acts, not herein specified, may also be deemed to be violations of section 4(7)(c) of the Act.

SECTION 3: UNFAIR DISCRIMINATION. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals or risks of the same class and of essentially the same hazard:

(a) Refusing to issue, refusing to renew or cancelling insurance coverage intended primarily for personal, family or household needs rather than for business or professional needs because of the geographic location of the risk, unless:

(1) Such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) Such refusal or cancellation is required by law or regulatory mandate.

DRAFTING NOTE: This subsection of the regulation is intended to prohibit insurance underwriting shortcuts which unfairly label risks as poor risks because of their geographic location. A refusal, nonrenewal or cancellation of insurance coverage is prohibited if the reason for such refusal, nonrenewal or cancellation is the geographic location of the risk. An exception to this general rule is provided, however, in situations where the refusal, nonrenewal or cancellation is based upon a legitimate business need and the refusal, nonrenewal or cancellation is not a mere pretext for unfair discrimination. Examples of such situations include refusals to insure when the risk is located in areas prone to natural catastrophes, i.e.,

earthquakes, floods, hurricanes, and refusals to insure because the insurer already has a very high concentration of risks in a particular geographic area. It is intended that the insurer must demonstrate conclusively the legitimacy of its claimed "business purpose" exception. Proof that such refusals, nonrenewals or cancellations are not a subterfuge for unfair discrimination must likewise be conclusive.

(b) Refusing to issue, refusing to renew or cancelling insurance coverage for a residential property risk or the personal property contained therein because of the age of the residential property, unless:

(1) such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) such refusal or cancellation is required by law or regulatory mandate.

(c) Unduly limiting the amount of insurance coverage available to a residential property risk or the personal property contained therein solely because of the age of the residential property.

SECTION 4: EFFECTIVE DATE.

This regulation shall take effect on_____.

****

EXHIBIT B

Proposed Specific Amendments to Section 4(7)
of the NAIC Unfair Trade Practices Act:
General Business Practice Violations Prohibited

February 16, 1979 Draft

(c) As a general business practice, refusing to issue, refusing to renew or cancelling insurance coverage intended primarily for personal, family or household needs rather than for business or professional needs because of the geographic location of the risk, unless:

(1) such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) such refusal or cancellation is required by law or regulatory mandate.

DRAFTING NOTE: This amendment is intended to prohibit insurance underwriting shortcuts which unfairly label risks as poor risks because of their geographic location. A refusal, nonrenewal or cancellation of insurance coverage is prohibited if the reason for the refusal, nonrenewal or cancellation is the geographic location of the risk. An exception to this general rule is provided, however, in situations where such denials of insurance are based upon a legitimate business need and the denials are not a mere pretext for unfair discrimination. Examples of such situations include refusals to insure when the risk is located in areas prone to natural catastrophes, i.e., earthquakes, floods, hurricanes, and refusals to insure because the insurer already has a very high concentration of risks in a particular geographic area. It is intended that the insurer must demonstrate conclusively the legitimacy of its claimed "business purpose" exception. Proof that refusals, nonrenewals or cancellations are not a subterfuge for unfair discrimination must likewise be conclusive.

(d) As a general business practice, refusing to issue, refusing to renew or cancelling insurance coverage for a residential property risk or the personal property contained therein because of the age of the residential property, unless:

(1) such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) such refusal or cancellation is required by law or regulatory mandate.

(e) As a general business practice, unduly limiting the amount of insurance coverage available to a residential property risk or the personal property contained therein solely because of the age of the residential property.

****

EXHIBIT C

Proposed Specific Amendments to Section 4(7)
of the NAIC Unfair Trade Practices Act:
Individual Violations Prohibited

February 16, 1979 Draft

(c) Refusing to issue, refusing to renew or cancelling insurance coverage intended primarily for personal, family, or household needs rather than for business or professional needs because of the geographic location of the risk, unless:

(1) such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) such refusal or cancellation is required by law or regulatory mandate

DRAFTING NOTE: This amendment is intended to prohibit insurance underwriting shortcuts which unfairly label risks as poor risks because of their geographic location. A refusal, nonrenewal or cancellation of insurance coverage is prohibited if the reason for the refusal, nonrenewal or cancellation is the geographic location of the risk. An exception to this general rule is provided, however, in situations where such denials of insurance are based upon a legitimate business need and the denials are not a mere pretext for unfair discrimination. Examples of such situations include refusals to insure when the risk is located in areas prone to natural catastrophes, i.e., earthquakes, floods, hurricanes, and refusals to insure because the insurer already has a very high concentration of risks in a particular geographic area. It is intended that the insurer must demonstrate conclusively the legitimacy of its claimed "business purpose" exception. Proof that refusals, nonrenewals or cancellations are not a subterfuge for unfair discrimination must likewise be conclusive.

(d) Refusing to issue, refusing to renew or cancelling insurance coverage for a residential property risk or the personal property contained therein because of the age of the residential property, unless:

(1) such refusal or cancellation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) such refusal or cancellation is required by law or regulatory mandate.

(e) Unduly limiting the amount of insurance coverage available to a residential property risk or the personal property contained therein solely because of the age of the residential property.

****

EXHIBIT D

NAIC Property Insurance Termination,
Declination and Disclosure Model Act

February 16, 1979 Draft

PREAMBLE: The purpose of this Act shall be to regulate cancellations, refusals to renew and declinations of certain policies of insurance and for providing specific reasons for such action.

SECTION I: APPLICATION. This Act shall apply to policies of insurance, other than automobile, inland marine, marine and workers' compensation insurance or policies issued by any residual market insurance mechanisms, on risks located within or resident in this state which shall be issued and take effect or which shall be renewed after the effective date of this Act, and insure any of the following contingencies:

A. Loss of or damage to real property used predominantly for the residual purposes of the named insured, and which consists of not more than four dwelling units.

B. Loss of or damage to personal property in which natural persons have an insurable interest, except personal property used in a commercial, professional or industrial activity.

SECTION II: DEFINITIONS.

A. "Renewal" or "to renew" means the issuance and delivery by an insurer, at the end of a policy period, of a policy superceding a policy previously issued and delivered by the same insurer, or the issuance and delivery of the certificate or notice extending the term of the policy beyond its policy period or term; provided, however, that any policy with a policy period or term of less than six months shall, for the purpose of this Act, be considered as if written for a policy period or term of six months. Provided further that any policy written for a period or term of more than one year, or any policy with no fixed expiration date, shall be considered, for the purposes of this Act, as if written for successive policy periods or terms of one year.

B. "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on the policy of insurance or any installment of such premium, where the premium is payable directly to the insurer or its agent, or indirectly under any premium finance plan or extension of credit. It shall include nonpayment of dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing the insurance.

C. "Termination" means either a cancellation or nonrenewal of insurance coverage. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection A.

D. "Declination" is the refusal of an insurer, an agent or a broker to issue an insurance policy on a written nonbinding application for coverage.

SECTION III: PERMISSIBLE CANCELLATION. After coverage has been in effect for more than 60 days, or after the effective date of a renewal policy, a notice of cancellation shall not be issued unless it is based upon at least one of the following reasons:

A. Nonpayment of premium.

B. Conviction of the insured of any crime having as one of its necessary elements an act increasing any hazard insured against.

C. Discovery of fraud or material misrepresentation made by or with the knowledge of the insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

D. Discovery of willful or reckless acts or omissions increasing any hazard insured against.

E. Substantial change in the risk increasing any hazard insured against, after the policy was issued or renewed.

F. Violation of any local fire, health, safety, building or construction regulation or ordinance, with respect to any insured property or the occupancy thereof.

G. A determination by the Commissioner of Insurance that the continuation of the policy would place the insurer in violation of the insurance laws of this state.

H. Real property taxes have been delinquent for two or more years and continue delinquent at the time notice of cancellation is issued.

SECTION IV: NOTIFICATION OF CANCELLATION, NONRENEWAL OR DECLINATION TO THE INSURED: WHEN EFFECTIVE, DISCLOSURE.

A. Upon declining to insure any risk the insurer, agent or broker declining the risk shall provide the agent, broker or party submitting the application the reason(s) for such decision. If the applicant by written request asks for the basis for the declination, the insurer, agent or broker to whom the request is made shall provide the applicant the specific reason(s) in writing.

B. If an agent, broker or insurer not represented by an agent or broker declines to provide a written application to a prospective applicant, the decliner, if requested, shall provide the applicant with the reason(s) for such refusal. In the event a verbal application is made and an agent, broker or insurer rejects the application, the applicant may

by written request within 60 days of such rejection ask for the basis for the rejection. The insurer, agent or broker to whom the request is made shall then provide the applicant within 30 days of receiving such request the specific reason(s) in writing for such rejection.

C. A notice of cancellation of coverage that has been in effect for 60 days or less shall be in writing, shall be delivered or mailed to the named insured at the last known address of the named insured, shall state the effective date of the cancellation which shall not be less than 10 days from the date delivered or mailed if delivered or mailed anytime during the initial 60-day period, and shall provide in writing the specific reason(s) for such cancellation.

D. After coverage has been in effect for more than 60 days, a notice of cancellation based upon a reason other than nonpayment of premium shall be in writing, shall be delivered or mailed to the named insured at the last known address of the named insured, shall state the effective date of the cancellation which shall not be less than 30 days from the date delivered or mailed, other than for nonpayment of premium, and shall state the specific reason(s) for such cancellation.

E. Unless the insurer, at least 30 days in advance of the end of the policy period as described in subsection II(A), delivers or mails to the named insured at the last known address of the named insured notice of its intention not to renew the policy and the specific reason(s) therefore, the insurer shall be required to offer to renew the policy. This subsection shall not apply if the policyholder has accepted replacement coverage with another insurer or has requested or agreed to the nonrenewal.

F. Notices of cancellation based upon nonpayment of premium shall be effective as provided in the contract of insurance.

G. Proof of mailing of a notice of cancellation, nonrenewal or declination and/or the reason(s) therefore to the named insured or applicant shall be sufficient proof of the notice required by this Act.

SECTION V: TERMINATIONS/DECLINATIONS: DISCRIMINATORY PRACTICES PROHIBITED.

No insurer shall terminate or decline to issue a policy of insurance subject to this Act if its decision is:

A. Based upon the race, religion, nationality, ethnic group, age, sex, or marital status of the individual.

B. Based solely upon the lawful occupation or profession of the individual, except that this provision shall not apply to an insurer which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

C. Based upon the age or location of the residence, unless such decision is for a business purpose which is not a mere pretext for unfair discrimination.

D. Based solely upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

E. Based upon the fact that the risk was previously insured through a residual market insurance mechanism.

For purposes of this section, a transfer of policyholders among companies within the same insurance group shall be considered a termination or declination. Requiring a reasonable deductible, requiring reasonable changes in the amount of insurance or reasonable deductions in policy limits or coverage which are directly related to the hazard(s) involved, however, shall not be considered a termination or declination for purposes of this section, unless such requirement is based upon one of the reasons proscribed in subsection A.

SECTION VI: IMMUNITY. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the commissioner of insurance, any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent, broker, firm, person or corporation furnishing to the insurer information as to reasons for termination or declination, for any statement made by any of them concerning an insured or applicant for insurance, unless such statement is shown to have been made in bad faith with malice in fact, in (a) any written notice of termination or declination

or any other written or oral communication specifying the reasons for termination or declination, (b) any communication providing information pertaining to such termination or declination, or (c) for statements made or evidence submitted in any court or administrative proceeding, hearing or informal inquiry in which such termination or declination is an issue.

SECTION VII: ENFORCEMENT PROVISIONS.

A. Complaint and Hearing. Upon a complaint of a person filed within 90 days of any declination or termination alleged to be in violation of section III or section V of this Act, the commissioner shall determine whether such complaint is reasonably founded. If the commissioner determines that such complaint is reasonably founded, or if the commissioner otherwise has reason to believe that an insurer, agent or broker has engaged in practices which violate section III or section V and that a proceeding in respect thereto would be in the public interest, the Commissioner shall set a date for a public hearing to determine whether a violation of this Act has in fact occurred. Such hearing shall be held upon no less than 10 days notice to the person charged and the complainant, if any. Such notice shall set forth the specific grounds upon which the complaint is based. If a hearing is based upon a complaint, the hearing shall be set no later than 30 days from the date the complaint was filed. The hearing shall take place before a hearing examiner who shall make a record of the evidence and set forth findings and conclusions. Once a declination or termination by the person charged has been established, the person charged shall have the responsibility of establishing that such declination or termination was based on a reason not prohibited by this Act. The findings of fact determined by the hearing examiner shall be reviewed by the commissioner who shall issue a final order. A petition for rehearing may be filed within 30 days of the final order of the commissioner.

B. Sanctions. If the commissioner determines in a final order that section III or section V of this Act has been violated:

(1) In the case of a final order based upon a complaint against an insurer, the commissioner shall require the insurer to offer to accept an application, to reinstate insurance coverage or to continue insurance coverage on the same terms and conditions as are available to other risks similarly situated;

(2) In the case of a final order based upon a complaint against an insurer, agent or broker, the commissioner may require any person violating this Act to indemnify the complainant for any losses not otherwise recovered through insurance which would have been paid under the insurance coverage that was declined or terminated.

(3) The commissioner may issue a cease and desist order to restrain any person from engaging in practices which the commissioner has determined violate section III or section V of this Act;

(4) The commissioner may assess a penalty of up to $500 for each willful and knowing violation.

C. Judicial Review. Any person aggrieved by any determination or order of the commissioner under this Act may seek judicial review in the _____ court. Failure of the commissioner to act upon a complaint under this Act within 30 days of the filing of such complaint shall constitute a determination that the complaint was not reasonably founded.

SECTION VIII: EFFECTIVE DATE. This Act shall take effect on _____.

(D) Redlining Task Force
Chicago, Illinois
March 21, 1979

The task force met at the O'Hare Hilton, Chicago, Illinois, March 21, 1979, at 10:30 a.m. Deputy Commissioner Richard J. Keintz of Wisconsin, chaired the meeting, with representatives of the following states present: Illinois and West Virginia. Also present were representatives of the Advisory Committee and Dave Brummond of the NAIC staff.

1. Joint NAIC and FIA Study of Redlining

No further word has been received on the progress of the FIA in its proposal. It is hopeful that an update will be available by the June NAIC meeting.

2. Holtzman Amendment

The chairman discussed the possibility of using the task force as a forum to express concerns the state regulators and industry may have with certain provisions of the amendment. The Property Subcommittee of the Advisory Committee indicated that many of these concerns have been addressed in various reports of the Advisory Committee and expressed a desire to publish these reports.

3. Federal National Mortgage Association

Representatives of this organization gave a presentation on the issues associated with "mortgage redlining." They expressed a desire to work with the Advisory Committee and the Task Force by sharing their findings and views on inner city redlining. After the presentation there was a general discussion of the common redlining issues faced by both industries.

4. Amendment of the NAIC Model Unfair Trade Practices Set and Accompanying Regulation

The chairperson of the Advisory Committee gave a brief historical development of the activity of the committee. The chairman of the Legal Subcommittee was then called on to report on the five alternatives set forth in the February 16, 1979 report of Dave Brummond. There was a discussion of the subcommittee's reasons for unanimously recommending exhibits B & D. It was then noted by the chairman of the Advisory Committee that the Advisory Committee had acted on the subcommittee's recommendations on March 20, 1979, and unanimously recommended exhibits B & D for consideration by the task force.

There was a discussion of the provisions of exhibit A (which included a general amendment to Section 4(7) of the Model Unfair Trade Practices Act) and exhibit B (which included a specific amendment to that act). Dave Brummond discussed the history and rationale of the general approach. A motion was made by West Virginia that the task force discuss exhibits A & D. At this time Deputy Commissioner Keintz outlined communications from the states of Michigan and Washington who were not in attendance, but had submitted written statements endorsing the use of exhibits A & D as the model regulations.

The Advisory Committee indicated it preferred exhibits B & D and since not all the task force members were present, it would mail a report to the task force members expressing the desire for the task force to adopt exhibits B & D, rather than exhibits A & D. The three states present voted to recommend to the task force the adoption of exhibits A & D with some modification in the language. Dave Brummond agreed to make the modifications to exhibit A and expressed a desire to have a drafting committee meet to modify exhibit D. The meeting chairman appointed a drafting committee which will meet April 18 in Milwaukee in order to provide a final exhibit D. As soon as the drafting committee has completed its charge, both exhibits A & D will be mailed to all task force members for their consideration with the hope that final action can be taken prior to the June NAIC meeting. *[The modified drafts follow this report.]*

There being no additional business, the task force adjourned at 3:30 p.m.

Hon. Susan Mitchell, Chairman, Wisconsin; Hon. Wesley Kinder, California; Hon. Richard Mathias, Illinois; Hon. Jean Carlson, Acting, Michigan; Hon. Jerry Buxton, Missouri; Hon. Donald W. Heath, Nevada; Hon. James Sheeran, New Jersey; Hon. Albert Lewis, New York; Hon. John Ingram, North Carolina; Hon. Dick Marquardt, Washington, Hon. Richard Shaw, West Virginia.

To: All Members of the NAIC Redlining Task Force and its Advisory Committee

From: David J. Brummond

Re: Distribution of Revised Model Law Alternatives

Date: April 20, 1979

At the March 21, 1979 meeting of the NAIC Redlining Task Force in Chicago, Illinois the three states represented at the meeting voted to recommend to the task force the adoption of exhibits A and D of my memorandum of February 16,

1979. Exhibit A of that memorandum contains a proposed general amendment to section 4(7) of the NAIC Unfair Trade Practices Act and an accompanying redlining regulation, while exhibit D contains a property insurance declination and termination model law.

In recommending the adoption of exhibit A the three states present at the Chicago meeting of the task force made a number of modifications in the language of exhibit A. These modifications included:

(1) The personal lines limitation in the proposed general amendment to the NAIC Unfair Trade Practices Act was eliminated.

(2) The scope of the proposed general amendment was limited to property and casualty insurance.

(3) An additional prohibition was added to the proposed general amendment to deal with limitations of insurance coverage which constitute unfair discrimination.

(4) A drafting note was added to the proposed general amendment which makes clear the notion that the amendment is intended to address all forms of unfair discrimination in property/casualty insurance underwriting, not just those types of unfair discrimination which have been labeled insurance "redlining."

(5) The limitation of the proposed model regulation to personal lines coverages was eliminated.

(6) Limiting amounts of insurance coverage because of the geographic location of the risk was added as an additional prohibition under the model regulation.

(7) References to "conclusive" proof of the "business purpose" exception were omitted from the drafting note to the model regulation.

The foregoing changes to the proposed amendment to the NAIC Unfair Trade Practices Act and its accompanying model regulation are contained in the April 18, 1979 redraft of exhibit A attached to this memorandum.

In addition to making modifications to exhibit A, the three states attending the March 21 meeting authorized the chairman of the task force to appoint a drafting committee to make modifications in the proposed model property insurance declination law in exhibit D. This drafting committee met at the NAIC Central Office on April 18, 1979 and drafted modifications to the model declination/termination law as directed by the task force chairman. A copy of the redraft of this model law is attached to this letter as exhibit D of April 18, 1979. Because the modifications to the model declination/termination law were numerous, they will not be summarized here. Members of the NAIC Redlining Task Force and its Advisory Committee should review the enclosed April 18 draft closely so that appropriate action can be taken at the April 30, 1979 meeting of the task force in Atlanta, Georgia.

****

EXHIBIT A

Proposed General Amendment to Section 4(7)
of the NAIC Unfair Trade Practices Act

April 18, 1979 Draft

(c) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards in the issuance, renewal, cancellation or limitation of any property or casualty insurance coverage.

DRAFTING NOTE: Although this amendment to the NAIC Unfair Trade Practices Act was prepared in the context of the insurance "redlining" debate, the amendment is intended to provide the necessary statutory authority for the commissioner of insurance to address all forms of unfair discrimination in property/casualty insurance underwriting.

****

Proposed Model Regulation to Interpret the Proposed
General Amendment to Section 4(7) of the
NAIC Unfair Trade Practices Act

April 18, 1979 Draft

SECTION 1: AUTHORITY. This regulation is promulgated pursuant to the authority granted under section 12 of the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.

SECTION 2: PURPOSE. The purpose of this regulation is to identify specific acts or practices of unfair discrimination under section 4(7)(c) of the NAIC Unfair Trade Practices Act which are commonly known as insurance "redlining" practices. This regulation is not exclusive and other acts, not herein specified, may also be deemed to be violations of section 4(7)(c) of the Act.

SECTION 3: UNFAIR DISCRIMINATION. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals or risks of the same class and of essentially the same hazard:

(a) Refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

DRAFTING NOTE: This subsection of the regulation is intended to prohibit insurance underwriting shortcuts which unfairly label risks as poor risks because of their geographic location. A refusal, nonrenewal, cancellation or limitation of insurance coverage is prohibited if the reason for such refusal, nonrenewal, cancellation or limitation is the geographic location of the risk. An exception to this general rule is provided, however, in situations where the refusal, nonrenewal, cancellation or limitation is based upon a legitimate business need and the refusal, nonrenewal, cancellation or limitation is not a mere pretext for unfair discrimination. Examples of such situations include refusals to insure when the risk is located in areas prone to natural catastrophes, i.e., earthquakes, floods, hurricanes, and refusals to insure because the insurer already has a very high concentration of risks in a particular geographic area. It is intended that the person charged with a violation of this regulation be given the burden of proof in establishing any "business purpose" exception. The burden of proving that a refusal, nonrenewal, cancellation or limitation of insurance coverage is not a subterfuge for unfair discrimination should likewise fall upon the person charged with a violation of this regulation.

(b) Refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

SECTION 4. EFFECTIVE DATE

This regulation shall take effect on _____.

****

EXHIBIT D

NAIC Property Insurance Declination,
Termination and Disclosure Model Act

April 18, 1979 Draft

PREAMBLE: The purpose of this Act shall be to regulate declinations, cancellations and refusals to renew certain policies of property insurance and for providing specific reasons for such action.

SECTION 1: SCOPE. This Act shall apply to policies of property insurance, other than policies of inland marine insurance and policies of property insurance issued through a residual market mechanism, covering risks to property located in this state which take effect or are renewed after the effective date of this Act and which insure any of the following contingencies:

A. Loss of or damage to real property which is used predominantly for the residential purposes of the named insured and which consists of not more than four dwelling units, or

B. Loss of or damage to personal property in which the named insured has an insurable interest where:

1. the personal property is used for personal, family or household purposes, and

2. the personal property is within a residential dwelling.

DRAFTING NOTE: Property insurance policies issued through a state FAIR Plan or other residual market mechanism are excluded from this Act because of the special underwriting considerations and regulatory treatment afforded such policies under state law. While the application of many of the substantive principles of this Act to such policies would be desireable and should be encouraged, the mechanism for implementing these principles should be the plan of operation of the state FAIR Plan or residual market mechanism, not a state law governing property insurance declinations and terminations in the voluntary market.

SECTION II: DEFINITIONS.

A. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superceding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. For the purposes of this Act, any policy period or term of less than six months shall be considered a policy period or term of six months and any policy period or term of more than one year or any policy with no fixed expiration date shall be considered a policy period or term of one year.

B. "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of property insurance subject to this Act, whether such payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" shall include the failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

C. "Termination" means either a cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection A. For purposes of this Act, the transfer of a policyholder between companies within the same insurance group shall be considered a termination, but requiring a reasonable deductible, reasonable changes in the amount of insurance or reasonable reductions in policy limits or coverage shall not be considered a termination if such requirements are directly related to the hazard involved and are made on the renewal date of the policy.

D. "Declination" is the refusal of an insurer, an agent or a broker to issue a property insurance policy on a written nonbinding application or written request for coverage. For the purposes of this Act, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage or the offering of insurance upon different terms than requested in the nonbinding application or written request for coverage shall be considered a declination.

SECTION III. NOTIFICATION AND REASONS FOR A DECLINATION OR TERMINATION.

A. Upon declining to insure any real or personal property subject to this Act the insurer, agent or broker making such declination shall either provide the insurance applicant with a written explanation of the specific reason(s) for the declination at the time of the declination or advise the applicant that a written explanation of the specific reasons for the declination will be provided within twenty-one (21) days of the timely receipt of the applicant's written request for such an explanation. An applicant's written request shall be timely under this subsection if received within 90 days of the date of the declination. No agent, broker or insurer not represented by an agent or broker shall decline to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker or insurer.

B. A notice of cancellation of property insurance coverage by an insurer shall be in writing, shall be delivered to the named insured or mailed to the named insured at the last known address of the named insured, shall state the effective data of the cancellation and shall be accompanied by a written explanation of the specific reason(s) for the cancellation.

DRAFTING NOTE: No time period for the effective date of a cancellation is included in this subsection because states may already have time periods specified in their insurance codes. In addition, a legislatively-mandated time period for the effective date of a cancellation would encourage fraud if too long or place undue burdens on policyholders if too short. Finding an appropriate balance between these competing considerations is extremely complex. For those states which may desire a specified time period, however, such states may wish to consider that the cancellation of a property insurance policy which occurs within 60 days of the date of issuance be effective 14 days from the receipt of notice of cancellation, while the cancellation of a property insurance policy which occurs more than 60 days after the date of issuance be effective 30 days from the receipt of notice of cancellation.

C. At least 30 days before the end of a policy period as described in subsection II(A) of this Act, an insurer shall deliver or mail to the named insured at the last known address of the named insured notice of its intention regarding the renewal of the property insurance policy. Notice of an intention not to renew a property insurance policy shall be accompanied by an explanation of the specific reasons for the nonrenewal.

SECTION IV: PERMISSIBLE CANCELLATIONS. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy a notice of cancellation shall not be issued unless it is based upon at least one of the following reasons:

A. Nonpayment of premium.

B. Conviction of the insured of any crime having as one of its necessary elements an act increasing any hazard insured against.

C. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

D. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against.

E. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed.

F. A violation of any local fire, health, safety, building or construction regulation or ordinance with respect to any insured property or the occupancy thereof which increases any hazard insured against.

G. A determination by the commissioner of insurance that the continuation of the policy would place the insurer in violation of the insurance laws of this state.

H. Real property taxes owing on the insured property have been delinquent for two or more years and continue delinquent at the time notice of cancellation is issued.

SECTION V: TERMINATIONS/DECLINATIONS: DISCRIMINATORY PRACTICES PROHIBITED. No insurer or agent shall decline to issue or terminate a policy of insurance subject to this Act if the declination or termination is:

A. Based upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

B. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to an insurer which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

C. Based upon the age or location of the residence of the applicant or named insured unless such decision is for a business purpose which is not a mere pretext for unfair discrimination.

D. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

E. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

SECTION VI: ENFORCEMENT PROVISIONS.

A. COMPLAINT AND HEARING. Upon a complaint of a person filed within 90 days of any violation of this Act, the commissioner shall determine whether such complaint is reasonably founded. If the commissioner determines that such complaint is reasonably founded, or if the commissioner otherwise has reason to believe that an insurer, agent or broker has engaged in practices which violate this Act and that a proceeding in respect thereto would be in the public interest, the commissioner shall set a date for a public hearing to determine whether a violation of this Act has in fact occurred. Such hearing shall be held upon no less than 10 days notice to the person charged and the complainant, if any. Such notice shall set forth the specific grounds upon which the complaint is based. If a hearing is based upon a complaint, the hearing shall be set no later than 30 days from the date the complaint was filed. The hearing shall take place before a hearing examiner who shall make a record of the evidence and set forth findings and conclusions. Once a prima facie violation of this Act has been established, the person charged in the complaint shall have the burden of showing that such violation was based on a reason not prohibited by this Act. The findings of fact determined by the hearing examiner shall be reviewed by the commissioner who shall issue a final order. A petition for rehearing may be filed within 30 days of the final order of the commissioner.

B. SANCTIONS. If the commissioner determines in a final order that:

1. An insurer has violated sections IV or V of this Act, the commissioner may require the insurer to:

   a. Accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated, or

   b. Reinstate insurance coverage to the end of the policy period, or

   c. Continue insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated;

2. Any person has violated any provision of this Act, the commissioner may:

   a. Issue a cease and desist order to restrain such person from engaging in practices which violate this Act, or

   b. Assess a penalty against such person of up to $500 for each violation of this Act, or

   c. Assess a penalty against such person of up to $5,000 for each willful and knowing violation of this Act.

C. CIVIL LIABILITY AND ACTIONS.

1. If the commissioner determines in a final order that an insurer, agent or broker has violated sections IV or V of this Act, the applicant or named insured aggrieved by the violation may bring an action in a court of competent jurisdiction in this State to recover from such insurer, agent or broker any loss, not otherwise recovered through insurance, which would have been paid under the insurance coverage that was declined or terminated in violation of this Act.

2. Any amount recovered under subsection (1) above shall not be duplicative of any recovery obtained through the exercise of any other statutory or common law cause of action arising out of the same occurrence. No action under this section shall be brought two years after the date of a final order of the commissioner finding a violation of section IV or V of this Act.

D. JUDICIAL REVIEW. Any person aggrieved by any determination or order of the commissioner under this Act may seek judicial review in the ------ court. Failure of the commissioner to act upon a complaint under this Act within 30 days of the filing of such complaint shall constitute a determination that the complaint was not reasonably founded.

SECTION VII: IMMUNITY.

A. There shall be no liability on the part of and no cause of action shall arise against:

1. The commissioner of insurance,

2. Any insurer or its authorized representatives, agents, or employees,

3. Any licensed insurance agent or broker, or

4. Any person furnishing information to an insurer as to reasons for a termination or declination,

for any communication giving notice of or specifying the reasons for a declination or termination or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a declination or termination under this Act.

B. Subsection (A) above shall not apply to statements made in bad faith with malice in fact.

SECTION VIII: EFFECTIVE DATE. This Act shall take effect on _____.

(D) Redlining Task Force
Atlanta, Georgia
April 30, 1979

The NAIC Redlining Task Force met at the NAIC Zone III meeting at the Atlanta Sheraton Hotel at 10:45 a.m. on April 30, 1979. The meeting was chaired by Deputy Commissioner Richard J. Keintz of Wisconsin with representatives of the following states in attendance: California, Illinois, Michigan, Missouri, Nevada, North Carolina, and West Virginia. David Brummond of the NAIC Central Office also attended the meeting.

The task force began its meeting with a discussion of the April 18, 1979 drafts of a general amendment to Section 4(7) of the NAIC Unfair Trade Practices Act, a model regulation to implement the general amendment with regard to insurance "redlining" practices and a property insurance declination, termination and disclosure model act. Since the December, 1978 meeting of the NAIC in Las Vegas the task force had met three times to review drafting improvements to these three models. The chairman of the task force briefly explained the rationale of the drafting improvements and noted that a concerted effort was made to accommodate the concerns of those task force and Advisory Committee members who had offered comments on the earlier drafts of the three models.

Following the discussion of the drafting improvements to the two model laws and the model regulation, the task force heard a presentation by the chairperson of the Advisory Committee, Ms. Laura Sullivan. Ms. Sullivan noted the opposition of the Advisory Committee to the proposed general amendment to the NAIC Unfair Trade Practices Act but explained that the Advisory Committee would support an amendment to the Unfair Trade Practices Act if the amendment was tailored to insurance "redlining" practices. Several other comments were then made by persons attending the task force meeting on the two proposed model laws and the proposed model regulation.

The task force then considered an amendment to the title of the proposed model regulation which would incorporate the word "redlining" into the title. In addition, several amendments to the proposed model property insurance declination act were received and reviewed. After considerable discussion the task force reached agreement on the amendment to the title of the model regulation and the various amendments to the proposed property insurance declination act. These amendments were then incorporated into the text of the model regulation and the model declination act.

A motion was made to adopt the general amendment to the NAIC Unfair Trade Practices Act, the accompanying model regulation dealing with insurance "redlining" practices and the Model Property Insurance Declination, Termination and Disclosure Act, as amended (attached). The motion passed by a vote of 6-0, with California abstaining.

There being no further business to come before the task force, the task force adjourned at 1:00 p.m.

Hon. Susan Mitchell, Chairman, Wisconsin; Hon. Wesley Kinder, California; Hon. Richard Mathias, Illinois; Hon. Jean Carlson, Acting, Michigan; Hon. Jerry Buxton, Missouri; Hon. Donald W. Heath, Nevada; Hon. James Sheeran, New Jersey; Hon. Albert Lewis, New York; Hon. John Ingram, North Carolina; Hon. Dick Marquardt, Washington, Hon. Richard Shaw, West Virginia.

General Amendment to Section 4(7)
of the NAIC Unfair Trade Practices Act

April 30, 1979

The following subsection (c) is hereby added to section 4(7) of the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance:

(c) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards in the issuance, renewal, cancellation or limitation of any property or casualty insurance coverage.

DRAFTING NOTE: Although this amendment to the NAIC Unfair Trade Practices Act was prepared in the context of the insurance "redlining" debate, the amendment is intended to provide the necessary statutory authority for the commissioner of insurance to address all forms of unfair discrimination in property/casualty insurance underwriting.

****

Model Regulation to Implement Section 4(7)(c) of the
NAIC Unfair Trade Practices Act
With Regard to Insurance "Redlining" Practices

April 30, 1979

SECTION 1: AUTHORITY. This regulation is promulgated pursuant to the authority granted under section 12 of the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.

SECTION 2: PURPOSE. The purpose of this regulation is to identify specific acts or practices of unfair discrimination under section 4(7)(c) of the NAIC Unfair Trade Practices Act which are commonly known as insurance "redlining" practices. This regulation is not exclusive and other acts, not herein specified, may also be deemed to be violations of section 4(7)(c) of the Act.

SECTION 3: UNFAIR DISCRIMINATION. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals or risks of the same class and of essentially the same hazard:

(a) Refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

DRAFTING NOTE: This subsection of the regulation is intended to prohibit insurance underwriting shortcuts which unfairly label risks as poor risks because of their geographic location. A refusal, nonrenewal, cancellation or limitation of insurance coverage is prohibited if the reason for such refusal, nonrenewal, cancellation or limitation is the geographic location of the risk. An exception to this general rule is provided, however, in situations where the refusal, nonrenewal, cancellation or limitation is based upon a legitimate business need and the refusal, nonrenewal, cancellation or limitation is not a mere pretext for unfair discrimination. Examples of such situations include refusals to insure when the risk is located in areas prone to natural catastrophes, i.e., earthquakes, floods, hurricanes, and refusals to insure because the insurer already has a very high concentration of risks in a particular geographic area. It is intended that the person charged with a violation of this regulation be given the burden of proof in establishing any "business purpose" exception. The burden of proving that a refusal, nonrenewal, cancellation or limitation of insurance coverage is not a subterfuge for unfair discrimination should likewise fall upon the person charged with a violation of this regulation.

(b) Refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(1) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(2) The refusal, cancellation or limitation is required by law or regulatory mandate.

SECTION 4. EFFECTIVE DATE

This regulation shall take effect on _____ .

****

NAIC Property Insurance Declination,
Termination and Disclosure Model Act

April 30, 1979

PREAMBLE: The purpose of this Act shall be to regulate declinations, cancellations and refusals to renew certain policies of property insurance and for providing specific reasons for such action.

SECTION 1: SCOPE. This Act shall apply to policies of property insurance, other than policies of inland marine insurance and policies of property insurance issued through a residual market mechanism, covering risks to property located in this state which take effect or are renewed after the effective date of this Act and which insure any of the following contingencies:

A. Loss of or damage to real property which consists of not more than four residential units, one of which is the principal place of residence of the named insured, or

B. Loss of or damage to personal property in which the named insured has an insurable interest where:

1. the personal property is used for personal, family or household purposes, and

2. the personal property is within a residential dwelling.

DRAFTING NOTE: Property insurance policies issued through a state FAIR Plan or other residual market mechanism are excluded from this Act because of the special underwriting considerations and regulatory treatment afforded such policies under state law. While the application of many of the substantive principles of this Act to such policies would be desireable and should be encouraged, the mechanism for implementing these principles should be the plan of operation of the state FAIR Plan or residual market mechanism, not a state law governing property insurance declinations and terminations in the voluntary market.

SECTION II: DEFINITIONS.

A. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superceding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. For the purposes of this Act, any policy period or term of less than six months shall be considered a policy period or term of six months and any policy period or term of more than one year or any policy with no fixed expiration date shall be considered a policy period or term of one year.

B. "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of property insurance subject to this Act, whether such payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" shall include the failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

C. "Termination" means either a cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection A. For purposes of this Act, the transfer of a policyholder between companies within the same insurance group shall be considered a termination, but requiring a reasonable deductible, reasonable changes in the amount of insurance or reasonable reductions in policy limits or coverage shall not be considered a termination if such requirements are directly related to the hazard involved and are made on the renewal date of the policy.

D. "Declination" is the refusal of an insurer, an agent or a broker to issue a property insurance policy on a written nonbinding application or written request for coverage. For the purposes of this Act, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage or the offering of insurance upon different terms than requested in the nonbinding application or written request for coverage shall be considered a declination.

SECTION III: NOTIFICATION AND REASONS FOR A DECLINATION OR TERMINATION.

A. Upon declining to insure any real or personal property subject to this Act the insurer, agent or broker making such declination shall either provide the insurance applicant with a written explanation of the specific reason(s) for the declination at the time of the declination or advise the applicant that a written explanation of the specific reasons for the declination will be provided within twenty-one (21) days of the timely receipt of the applicant's written request for such an explanation. An applicant's written request shall be timely under this subsection if received within 90 days of the date of notice of the declination. In the event of a declination by an insurer of a risk submitted by an agent or broker on behalf of the applicant, the insurer shall provide the agent or broker with a written explanation of the reasons for the declination. In the event the agent or broker is unable to effect insurance for the applicant through an admitted insurer other than a residual market mechanism, the agent or broker shall submit an explanation in writing to the applicant of all insurer declinations. No agent, broker or insurer not represented by an agent or broker shall decline to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker or insurer.

[Amendments as made by the Executive Committee, see pp.34-5. The third sentence in the above section is shown as it was further amended by the Plenary Session. See p. 31 .]

B. A notice of cancellation of property insurance coverage by an insurer shall be in writing, shall be delivered to the named insured or mailed to the named insured at the last known address of the named insured, shall state the effective data of the cancellation and shall be accompanied by a written explanation of the specific reason(s) for the cancellation.

DRAFTING NOTE: No time period for the effective date of a cancellation is included in this subsection because states may already have time periods specified in their insurance codes. In addition, a legislatively-mandated time period for the effective date of a cancellation would encourage fraud if too long or place undue burdens on policyholders if too short. Finding an appropriate balance between these competing considerations is extremely complex. For those states which may desire a specified time period, however, such states may wish to consider that the cancellation of a property insurance policy which occurs within 60 days of the date of issuance be effective 14 days from the receipt of notice of cancellation, while the cancellation of a property insurance policy which occurs more than 60 days after the date of issuance be effective 30 days from the receipt of notice of cancellation.

C. At least 30 days before the end of a policy period, as described in subsection II(A) of this Act, an insurer shall deliver or mail or the named insured, at the last known address of the named insured, either of the following:

1. Written notice of the insurer's offer to renew the policy if the applicable premium for the policy is received within a specified billing period, or

2. Written notice of the insurer's intention not to renew the policy upon expiration of the current policy period. The notice of intention not to renew shall include or be accompanied by a written explanation of the insurer's specific reason on reasons for the nonrenewal.

Proof of mailing of either notice shall be retained by the insurer for a period of not less than one year. If the insurer fails to comply with either (1) or (2) above, coverage shall be deemed renewed under the same terms and conditions until the named insured has accepted replacement coverage with another insurer or until the named insured has agreed to the nonrenewal.

SECTION IV: PERMISSIBLE CANCELLATIONS. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy a notice of cancellation shall not be issued unless it is based upon at least one of the following reasons:

A. Nonpayment of premium.

B. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

C. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against.

D. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed.

E. A violation of any local fire, health, safety, building or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against.

F. A determination by the Commissioner of Insurance that the continuation of the policy would place the insurer in violation of the insurance laws of this state.

G. Real property taxes owing on the insured property have been delinquent for two or more years and continue delinquent at the time notice of cancellation is issued.

SECTION V: TERMINATIONS/DECLINATIONS: DISCRIMINATORY PRACTICES PROHIBITED. The declination or termination of a policy of property insurance subject to this Act by an insurer, agent or broker is prohibited if the declination or termination is:

A. Based upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

B. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to an insurer, agent or broker which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

C. Based upon the age or location of the residence of the applicant or named insured unless such decision is for a business purpose which is not a mere pretext for unfair discrimination.

D. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

E. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

SECTION VI: ENFORCEMENT PROVISIONS.

A. COMPLAINT AND HEARING. Upon a complaint of a person filed within 90 days of any violation of this Act, the Commissioner shall determine whether such complaint is reasonably founded. If the Commissioner determines that such complaint is reasonably founded, or if the Commissioner otherwise has reason to believe that an insurer, agent or broker has engaged in practices which violate this Act and that a proceeding in respect thereto would be in the public interest, the Commissioner shall set a date for a public hearing to determine whether a violation of this Act has in fact occurred. Such hearing shall be held upon no less than 10 days notice to the person charged and the complainant, if any. Such notice shall set forth the specific grounds upon which the complaint is based. If a hearing is based upon a complaint, the hearing shall be set no later than 30 days from the date the complaint was filed. The hearing shall take place before a hearing examiner who shall make a record of the evidence and set forth findings and conclusions. Once a prima facie violation of this Act has been established, the person charged in the complaint shall have the burden of showing that such violation was based on a reason not prohibited by this Act. The findings of fact determined by the hearing examiner shall be reviewed by the Commissioner who shall issue a final order. A petition for rehearing may be filed within 30 days of the final order of the Commissioner.

B. SANCTIONS. If the Commissioner determines in a final order that:

1. An insurer has violated sections IV or V of this Act, the Commissioner may require the insurer to:

   a. Accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated, or

   b. Reinstate insurance coverage to the end of the policy period, or

   c. Continue insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated;

2. Any person has violated any provision of this Act, the Commissioner may:

   a. Issue a cease and desist order to restrain such person from engaging in practices which violate this Act, or

   b. Assess a penalty against such person of up to $500 for each violation of this Act, or

   c. Assess a penalty against such person of up to $5,000 for each willful and knowing violation of this Act.

C. CIVIL LIABILITY AND ACTIONS.

1. If the Commissioner determines in a final order than an insurer, ~~agent or broker~~ has violated sections IV or V of this Act, the applicant or named insured aggrieved by the violation may bring an action in a court of competent jurisdiction in this State to recover from such insurer, ~~agent or broker~~ any loss, not otherwise

recovered through insurance, which would have been paid under the insurance coverage that was declined or terminated in violation of this Act.

[Amended by the (D) Committee. See p. 525]

2. Any amount recovered under subsection (1) above shall not be duplicative of any recovery obtained through the exercise of any other statutory or common law cause of action arising out of the same occurrence. No action under this section shall be brought two years after the date of a final order of the Commissioner finding a violation of section IV or V of this Act.

D. JUDICIAL REVIEW. Any person aggrieved by any determination or order of the Commissioner under this Act may seek judicial review in the ------ court. Failure of the Commissioner to act upon a complaint under this Act within 30 days of the filing of such complaint shall constitute a determination that the complaint was not reasonably founded.

SECTION VII: IMMUNITY.

A. There shall be no liability on the part of and no cause of action shall arise against:

1. The Commissioner of Insurance,

2. Any insurer or its authorized representatives, agents, or employees,

3. Any licensed insurance agent or broker, or

4. Any person furnishing information to an insurer as to reasons for a termination or declination,

for any communication giving notice of or specifying the reasons for a declination or termination or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a declination or termination under this Act.

B. Subsection (A) above shall not apply to statements made in bad faith with malice in fact.

SECTION VIII: EFFECTIVE DATE. This Act shall take effect on ------.

To: Jon S. Hanson

From: David J. Brummond

Re: Proposals to Amend Section 4(7) of the NAIC Unfair Trade Practices Act

Date: May 24, 1979

At the April 30, 1979 meeting of the NAIC Property and Casualty (D) Committee in Atlanta, Georgia a question was raised about the status of an amendment to the NAIC Unfair Trade Practices Act which was adopted at the December, 1978 meeting of the NAIC. You will recall that there was much discussion at the Las Vegas meeting about age, sex and marital status classification criteria in automobile insurance rates. Although a proposal was adopted by the Rates and Rating Procedures Task Force of the NAIC Automobile Insurance (D3) Subcommittee to eliminate sex and marital status as rate classification criteria, this proposal was not adopted by the NAIC Executive Committee.

Rather than adopting the recommendation of the Rates and Rating Procedures Task Force, the NAIC Executive Committee modified the report of the task force so that some of the recommendations of the task force were adopted while consideration of other recommendations was postponed until June, 1979. One of the recommendations of the task force which was affirmed by the Executive Committee was the recommendation to amend the NAIC Unfair Trade Practices Act to prohibit underwriting in property or casualty insurance based upon the sex or marital status of an individual. It is the Executive Committee's treatment of this recommendation which has caused considerable uncertainty regarding the current status of the NAIC Unfair Trade Practices Act.

The purpose of this memorandum will be to describe the current status of the Rates and Rating Procedures Task Force recommendation to amend the NAIC Unfair Trade Practices Act, to identify some shortcomings of the sex and marital status proposal, to summarize other Unfair Trade Practice Act amendments which are likely to come before the NAIC at its Chicago meeting in June 1979, and to briefly review the two basic drafting alternatives available to the NAIC regarding amendments to the Unfair Trade Practices Act.

I. Status of Rates and Rating Procedures Task Force Proposal

In its amended report of November 22, 1978 the Rates and Rating Procedures Task Force of the NAIC Automobile Insurance (D3) Subcommittee made seven recommendations in section I of its report regarding automobile insurance rating and underwriting practices. Recommendation number four of the task force involved the adoption of an amendment to the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Despective Acts and Practices in the Business of Insurance which would take effect on June 30, 1979. The Task Force amendment to the NAIC model act added a new subsection "(D)" to section 4(7) of the act which would include as an unfair trade practice the "refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of its sex or marital status of the individual." In addition to this recommendation in section I of the task force report, the task force adopted a "Resolution on Automobile Insurance Rating Procedures" in exhibit four of its report which summarized the task force position on automobile insurance classification and rating procedures. The fifth resolved clause of this resolution stated that "the NAIC should adopt amendments to the model unfair trade practices bill to prohibit discriminatory underwriting based on the sex or marital status of an individual". Thus, there are two references to the NAIC Unfair Trade Practices Act in the November 22 task force report; at one point the task force specifically adopted an amendment to the model act while at another point the task force resolved that the NAIC should adopt an amendment to the act which prohibits discriminatory underwriting based on sex or marital status.

The entire report of the Rates and Rating Procedures Task Force was adopted by both the Automobile Insurance (D3) Subcommittee and the Property and Casualty (D) Committee during the Las Vegas meeting. When the report of the Rates and Rating Procedures Task Force was presented to the NAIC Executive (EX) Committee, however, the report was substantially revised. The Executive Committee adopted only four of the seven task force recommendations in section I of the Task Force report. One of the recommendations which was adopted, however, was the specific recommendation to amend the NAIC Unfair Trade Practices Act. In addition, the Executive Committee substantially revised the "Resolution on Automobile Insurance Rating Procedures" in exhibit four of the task force report. Basically, the Executive Committee struck the first five "resolved" clauses of the resolution and in lieu thereof substituted three of its own resolved clauses. One of the resolved clauses which was struck by the Executive Committee was the fifth resolved clause dealing with the sex and marital status amendment to the Unfair Trade Practices Act. Although the intent of the Executive Committee regarding the amendment to the NAIC Unfair Trade Practices Act is not very clear, it appears that the Executive Committee has adopted the recommendation of the task force to amend the NAIC Unfair Trade Practices Act to prohibit discriminatory underwriting based on the sex or marital status of an individual. Included in this recommendation was the provision that the amendment would not take effect until June 30, 1979.

II. Shortcomings of the Proposed Sex and Marital Status Amendment to the NAIC Unfair Trade Practices Act

The adopted amendment to the NAIC Unfair Trade Practices Act regarding discrimination based on sex or marital status was not given a great deal of attention by the NAIC at its Las Vegas meeting. As a result, the adopted amendment contains a number of shortcomings which need to be corrected before the amendment takes effect on June 30, 1979.

One of the shortcomings of the sex and marital status amendment is that the new subsection "(D)" to section 4(7) of the NAIC Unfair Trade Practices Act is not consistent with the existing subsections to section 4(7). In the current version of subsection 4(7) capital letters are not used to designate subsections of that section; the adopted amendment should therefore be "(d)" rather than "(D)". Moreover, the adopted amendment adds a new subsection "(D)" to section 4(7) even though there is no subsection "(c)" to the current model act. Although the NAIC Redlining Task Force has adopted an amendment to section 4(7) which would add a new subsection "(c)", the Redlining Task Force proposal has not yet been adopted by the NAIC.

In addition to the foregoing "housekeeping" considerations, there are a number of more substantive shortcomings of the sex and marital status amendment to the Unfair Trade Practices Act. First, the amendment is not limited to unfair discrimination in automobile insurance underwriting. The amendment, as drafted, covers all lines of insurance. There is

considerable doubt whether the Rates and Rating Procedures Task Force intended its amendment to go beyond automobile insurance. Furthermore, by specifically prohibiting refusals to insure and limitations of coverage because of the sex or marital status of individuals the new amendment implies that such refusals or limitations are not currently prohibited in the life and health field under existing subsections (a) and (b) of section 4(7). Since the NAIC has promulgated a model regulation dealing with sex discrimination and has used subsections (a) and (b) of section 4(7) of the Unfair Trade Practices Act as the appropriate statutory authority for the regulation, the new subsection "(D)" amendment raises doubts about the sufficiency of this earlier statutory authority. Finally, the subsection "(D)" amendment does not prohibit cancellations of insurance coverage because of the sex or marital status of an individual. The work of the NAIC Redlining Task Force reveals that insurance cancellations are a category of underwriting decisions which should be included in any prohibition against discriminatory practices.

III. Other Amendments to Section 4(7) of the Unfair Trade Practices Act

The sex and marital status amendment to the NAIC Unfair Trade Practices Act which takes effect on June 30, 1979 is not the only amendment to section 4(7) of that act which will be reviewed by the NAIC at its Chicago meeting in June 1979. There are two other proposed amendments to section 4(7) which will be considered at the June meeting for possible adoption by the NAIC.

As noted earlier, a general amendment to section 4(7) of the Unfair Trade Practices Act is being proposed by the NAIC Redlining Task Force. The Redlining Task Force proposal would define as an unfair trade practice:

(c) making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards in the issuance, renewal, cancellation or limitation of any property or casualty insurance coverage.

It is the intent of the Redlining Task Force to establish a statutory prohibition against unfair discrimination in insurance underwriting practices which is broad enough to encompass all property and casualty coverages. To address the specific problems of insurance "redlining" the Task Force has adopted a model regulation to accompany its proposed amendment which prohibits insurers from refusing, terminating or limiting insurance coverage because of the geographic location or age of a risk.

In addition to the proposed amendment by the Redlining Task Force, the NAIC Task Force to Investigate Discrimination Against the Handicapped is expected to offer an amendment to section 4(7) of the NAIC Unfair Trade Practices Act at the Chicago meeting in June. The Handicapped Task Force is expected to recommend that section 4(7) be amended to include as an unfair trade practice:

(e) refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of property or casualty insurance coverage available to an individual solely because of a mental or physical impairment.

It is possible that the Handicapped Task Force will draft an exception to this prohibition in cases where a handicapped person is unable to obtain a license to perform the activity insured against, i.e. driver's license. In any event, this proposal is likely to be presented for final action by the NAIC in June.

IV. Unfair Discrimination Amendments: The Basic Alternatives

The proposals by the Redlining and Handicapped Task Forces, as well as the previously adopted amendment by the Rates and Rating Procedures Task Force, offer the NAIC two basic drafting alternatives for dealing with unfair discrimination under the NAIC Unfair Trade Practices Act. The first alternative involves a broad general amendment to the Act with accompanying specific regulation(s) which define the meaning of the general amendment in specific contexts. This general approach is favored by the NAIC Redlining Task Force. The second alternative involves several separate amendments to the Act which specifically identify individual forms of unfair discrimination. This specific approach is favored by the Handicapped Task Force and the Rates and Rating Procedures Task Force. There are advantages and disadvantages associated with both alternatives.

A. The General Amendment Alternative

The principal advantage of the general amendment drafting alternative is the flexibility it affords for promulgating regulations which specifically identify forms of unfair discrimination. The language of the proposal adopted by the

Redlining Task Force would enable commissioners to identify individuals or risks involving "essentially the same hazards" within a given "class" of individuals or risks which must be treated "fairly" by insurance underwriters. The similar hazards, the general class and the type of fair treatment involved in this identification would be left to the discretion of individual commissioners. As business practices and social mores change over time commissioners could formulate interpretative regulations under this general statutory prohibition to meet the needs of such new circumstances.

A second advantage of the general amendment is that it closely tracks the statutory language found in the two current subsections to section 4(7) of the Act. Those two subsections generally prohibit unfair discrimination between individuals of the same class and of essentially the same hazards in life and health insurance. The proposed general amendment of the Redlining Task Force would simply apply this same prohibition to property and casualty insurance. Not only would this consistent application of statutory language facilitate a clearer understanding of legislative intent, but it would also enable courts to utilize prior case law to decide controversies which may arise under the new general amendment.

The principal disadvantage of the general amendment is that it does not offer clear guidance as to what constitutes "unfair discrimination" in specific circumstances. Some state legislatures may be reluctant to delegate broad authority to the commissioner to define particular forms of unfair discrimination in property/casualty insurance underwriting, although a number of legislatures have not found this to be a serious problem. (The states of Alaska, Colorado, Connecticut, Iowa, Maryland, Nebraska, New Hampshire, Ohio and Pennsylvania have enacted general provisions in their unfair trade practices acts which are at least as broad in scope as the proposal of the NAIC Redlining Task Force.) Moreover, the broad prohibition against unfair discrimination may generate litigation in a variety of property/casualty contexts if the commissioner does not take the initiative to promulgate interpretive regulations.

B. The Specific Amendment Alternative

The major advantage of the specific amendment alternative is that it enables state legislatures to establish public policy regarding specific forms of unfair discrimination. Each specific amendment would be subject to the legislative process; if enacted, it would reflect the opinion of a majority of the state electorate on particular industry practices. Similarly, the specific amendment would embody a clearer expression of public sentiment than the general amendment alternative. Hopefully, each specific amendment would be drafted in such a way as to leave few doubts about the scope of its prohibition.

The specific amendment alternative is not free of disadvantages, however. Its principal disadvantage is that it requires specific legislative action every time a particular industry practice becomes the subject of public indignation. Each new discrimination "crises" is likely to lead to an additional amendment to the Unfair Trade Practices Act, with the result being a "laundry list" of prohibitions under section 4(7). Moreover, state legislatures may formulate specific prohibitions under section 4(7) which are aimed more at social inequities than actual insurance industry absuses. Unlike the regulatory process, the legislative process is not particularly suited to structuring specific remedies to complex insurance problems.

V. Implementing the Desired Alternative

The general and specific amendments to the NAIC Unfair Trade Practices Act offer two separate drafting alternatives to the NAIC. Because of the philosophical, political and legal differences between the two alternatives, the NAIC will be forced to choose between alternatives at its June meeting. Regardless of the eventual outcome of this decision, modifications will be required in existing task force proposals to make those proposals compatible with the desired drafting alternative.

If the NAIC adopts the general amendment to the NAIC Unfair Trade Practices Act pursuant to the recommendation of the Redlining Task Force it should revise its earlier amendment to the Act regarding sex and marital status before that amendment takes effect on June 30, 1979. More specifically, if the NAIC continues to take the position that underwriting decisions based on the sex or marital status of individuals should be prohibited, a model regulation should be substituted for the pending amendment to section 4(7) of the Unfair Trade Practices Act. This model regulation should be modified as suggested earlier by limiting its scope to automobile insurance and by adding insurance cancellations as a prohibited act. In addition, if the NAIC desires to prohibit underwriting decisions based on a mental or physical handicap

of an individual, it should likewise translate the current proposed amendment of the Handicapped Task Force into a model regulation. These model regulations would both be valid exercises of regulatory authority under the proposed general amendment of the Redlining Task Force.

If the NAIC does not adopt the general amendment proposed by the Redlining Task Force it should revise its earlier adopted amendment regarding sex and marital status. This revision should include the same substantive amendments as discussed previously as well as the procedural "housekeeping" revisions needed to make the amendment compatible with the existing Act. In addition, if the NAIC rejects the general amendment approach of the Redlining Task Force it should nevertheless consider a specific "redlining" amendment to section 4(7) of the Unfair Trade Practices Act. Since the Redlining Task Force has drafted a number of specific amendments in the past those drafts could easily be used to formulate a specific amendment which is acceptable to the NAIC. Finally, any proposal by the Handicapped Task Force should be reviewed carefully before adoption by the NAIC to insure that it is substantively and procedurally consistent with the action taken on the Redlining Task Force proposal.

[Editor's Note: The Executive Committee referred all passed amendments to the Unfair Trade Practices Act to the Central Office to assure that these published Proceedings conform to the existing text.]

To: Advisory Committee to NAIC Redlining Task Force

From: Laura P. Sullivan, Chairperson, Advisory Committee

Date: June 19, 1979

Re: Progress and Future Work

At the June NAIC meeting in Chicago, several actions were taken relating to the work of the task force on insurance redlining and this Advisory Committee.

On Sunday, June 3rd I presented the report of the Advisory Committee concerning its work since the December, 1978 regular meeting of the NAIC. A copy of that report, as retyped by Aetna, is attached.

On Thursday, June 7th, I presented the arguments of the Advisory Committee in favor of adoption of specific redlining amendments to the Unfair Trade Practices Act to the Property and Casualty (D) Committee. Testimony was also presented by Independent Insurance Agents of America in favor of amending the Model Declination, Termination and Disclosure Act, and by Greg Squires recommending specific exceptions as well as specific prohibitions against redlining. The Alliance of American Insurers also submitted a statement for the record in support of the Advisory Committee recommendations. After much discussion, the following action was taken by the (D) Committee with respect to the model bills:

A. The words "agent or broker" in lines 1 and 4, Section VI (C)(1) of the April 30, 1979 draft of the Proposed Property Insurance Declination, Termination, and Disclosure Model Act were deleted.

B. A substitute specific amendment to the NAIC Model Unfair Trade Practices Act was adopted in lieu of the Proposed General Amendment of the Redlining Task Force. Because of the inclusion of the substance of the Proposed Model Regulation of the task force within the substitute specific amendment, the need for a separate model regulation was obviated.

On Friday, June 8th, the Property Insurance Declination, Termination and Disclosure Model Act was further amended by the Executive Committee and the Plenary Session.

In addition to the action taken with respect to the model laws, the Property and Casualty (D) Committee also charged the Redlining Task Force "to consider developing a model automobile declination termination and disclosure law, with the target date for the completion of this project of December, 1979."

In response to this charge from the (D) Committee, Commissioner Mitchell of Wisconsin has written to me requesting that the Legal Subcommittee of the Advisory Committee begin work on an initial draft of such a model bill. The tentative timetable for action on this project would be as follows:

September 7, 1979 – Initial draft to be mailed to Redlining Task Force Chairman.

September 23, 1979 – Exposure draft to be considered by the task force and Advisory Committee meeting at Zone IV in Detroit.

October 15, 1979 – Draft proposed for adoption in December to be distributed to (D) Committee.

I have discussed this tentative timetable with Steve Martin, Chairman of the Legal Subcommittee, and he has advised me that he will be in touch with his subcommittee by mail during the summer months, and hopefully will be able to offer something for consideration by the task force by the September 7 deadline. Since the Legal Subcommittee will be doing the bulk of the work in the next few months, I would suggest that you send any suggestions or comments on this new project directly to Steve Martin.

Best wishes for an enjoyable summer, and I look forward to seeing you again in the fall.

****

Report of the Advisory Committee to the NAIC Redlining Task Force
Chicago, Illinois

June 3, 1979

The Advisory Committee to the NAIC Task Force on Insurance Redlining has met several times since the December, 1978 NAIC meeting. Additionally, the Legal and Property Subcommittees of the Advisory Committee have been actively involved in pursuing specific follow-up charges from the task force.

During the past six months, the Advisory Committee has concentrated its efforts in the following areas:

(1) Assisting the task force in its review of proposed amendments to the Model Unfair Trade Practices Act,

(2) working with the task force in the development of a Model Property Insurance Declination, Termination, and Disclosure Act,

(3) development of suggested underwriting criteria for use in the writing of homeowner's insurance by those residual market plans which feel the need to provide such insurance, and

(4) preliminary work in the development of depopulation incentives related to residual property insurance plans.

At the request of the chairman of the task force, I have also consulted with the three major property and casualty trade associations to review the distribution of earlier reports of this Advisory Committee within the insurance industry.

The results of our labors relating to the various pieces of proposed model legislation were presented to the task force earlier this spring. As you know, there continue to be some differences of opinion between the Advisory Committee and the task force concerning the proposed models which were adopted by the task force at its April 30 meeting in Atlanta. Therefore, I will once again be expressing the Advisory Committee's preference for specific legislation directed to the problem of redlining at the meeting of the Property and Liability (D) Committee on Thursday of this week.

The work product of the Property Subcommittee of the Advisory Committee relating to underwriting criteria for homeowner's insurance and residual market plans, and incentives for depopulation of property insurance residual market is attached to this report. You will note that the subcommittee elected to present this material as additional text and appendices completing its response to the earlier challenge from the task force to "develop a model approach to the offering of homeowner's insurance for those FAIR plans which feel the need to provide such insurance."

Specific underwriting rules recommended by the committee are included as an appendix to the report and address such matters of concern as questions to be asked on the application, inspection for underwriting and rating purposes, binding procedure, grounds for termination or declination, and insurance to value requirements.

In addressing the subject of incentives for depopulation of residual market property insurance plans, the subcommittee reiterated its early position that the greatest attention must be given to encouraging the best possible voluntary market, and not creating a residual market which would be more attractive to companies, producers, or insureds. Additionally, greater attention should be given to the project of improving access to the voluntary market by use of placement facilities such as the Consumer Information Center in Milwaukee, the Connecticut Open Line, and FAIR Plan communications such as the Minnesota FAIR Plan program which requires a producer unable to place a FAIR Plan renewal in the voluntary market to make information on the risk available for solicitation to other producers 45 days prior to renewal. Finally, the committee report addresses the subject of actuarial incentives for depopulation of residual markets. It notes that while keep out and take out programs have been utilized for many years in auto insurance plans and some windstorm pools, there are problems in attempting to simply transfer these mechanisms to a property insurance residual market. Therefore, the committee has recommended that this topic be an ongoing subject for consideration by the newly created personal lines residual market subcommittee of the National Committee on Property Insurance, and that the Redlining Task Force look to that NCPI subcommittee for further assistance in this area.

Lastly, I am able to report that based on communications I have received from the presidents of each of the three major property and casualty trade associations it appears that the early reports of this Advisory Committee have been widely distributed within the industry. The Alliance of American Insurers advised that the reports of the Advisory Committee have been distributed to all of their member companies and to their board of directors. The National Association of Independent Insurers advised that essential elements of the 90 Day Report of the Advisory Committee were presented to NAII Board of Governors, and the second report was also distributed broadly within NAII membership. NAII also noted that each of the reports has been endorsed by their Property Insurance Committee. The American Insurance Association advised me that the reports of the Advisory Committee have been made available to the members of its Property Insurance Committee, and other senior executives whose companies are not members of that committee. Additionally, I can report that I have received several requests for copies of our reports from both industry and nonindustry representatives.

I believe that the Advisory Committee has now completed its assigned responsibilities. I trust that the results of our work representing input from consumers, producers, and insurers has been of assistance to the task force.

Laura P. Sullivan, Chairperson, Illinois; Mr. Patrick Casey, Illinois; Mr. Robert Doucette, Wisconsin; Mr. David S. Murphy, Illinois; Mr. Gregory D. Squires, Illinois; Mr. R. L. Jewell, Illinois.

Challenge No. 7

Development of a model approach to the offering of homeowners insurance for those FAIR Plans which feel the need to provide such insurance.

Alternatives to the Inclusion of Homeowners Coverage in the FAIR Plans

The Advisory Committee is concerned that the creation of a "model approach" as suggested in Challenge No. 7 could prove misleading. It implies that a single convenient solution can be used to solve a variety of complex problems. Local conditions and circumstances vary widely. No single "model approach" could apply effectively in more than a very few states. Consequently, we have developed an approach to determine the presence and extent of a problem, as well as a procedure which a given commissioner might follow in tailoring an appropriate solution to the particular problem in his state. Although we do not support a single model approach, there are some uniform components that are appropriate for general use. We believe that individual state treatment of the problem will not result in unreasonable delay.

Section I. New Products

We do not believe that the solution for any homeowners market problem will be found simply by mandating the inclusion of homeowners coverage in the FAIR Plan. Rather, we suggest that it is far preferable to address any such problem by finding ways to write the coverage in the voluntary market.

A number of new products designed to solve, or partially solve the problem of insuring homes with a large disparity between market value and replacement cost already have been developed by various companies and trade associations. For example, the Repair Cost Program of the NAII and Allstate's Basic Homeowners Policy, the ISO Homeowners 8, the HO-256 and the Aetna Life & Casualty's Replacement Cost Adjustment Endoresement each offer a program for the individual who cannot, or does not wish to purchase insurance equal to at least 80% of the replacement cost. Filings necessary to implement these programs have been approved in a number of states. Other states have taken no action on the filings, or have turned them down. These programs offer significant alternatives to many people who have had difficulty in purchasing homeowners insurance. We urge insurance departments to approve the necessary filings as quickly as possible.

Determining the Need

If these forms are in use in a given state, and it still appears that there is an availability problem, we suggest that the commissioner appoint a small Advisory Committee (to include consumers, agents or brokers, and the major personal lines property insurers in his state) to assist him in evaluating local needs. It is difficult to use specific numbers of percentages as need criteria, but some, or all of the following should be considered:

A. Percent of dwelling insurance volume in FAIR Plan.

B. Growth of dwelling business in FAIR Plan.

C. Complaints received by insurance department and industry.

D. Complaints of lenders concerning inability to get insurance to support loans.

E. Failure of alternative voluntary programs (if any) to solve the problem.

F. Extent of the problems – Urban vs. Rural; Protected vs. Unprotected, etc.

G. Nature of the problem – is it rate inadequacy, failure to get approval of new programs, or other aspects which might be solved short of setting up a residual market mechanism?

Working together, the commissioner and the Advisory Committee should evaluate the situation, determine the seriousness of the problem, and propose appropriate solutions for that state.

Alternative Voluntary Solutions

Before any change is made relating to a mandatory residual market mechanism, we strongly urge that a number of alternative voluntary actions be considered. Depending upon the extent and the tupe of the availability problem, any one of the alternatives may solve or reduce the problems more easily, more quickly, more economically and more effectively than a formal residual market mechanism. In some situations, a combination of the suggested alternatives could be utilized successfully. For example:

If the difficulties are perceived by the commissioner and his Advisory Committee to be relatively small, and primarily the result of a communications gap between consumers or consumer groups and the industry, an Outreach Program might be quickly established to help bring consumers and industry together.

One such program is now working very well in Milwaukee. As reported in the National Underwriter, it is a "free, no gimmick public service to the consumer – an eyeball to eyeball effort to help people with insurance difficulties." Known as the Community Insurance Information Center, it is located in the heart of Milwaukee's inner city and is currently servicing the needs of about 30 people per week. It sells no insurance; rather, it is a communications bridge which, to date, has managed to successfully bring consumer and industry together to resolve insurance difficulties. Almost all the consumers who have utilized it report satisfaction with the service.

Another example of a program designed to improve communications is The Voluntary Insurance Placement Register, established by the District of Columbia Department of Insurance. Rather simple in concept, it provides

that those who have difficulty in purchasing insurance file their name and pertinent information with the insurance department. Then producers who can furnish the indicated insurance do so.

In Georgia, the Voluntary Residential Insurance Placement Committee, established at the request of Commissioner Caldwell, reviews each individual case of alleged unjust coverage denial because of geographical location, and assists in securing coverage within the voluntary market. The result? Very few problem cases have surfaced and those have been resolved quickly, efficiently – and successfully.

Cleveland and a number of other Ohio cities have, or are commencing, programs to assit consumers in finding solutions to their insurance availability problems. Connecticut has also introduced a program for its larger cities. To date, the available information indicates considerable success when compared with any known formal involuntary market program.

Surely it is to the advantage of the consumer and the industry to work together to solve any availability problems in the voluntary market before automatically jumping to a formal residual market mechanism which may be unnecessary, cumbersome and unpopular to all concerned.

Section II. Residual Market Mechanism

If, however, in the final analysis it is determined that changes must be made in the mandatory residual market mechanism in a given state, consideration must first be given to a number of legal questions. For example, in a state where "essential insurance" is defined by law, can the authority of an existing FAIR Plan be broadened to include the writing of homeowners insurance without changing that definition? In the absence of such a legislative change, is it sufficient if the membership of the plan approves the expansion of coverage by a unanimous vote? These legal questions must be evaluated on a state-by-state basis.

Regardless of the answers to these legal questions, it is the consensus of the Advisory Committee that if, ultimately, a residual mechanism for homeowners is deemed necessary, it should be structured along the following lines:

Mechanism

First, we suggest that a pooling mechanism be established, but not an assigned risk plan or reinsurance facility. To the extent possible, homeowners insurance should be regulated by the state free from federal regulation. To accomplish this in states where FAIR Plans exist, it may be appropriate for the industry to contract with the FAIR Plan to administer this business. If this is impractical, or if no FAIR Plan is in existence, a separate JUA/Syndicate type of operation, or a JUA/Servicing Carrier Mechanism can be established. In arriving at an approach, each state should be considered individually, and the capability of an existing FAIR Plan to provide proper service should be evaluated. In all cases, the most efficient and cost effective mechanism should be utilized.

Product

The consumer should have the choice of three to four products generally available in the market place, subject to eligibility, limits of liability and underwriting criteria adopted by the mechanism. The Advisory Committee suggests the following:

A. Dwelling Fire and Extended Coverage, where not presently offered in existing FAIR Plans.

B. The standard Homeowners Form 1 written for at least 80% of the replacement cost and requiring the property to be rebuilt at the same site before the difference between replacement cost and actual cash value is paid. The relationship of contents coverage to Coverage A should be the same as now – 50%. For a listing of manual options available, see Appendix A.

C. A "Repair Cost" policy with limited theft coverage and written for the market value of the dwelling. The amount of insurance may vary up to 20% from the market value of the property for which insurance is sought where the reasons for such variance are consistent with the needs of the community and the applicant. It should provide for payment of any loss (up to the policy limit) on a "Repair Cost" basis. Policy coverage and options should follow those generally available in the "Repair Cost" programs currently in use. However, scheduled personal property coverage should not be available.

D. Situations may develop in which customers neither want to buy at least 80% of replacement cost value, nor desire the "Repair Cost" policy; consequently, it is recognized that the use of a Variable Percentage Replacement Cost Settlement Clause (HO-256), or some variation thereof, providing for full replacement cost coverage up to the market value may later be demonstrated to be necessary.

The maximum Coverage A dwelling limit should be the same as the current FAIR Plan maximum for dwelling fire, the minimum equal to the prevailing filed minimum amount for Homeowners 1 written in the voluntary market. The standard Section 1 deductible applicable to all perils should be $100. In the interest of affordability, higher deductible amounts should be made available.

Pricing

The residual market plan should be set up as nonprofit. In addition, in establishing rates, the Plan should seek a balance among affordable rates, Control of the deficit and subsidy cost to the voluntary market, and an inhibition of unintended and undesirable growth of the Plan.

Accordingly, the rates initially utilized by the Plan should be established at a level which is moderately higher (10% to 30%) than the rates normally used in the voluntary market, with the latter being the rates or advisory rates established by the principal state licensed rating organization. The residual market plan rates should also be revised to coincide with any changes made in the voluntary market rates.

As residual market statistical data becomes available, the rates should be determined on the basis of the Plan's own experience to the extent that it is credible. The rates would be subject to a maximum of +30% above the rates normally used in the voluntary market.

In establishing both the initial and subsequent rates of the residual market plan, the Plan should review its rates in relation to the voluntary rates of the leading writers in the state to be certain that prices are not at a level which is unreasonably or artificially low and which would induce an unintended influx of business into the Plan. If the Residual Market Plan's rates are determined to be at a level which would induce such an influx, they should be adjusted accordingly.

Recognizing that the principal state licensed rating organization does not at this time file or publish advisory rates for the "Repair Cost" product, we recommend that the Plan pricing follow the approach described in the preceding paragraph until such time as the rating organization makes such rates available.

There should be no fewer territorial classifications than those employed by the principal ratemaking organization in the state.

Condition charges and safety and loss prevention credits should be allowed to the same extent as provided for in the voluntary market.

A payment plan, with an adequate finance charge and something in the nature of the typical 40/30/30 program should be available for any of the coverage options.

Funding of Deficits

By limiting the level of premiums in the residual plan, it should be recognized that in many states there will be a resultant deficit. Any deficit must be automatically funded either from public funds or by a subsidy charge levied against property insurance policies written in the state.

At least four different types of mechanisms have been proposed to fund such deficits, and are described below:

I. Premium Surcharge Reimbursement Plan

New Jersey – Twice a year the FAIR Plan determines whether it is running a deficit. If it is, the Plan asks the commissioner for reimbursement. If the commissioner approves the request, the State Treasurer is notified and the FAIR Plan is reimbursed from the New Jersey Insurance Development Fund. To insure the Fund has sufficient monies, the commissioner is empowered to authorize the member companies to surcharge up to 5% of premium on all property insurance policies, habitational and commercial. (For a homeowner's policy the surcharge is applicable to 85% of premium and for a CMP policy 65% of premium.) Insurers collect the surcharge and remit it to the State Treasurer. The surcharge is separately identified and this collection is mandated. The surcharge is not subject to producers' commission or premium tax.

II. Premium Tax Offset Proposal

An insurer would be provided with a credit against premium taxes owed in an amount equal to 90% of the amount assessed and collected from the insurer by the Residual Plan. Any credit in excess of the amount of premium tax payable in any taxable year would be allowed as a credit which may be applied in any succeeding taxable year. This credit would be in addition to all other credits allowed by law.

III. Premium Surcharge Fund Proposal

The Regulator would approve Residual Plan rates that he deems to be in the public interest. To the extent the rate approved is less than an actuarially sound rate calculated to be self-supporting, the difference between the self-supporting rate and the rate approved would be prospectively collected by the use of an annual surcharge upon all property insurance premiums for the types of coverages written by the Plan. The surcharge would not be subject to producers' commissions or taxes. The surcharge collected would be remitted to a stabilization reserve fund. This Fund would then be used to compensate the Plan for any deficit arising out of operations. The surcharge would be collected from both the voluntary and involuntary markets until the net value of the fund exceeds $50 million. Thereafter annual surcharges would be made only when the net value of the fund is less than $25 million, and the surcharges would continue until the net value again exceeds $50 million.

IV. Rate Factor Assessment Offset Proposal

The Residual Plan would be authorized to levy periodic deficit assessments against member insurers to cover projected or existing Plan deficits. The plan of operation of the Plan would allow recoupment by calculating rating factors or increments to be applied to direct premiums for basic property insurance written in the state. At their option, member insurers could recoup levied assessments by adjusting premiums to reflect the rating factor or increment.

Commissions

The Advisory Committee feels that the Homeowners Residual Market commissions should be somewhat lower than normal in order to encourage producers to seek coverage for homeowners in the voluntary market, and to discourage, to the extent possible, the expansion of the residual market.

Statistics

For ease of handling, as well as compatability with existing company statistical programs, any residual mechanism should use the same statistical plans presently used for homeowners and residential fire business. In other words, the statistical plan should be identical to that of the principal statistical agency in the state, thereby facilitating the possible development of depopulation and territorial credit programs, as well as assisting in the development of subsidy programs.

These statistical requirements are designed to provide information for the analysis of rate and classification distribution. They are not intended to preclude the collection, as necessary, of additional information which could be utilized to monitor market availability. For discussion of the collection of statistical information for the purpose of monitoring the marketing practices by geographical location, reference should be made to the prior actions of the Redlining Task Force.

Service to Policyholders

It is the Advisory Committee's strong belief that the residual market plans should give service equal to that of the voluntary market. As noted in the 90 Day Report of this Advisory Committee, the National Committee on Property Insurance (NCPI) is currently taking steps to assist the property insurance residual market plans in accomplishing this goal.

Nonindustry Representatives

The experience of serving on this broadly based Advisory Committee has demonstrated to many the value of input from nonindustry representatives in areas of decision making which affect the industry as a whole. The Advisory Committee therefore recommends that the management of the homeowners residual market mechanisms should, in each state, include a small but significant number of nonindustry representatives.

Continuing Efforts

The Advisory Committee feels that there is an urgent need for an industry level organization to continue the work begun by this committee in addressing the needs of the personal lines residual property market. In recognition of this fact, it has recommended to the National Committee on Property Insurance that a personal lines property residual market subcommittee be established, and NCPI has appointed such a committee.

SECTION III. Underwriting Considerations for Residual Market Homeowners

The introduction of a residual market homeowners policy requires a different set of guidelines from those which apply for dwellings insured for Fire & ECE in the FAIR Plan because:

1. coverage is extended to personal liability with limits of $25,000 and up;
2. theft is covered;
3. automatic coverage is applied to outbuildings, contents and additional living expense;
4. replacement cost may be provided with rates based on insurance to value;
5. dwellings are all owner occupied;
6. many optional limits and coverages are available; and
7. rates are generally lower than equivalent monoline coverages.

Because more than one homeowners product may be offered and both the products and pricing may vary by state, the attached exhibits are intended as guides in the development of Underwriting Rules by the state Residual Market governing committees. These guides will allow each governing committee to tailor its rules to meet its specific situation.

The guides shown need to be matched to the product, and the underwriting should vary by product mix. The guidelines are based on the products indicated in the report. If other products are contemplated, appropriate modifications should be considered.

Principal Considerations

These rules are intended to apply to risks which have been unable to secure coverage in the voluntary market. It is the objective of this Plan to provide coverage for a majority of applicants, recognizing that some applicants will be ineligible because of underwriting considerations. But, in any event, all applicants should be fully aware of their option to seek coverage in the voluntary market and that they are, in fact, applying for coverage in the residual market.

Rules should be specific and objective. They should be published to producers and available for public review. With the exception of extreme natural or external exposure not contemplated in the rate structure, declination should be based on

individual risk deficiencies which should be brought to the applicant's attention to correct in order to qualify for coverage. No eligible risk should be rejected for physical deficiencies without inspection.

This committee recognizes the growing need to control loss costs, particularly deliberate acts such as arson, through more specific underwriting information as conflicting with limitations on privacy rights. We believe the design of the application should appropriately balance these considerations.

Conversion During Initial Period

The FAIR Plan is to send special mailings to all owner occupied dwelling policyholders explaining the availability and extent of homeowners coverage available in both the voluntary and involuntary markets.

Examples of underwriting rules are contained in Appendix B.

Depopulation Incentives

We endorse the concept that the insurance industry's primary objective should be to meet as much of the demand for property insurance as possible in the voluntary market. To meet this objective, insurers must focus their marketing, underwriting and pricing activities in the voluntary market so as to minimize the attractiveness of the involuntary market mechanism. This means that the involuntary market should not be competively priced, nor should it be an easy repository for business which might otherwise be acceptable in the voluntary market. Furthermore, efforts should be made to restrict the involuntary market to risks that are uninsurable in the voluntary market.

To accomplish the foregoing, the insurance industry must, as a first step, provide the means by which consumers are made more aware of the voluntary market and the means of access to it. Consumer information centers, outreach programs, media campaigns and mailings to FAIR Plan customers are but a few examples of the ways in which this goal could be accomplished. In addition, wording of cancellation and nonrenewal notices to insureds so as to make clear that the Residual Market is not the only alternative for the uninsured consumer would be helpful. In addition to the efforts already cited, we believe that the development of depopulation incentives are of utmost importance since they will provide the mechanisms by which the industry can minimize the size of the involuntary market.

Additionally, as we have emphasized throughout our report, each state and major urban area presents a different set of market conditions and the components for minimizing and controlling residual market size should be tailored to each situation as part of the entire market solution. Our recommendations are intended to provide a basis for each state to design its own program.

Encourage the Best Possible Voluntary Market

The health of the voluntary market is clearly the driving factor in both the short and long term size and quality of the residual market. The latter is a mirror image, representing among other things a favorable/unfavorable regulatory and legislative climate, rate adequacy/inadequacy a possible lack of capacity and/or efficiency of the competitive market.

A large majority of states today have insignificant residual markets. Generally these states are seen by insurers as offering a reasonable opportunity to achieve a fair return on their commitment of capacity and capital. The competitive environment not only makes a broad market available but also provides a range of pricing, which further reduces the significance of a residual market.

We obviously believe that rate adequacy, encouragement of a range of competition and the opportunity for each carrier to develop products which meet the public's needs are the most effective and desirable ways to minimize the residual market.

Other sections of this report have emphasized the need to introduce new homeowner's products designed for older homes and to overcome the Replacement Cost problem. We reemphasize this point.

Similarly, we have discussed various programs which are designed to improve the buyer's insurance shopping and purchasing skills. These include:

Consumer Information Centers which are operational in several cities, the most notable one being in Milwaukee.

Consumer Guides which are being issued by many insurance departments and companies.

Consumer Hot Lines which are sponsored by insurance departments, e.g., Pennsylvania and Connecticut and local agents associations, e.g., Cleveland.

FAIR Plan mailings which would provide a direct source of contact with those who would probably benefit most from improved shopping skills.

Provide Disincentives for the Residual Market

If the voluntary market is to be the primary source for providing insurance, the residual market must be a less attractive alternative to all companies, producers and insureds.

Whenever the residual market offers either lower cost or better coverage, it will grow even in spite of a healthy competitive market. This has been demonstrated repeatedly by all types of residual market plans. An extreme example can be seen today in Massachusetts and Rhode Island where the growth of the homeowners in the FAIR Plan is unrestrained because there are literally no disincentives other than lower producer's commissions.

Our report has already proposed a number of disincentives:

Pricing

Reasonable rate differentials are essential not only because of the probability that they may have a favorable impact on plan size (keep them small) but also, because we believe that the consumers in the Residual Market should bear at least part of the burden of Residual Market losses.

Commissions

We believe that the commission paid for residual market business should be lower than that paid for voluntary market business. Currently, the lower commission levels for residual market business are offset to some degree by the generally higher rate levels. Because of this relationship between price and commission, consideration may be given to a greater commission differential. The rationale for a greater differential is two fold: first, an even lower commission applied to a higher premium is still more attractive than losing the business; second, it confirms the general principle that additional, unwanted growth will be generated if residual market compensation is attractive. However, rather than arbitrarily requesting a reduction in the commission level, we recommend that the insurance department investigate the adequacy or inadequacy of residual market compensation. Similarly, we recommend that the insurance departments investigate additional fees for service to determine their legitimacy. If they are legitimate, they should be regulated by the departments.

Product Modification

Depending on the condition of the risk, each plan should have the ability to modify coverage and/or limits in order to make the risk insurable.

Improve Voluntary Market Access Through Placement Facilities

In some instances risks which are insurable in the voluntary market find themselves insured in the residual market. We believe that the utilization of a voluntary placement program would substantially reduce this inequity.

Several voluntary placement options are available:

FAIR Plan Mailings

These would be direct mailings to FAIR Plan insureds informing them of the voluntary market and how to access agents.

The Milwaukee Program

The Consumer Information Center has a voluntary placement facility.

Connecticut "Open Line"

This is a complaint and market inquiry center with a voluntary back-up inspection and placement facility.

Minnesota FAIR Plan "Depopulation"

If a producer is unable to place a FAIR Plan renewal in the voluntary market, the information on the risk is made available for solicitation to other producers 45 days prior to renewal (see Appendix C).

Actuarial Depopulation Incentives (Keep-Out/Take-Out)

Even if some, or all of the previously mentioned programs or concepts were in place, there may still be a need for a residual market. This stems from the fact that there are risks which are not eligible for the voluntary market. However, the presence of a residual market undoubtedly presents the potential for abuse. The most flagrant abuse would be any business practice which results in the placement of consumers in Plans when they, in fact, are eligible for insurance in the voluntary market. It is therefore, of utmost importance that actuarily based depopulation incentives, known as keep-out and take-out programs, be analyzed to determine if they are viable mechanisms by which the industry can minimize the size of the residual market.

Keep-out and take-out programs have been utilized for many years for various lines of business. Most Auto Plans have keep-out credits, as do several Windstorm Pools. There currently are no keep-out credits for FAIR Plan business. Similarly, several Auto Plans have take-out mechanisms, and three FAIR Plans (California, Georgia and New York) have take-out provisions. New York's take-out applies to Fire and Extended Coverage on a state wide basis. Georgia's is coastal only, and California's applies to brush fire writings only.

The primary objective of these programs is to offer incentives to insurers and agents to write in the voluntary market that business which otherwise might have been placed in the residual market. The incentive to companies is primarily financial in that any eligible business written voluntarily by a company reduces its participation assignment. The amount of reduction is dependent upon the credit multiple – the higher the credit multiple the greater the reduction and thus, a greater incentive. The primary incentive to an agent is also financial in that he will be paid a higher commission. However, in some agents' eyes, this incentive is insignificant since, inherent in any take-out program, they face the possible loss of business and commission.

Before we discuss these keep-out and take-out programs, there are several stipulations which should be stated:

> We recommend that each state thoroughly analyze its residual market to determine the need for an actuarial incentive program/s. For example, whenever the quality of business in the residual market is poor, or badly underpriced by objective standards, or where insurers believe voluntary rates are genuinely inadequate, depopulation plans are less effective, if not totally ineffective.
>
> Incentive programs should be used very selectively. If a state's residual market is small in relation to the voluntary market, the potential incentive will also be small, thereby rendering the program ineffective. Obviously such a state does not need to use an incentive program.
>
> We recommend adoption of keep-out/take-out programs only when it has been determined that there is a problem which will not respond to proposals contained in this report.

Keep-Out

This form of incentive is intended to encourage insurers to voluntarily write business which might otherwise be placed in the residual market.

Historically, there have been several different keep-out approaches in the automobile line. One of the more common examples of a keep-out is the young driver credit in the Automobile Insurance Plan.

The normal share of market distribution is modified by calculating for each carrier a supplemental debit or credit based on whether its share of young drivers was above or below the market norm for that class relative to its overall market share. Credits and debits are balanced exactly. All keep-out plans are variations on this approach.

Take-Out

Take-out programs are designed to encourage insurers to write in the voluntary market – at normal rates – those insureds currently in the involuntary market.

Take-outs have existed in both property and auto markets with varying degrees of success. With one exception, we believe there are significant problems which make take-out plans an ineffective solution. The exception would be the application of a one time credit during the introduction of a residual homeowners program. Even then, such a take-out should be utilized only where analysis clearly indicates there is writeable residual business which has not responded to any other incentive.

The reasons for limiting the discussion of take-out plans are the significant problems alluded to above. Briefly, they are:

1. It is necessary for agents and insurers to record and report each risk taken out, thereby adding significantly to the administrative expense.

2. There are two types of actuarial take-out programs, either of which can be found in several existing AIP plans. First, there's the program where an offer is made by the insurer to voluntarily write the risk. Second, there is a program where the voluntary offer plan is combined with a program where the company is mandated to offer voluntary coverage if a risk meets certain requirements.

   Obviously, while agents are less disenchanted with the voluntary only program, there is strong producer group opposition to both programs because of issues dealing with ownership of renewals. We would anticipate equally strong opposition to any type of property take-out program, be it voluntary or mandated.

3. Since take-out plans require a decision by the insured to leave the residual market, such plans become progressively less effective when the price margin between voluntary and residual market narrows.

4. In view of the various marketing methods used by companies in the industry, a solution to be equitable must address different marketing approaches.

Conclusion

We have paralleled the recommended approach to minimizing and controlling the residual market to the sequential steps in our recommendations for development of a residual market homeowners program. In all but a few states we feel encouragement of the voluntary market should be sufficient. However, if study shows further incentives are needed, this section provides the alternatives available to develop a program for each individual situation.

We have limited the discussion of the specific form of actuarial depopulation incentives in this report for a number of reasons. While the basic concepts utilized in existing take-out and keep-out programs in the Auto Plans and a number of FAIR Plans or Windstorm Pools can be applied in developing depopulation incentives for Residual Market Homeowners, there are also material differences between the operational structures of the various residual plans which mandate against simply adopting an existing program. For example:

Unlike Auto Plans, where each company has copies of its signed policies, the FAIR Plan syndicate holds all policy information, and policies are issued in the FAIR Plan name. This difference increases the difficulty, under a take-out approach, of specifically soliciting expiring FAIR Plan risks.

Since much of the business qualifying for depopulation incentives is presently written on a Standard Fire basis, decisions must be made as to whether conversion to voluntary homeowners should provide equal credit to that of a voluntary fire policy.

Property rating territory configurations tend to be much broader than auto territories and the basis for defining territorial incentives requires further study.

As a result, it is the opinion of the Advisory Committee, while we support the use of depopulation incentives where a specific need is established, that there is further work required to develop programs suitable for the Residual Market Homeowners.

Such work has already been initiated through NCPI and, with the appointment of the NAIC Redlining Property Advisory Subcommittee as the Personal Lines Subcommittee of NCPI, we believe a proper continuity will be achieved.

It is our recommendation that the general approach outlined in this section be approved, with direction to NCPI to complete specific proposals, and that individual states adopting Residual Market Homeowners programs look to NCPI for support in determining the depopulation incentives suited to their requirements.

****

Appendix A

Section I – HO-1

Options Included	Options Excluded
1) Building Additions and Alterations	1) Scheduled Glass
2) Earthquake Coverage	2) Personal Property – Scheduled
3) Inflation Guard	3) Rental to Others – Theft Coverage
4) Loss of Use – Increased Limits	
5) Office Professional, Private School or Studio Use	
6) Other Structures	
7) Personal Property – Coverage C	
8) Premium Credits for Protective Devices	
9) Credit Card, Forgery and Counterfeit Money	
10) Increased Special Limits of Liability	
11) Theft Coverage Extension	

Section II – HO-1

Options Included	Options Excluded
1) Coverage E or F – Increased Limits	None
2) Business Pursuits	
3) Incidential Farming – Personal Liability	
4) Office, Professional, Private School or Studio Use	

Options Included

5) Outboard Motors and Watercraft

6) Owned Snowmobile

7) Personal Injury

8) Secondary Residence Premises

9) Multiple Company Insurance

****

Appendix B

Specific Underwriting Rules

Application

All submissions must be made on a prescribed application. All questions must be answered and the application must be signed by both producer and applicant.

A statement should exist on the applications that the applicant is aware that he is seeking coverage in the residual market and has the option of seeking coverage in the voluntary market.

1) Suggested underwriting questions on application in addition to questions contained in conventional application:

Name of prior insurance carrier and reason for rejection or termination.
Prior losses in past three years – type, cause and amount.
Violations of fire, safety, health, building or construction codes on property – type and date, and if corrected.
Are real estate taxes unpaid more than (X months) or tax liens on property? – amount.
Are mortgage payments delinquent more than (X months) or property is under foreclosure proceedings?
Has the insured or any individual with ownership interest been under indictment (or convicted) of any crime having as one of its necessary elements an act increasing any hazard insured against? Specify with date.

Value:

Construction date of dwelling (approximate).
Purchase date of dwelling – cost.
Estimated present market value of property, excluding value of land.
Estimated replacement cost of dwelling.

2) Consideration should be given to need for short renewal questionnaire designed primarily to pick up vacancies, tax liens, violations, correction of inspection deficiencies, improvements and structural changes.

Inspection for Underwriting and Rating Purposes

All eligible submissions should be inspected. No submission should be declined for specific risk deficiencies without an inspection and written notice to the producer and insured which provides specific reason(s) for the declination and, if applicable, notice of an opportunity to correct such deficiencies with a date by which the deficiencies must be corrected. It should be the obligation of the applicant and producer to provide notice when the deficiency has been corrected and make the property available for reinspection.

A copy of all inspection reports should be made available to the producer. The purpose of the inspection is to qualify the risk for acceptance and, as a public service, it is appropriate to advise the policyholder of deficiencies. However, to provide this, the mechanism needs some sort of immunity either in the form of a disclaimer or by statute.

Binding Procedure

New risks may be bound by producer (for a specified period) if:

An application has been completed and signed by applicant and producer – with proposed binding date and time indicated.

Specified minimum down payment has been made.

Binding conditions, i.e., effective date and maximum limit of risk, should be incorporated in the application form.

Applicant is in full compliance with all Sections of Underwriting Rules.

A homeowners policy will be issued to replace the binder only on completion of inspection and correction of indicated deficiencies.

Note:

If after inspection the risk does not meet standards for coverage requested, but meets standards for alternate programs, the insured will be provided proper advance notice or an opportunity to accept such alternate products.

Grounds for Cancellation Refusal to Renew or Write or Reasons Why a Conditional Binder may be terminated

I. A policy may be cancelled for:

a) Nonpayment of premium.

b) Conviction of the insured for any crime which has as its principle element an act or omission increasing any hazard insured against or insurance fraud.

c) Fraud or material misrepresentation made by or with the knowledge of the insured in applying for or obtaining the policy, continuing the policy, or in presenting a claim under the policy.

d) Insured premises have been condemned or declared unfit for human habitation by an appropriate authority.

e) Failure to meet inspection standards in a reasonable period of time after notification of deficiencies to be corrected.

f) Unpaid real property taxes delinquent for two or more years at the time of underwriting action.

II. A policy may be refused renewal, subject to any required notice, for the reasons above and for:

a) Substantial change in the risk, increasing any insured hazard as evidenced by:

1. Violation of specified fire, health, safety, building or construction codes, regulations or ordinances imposed by an appropriate authority with respect to the building, its premises or occupancy. (Note – because there is an infinite variety of possible violations, with some of limited importance to insurance, the specifics must be developed locally and should also include frequency criteria. The listed violations must result in an increase in the material hazard of the risk.)

2. Vacant or abandoned property – with vacancy in excess of 60 days or with no reasonable expectation of reoccupancy. Buildings with any water, heat or electricity service discontinued are considered vacant. (Note – a localized definition of "abandoned" is required. In some cities, this has an official status as part of a proceding to take over property for taxes).

III. An applicant may be refused coverage for the reasons above in Sections I and II and for:

Extreme natural hazard not contemplated in Plan rules/rates which materially increases the exposure including windstorm and brush or forest fire unless provisions are made for special rating.

Insurance to Value

I. Repair Cost Policy

a) Minimum Amount of Insurance

Current Market Value (100%) of insured premises with reasonable deduction for land value.

b) Maximum Amount of Insurance

Current Market Value of insured premises plus up to 25% (for normal increase in value and property improvements); or

Amounts in excess of Market Value + 25% require specific validation such as renovation contract, etc.; or

Market Value to be established by any customary method including:

– Real Estate or Appraiser's estimate

– Current price or sales of similar homes

– Actual cost of dwelling in recent purchase

– Cost plus improvements.

II. Replacement Cost Policy (Form 1)

a) Minimum Amount of Insurance

80% of current replacement cost.

b) Maximum Amount of Insurance

Not to exceed 150% of market value. If this value is less than required by Rule (a), coverage cannot be written on a Replacement Value form. A rebuilding clause requiring the rebuilding of the dwelling at the same location would lessen the need for this limitation.

Replacement cost may be determined by any customary system:

– Sale cost of new home;

– Appraiser's value;

– Published system using square footage or room count.

Example: Massachusetts' Underwriting Standards

In determining whether or not to accept a risk, the Association shall follow "reasonable underwriting standards" which include, but are not limited to, the following:

A. Physical condition of the property, such as its construction, heating, wiring, evidence of previous fires, or general deterioration.

B. Its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials;

C. Specific characteristics of ownership, condition, occupancy, or maintenance which are violative of public policy and result in unreasonable exposures to loss.

Reasonable underwriting standards with respect to Section I of homeowner insurance coverage shall include the general standards and in addition shall include, but not be limited to, excessive loss frequency when the applicant has failed to take reasonable steps to correct any situation which has given rise to past losses, unless the applicant is willing to accept reasonable deductibles.

Reasonable underwriting standards with respect to Section II of homeowner insurance shall include the general standards and in addition shall include, but not be limited to, the following:

A. Hazardous physical conditions including, but not limited to, unfenced swimming pools.

B. Presence of vicious animals.

C. Excessive loss frequency when the applicant has failed to take reasonable steps to correct any situation which has given rise to past losses.

Applicants or properties which violate any of the above "underwriting standards" are ineligible or uninsurable through the Massachusetts FAIR Plan.

Inspections

A. Any person having an insurable interest in real or tangible personal property at a fixed location in Massachusetts is entitled to an inspection of the property without cost.

B. Upon receipt of the application, the property may be inspected and rated.

C. Inspections will generally be made in the company of the property owner or their representative. The inspector must be provided full access to the building. An inspection report shall be made for each property inspected, and a copy sent to the Association.

Example: Rhode Island's Underwriting Standards

In determining whether or not to accept a risk, the Association shall follow "reasonable underwriting standards" which include, but are not limited to, the following:

A. Physical condition of the property, such as its construction, heating, wiring, evidence of previous fires, or general deterioration (however, the mere fact that a property does not satisfy all building code specifications would not in itself justify declining the risk);

B. Its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish, or flammable materials;

C. Unoccupied habitational property, unless the property (dwelling) has adequate public fire protection service, as defined by a recognized fire insurance rating organization:

D. Idle or unoccupied commercial property, unless the property (building) owner or tenant has provided for central station alarm, sprinkler, or watchman security;

E. Violation of law or public policy which results in increased exposure to loss including, but not limited to, risks on which there is an:

a. outstanding order to vacate;

b. outstanding demolition order;

or

c. which have been declared unsafe in accordance with applicable law;

F. Structures on which any one of the following exists:

a. failure to pay Real Estate Taxes on the property for three years or more;

or

b. failure, within the insured's control, to furnish heat, water, or public lighting for thirty (30) consecutive days or more;

or

c. failure within a reasonable time to correct conditions dangerous to life, health, or safety;

G. Provided that a risk shall not be declined for neighborhood or area location or any environmental hazard beyond the control of the property owner;

I. Where the applicant is indebted to an agent, broker, or company for the type coverage being sought;

J. The right to apply by endorsement in accordance with the waiver provisions of the statutory standard fire insurance policy of the state of Rhode Island a "Modern Materials" provision which would permit repairs with modern materials, not necessarily those of like, kind, and quality provided that the structure's integrity, utility, and value are not impaired.

Applicants or properties which violate any of the above "underwriting standards" are ineligible or uninsurable through the Rhode Island FAIR Plan.

Inspections

A. Any person having an insurable interest in real or tangible personal property at a fixed location in Rhode Island is entitled to an inspection of the property without cost.

B. Upon receipt of the application, the property may be inspected and rated.

C. Inspections will generally be made in the company of the property owner or their representative. The inspector must be provided full access to the building.

D. An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photocopy of the inspection report will be made available to the applicant or agent upon request.

****

To: Producers and Companies

From: W. C. Freitag, Manager, Minnesota Property Insurance Placement Facility
12 South Sixth Street, Room 1229
Minneapolis, Minnesota 55402

Date: May 15, 1973

Re: Minnesota FAIR Plan "Depopulation"

The Governing Committee of the Plan is aware that there are a number of properties insured through the FAIR Plan which should be afforded coverage outside the Plan.

A procedure to provide "depopulation" of the Minnesota FAIR Plan has been discussed by the committee with the Minnesota Insurance Department and representatives of the state agents' associations, with the result that the following is to become effective immediately.

1.a. An Expiration Notice for a policy written through the Minnesota FAIR Plan, will be sent to the producer of record by the Placement Facility 75 days prior to the policy expiration date. Each such Expiration Notice will be accompanied by a Special Note which will state that the procedure described herein is to be followed.

b. Any producer having FAIR Plan policies in his book of business should make a strong effort to place the coverage outside the FAIR Plan in the succeeding 30 days. This will be the period after the producer's receipt of the Expiration Notice and prior to 45 days before the expiration date.

2.a. If the producer of record is successful in placing his business outside the FAIR Plan, a notation must be made on the FAIR Plan Expiration Notice indicating coverage is placed elsewhere. This expiration form with the notation must be sent to the facility promptly.

b. If the producer of record is not successful in placing his business outside the FAIR Plan before 45 days prior to the expiration date, the application form attached to the Expiration Notice must be completed and sent to the facility in order that it can be processed. It is essential that the policyholder be assured of coverage at all times in this procedure.

3. Each week the Placement Facility will make available to licensed producers and companies, at the facility office, a list of policies which expire 45 days following their appearance on the list. The list will contain the name and address of the insured, address of the insured property, class of property (habitational or commercial) and the expiration date of the policy.

4. Any producer which selects one or more of the properties on the facility list is expected to make a strong effort to place such business outside the FAIR Plan. If this is accomplished, the facility must be notified of this action not less than 30 days prior to the FAIR Plan policy expiration date.

NOTE: Insurance Commissioner B. W. Heaton has indicated that if a producer selects a property from the facility list and places coverage outside the FAIR Plan, the new insurer must retain the business for not less than one year. This is to avoid the possibility of any such new insurer cancelling this newly acquired business and returning it to the FAIR Plan.

****

APPENDIX C

To: Producers

From: W. C. Freitag, Manager, Minnesota Property Insurance Placement Facility
12 South Sixth Street, Room 1229
Minneapolis, Minnesota 55402

Re: "Depopulation" of the Minnesota FAIR Plan

In line with the "Depopulation" program announced to you in our letter of May 15, 1973, this is notice to you that the procedures stated in our letter are in effect for the property insurance indicated in the attached Expiration Notice.

1. You now have 30 days in which you should make a strong effort to place this business outside the FAIR Plan. If you are successful, please make such a note on the Expiration Notice and send it to the facility.

2. If you are not able to place this business outside the FAIR Plan, the application should be completed and sent, together with the Expiration Notice, to the facility not later than 45 days prior to the expiration date.

To: The NAIC Property and Casualty (D) Committee

From: Alliance of American Insurers
20 North Wacker Drive
Chicago, Illinois 60606

Date: June 7, 1979

Re: The Proposed Amendment to the Unfair Trade Practices Act and Regulation Adopted by the NAIC Redlining Task Force

The Alliance is deeply concerned that any redlining proposal adopted by the NAIC offer an effective, practical solution to the problem without adverse consequences to the public and insurance industry. To this end, we have worked with the Advisory Committee to the NAIC Redlining Task Force since its inception. The Alliance strongly supports the recommendations of the Advisory Committee as a positive, practical and effective response to the practice of redlining. We oppose the proposals of the NAIC Redlining Task Force, which are vague, overly broad and not specifically responsive to the redlining problem.

The recommendations of the Advisory Committee offer specific and concrete remedies to the practice of redlining. The Advisory Committee amendment to the NAIC Unfair Trade Practices Act prohibits, as a general business practice, the refusal to issue, nonrenewal or cancellation of personal lines insurance coverage because of the geographic location or age of the risk. An individual, victimized by redlining practices, is given specific redress through the provisions of the NAIC Property Insurance Termination, Declination and Disclosure Model Act. This proposal restricts the termination or declination of a subject insurance policy where such action is based upon the race, religion, nationality, ethnic group, age, sex or marital status of the individual. Also, specific reasons for declination or termination must be provided to the individual.

In the view of the Alliance, the Advisory Committee Recommendations present the best chance for the swift enactment of legislation dealing with the redlining problem. The Advisory Committee proposals were developed by a broad-based group reflecting consumer, agent and industry interests. The committee recommendations enjoy support from these diverse groups. In addition, the recommendations avoid the serious deficiencies which have caused strong and widespread opposition to the proposals of the NAIC Redlining Task Force. If the states are serious about addressing the redlining issue legislatively, adoption of the Advisory Committee recommendations greatly improve the political feasibility of enacting such legislation because the committee's legislative proposals are acceptable to diverse interest groups.

The NAIC Redlining Task Force proposals present serious deficiencies which merit their rejection in favor of the Advisory Committee recommendations. As a result of these objections, the Alliance joins the Advisory Committee and other groups in expressing strong opposition to the recommendations of the NAIC Redlining Task Force.

In contrast to the specific remedies proposed by the Advisory Committee, the task force proposed amendment to the NAIC Unfair Trade Practice Act is a vague, overly broad, statutory provision which shifts the original focus of regulation from the specific practice of "redlining" to purportedly "address all forms of unfair discrimination in property/casualty insurance underwriting." It would make unlawful any act of an insurer: "(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards on the issuance, renewal, cancellation or limitation of any property or casualty insurance coverage."

The task force proposal would apply to single violation rather than a "general business practice." Also, while the expressed concern over redlining dealt with personal coverages in the inner city, the proposed amendment would apply to all personal and commercial forms of property and casualty insurance.

The most serious objection to the task force general amendment is that it does not specifically address the issue of insurance redlining. This is of particular concern to nonindustry groups on the Advisory Committee. The task force language about "risks of the same class and essentially the same hazards" may be confusing in its similarity to language concerned with discrimination in rating classifications. It is possible that this general amendment may be incorrectly interpreted as not providing authority to deal with specific redlining practices.

The general amendment to the NAIC Unfair Trade Practices Act proposed by the task force is subject to serious legal objection. A number of Alliance lawyers looking at the task force language tell me that it could be struck down by the courts as unconstitutionally vague. This result is due to the fact that an insurer reading the statute cannot know what acts might subject it to serious penalties for "unfair discrimination." It should be clear to even nonlawyers that the vagueness of the task force proposal will foster a lot of expensive litigation for all concerned before we can begin to know what it means.

The breadth of scope of the task force general amendment appears to mandate that regulators maintain close and exacting surveillance of all of an insurer's underwriting decisions to determine if "unfair discrimination" is taking place. Without specific standards in the legislation to guide a regulator's discretion, his responsibility requires department scrutiny of every underwriting decision. As a practical matter, such a responsibility cannot be adequately met by regulators without vast increases in staff and budget. The Advisory Committee recommendations, in contrast, are directed at specific redlining practices and provide feasible standards and tools of regulation.

The Alliance shares the concern of Advisory Committee members that the broad scope of the task force general amendment brings into question other areas of the insurance business with possible consequences that were never really considered by the task force or Advisory Committee. For example, the phrase "limitation of coverage" is uncertain. We don't know how this phrase would affect territorial rating plans or the introduction of alternative homeowners forms. These new policies are being developed to address the problem of disparity between the market value and replacement costs of older homes.

A great concern of the Alliance and of insurance industry in general is that the task force general amendment unnecessarily restricts the concept of individual underwriting, which is the very heart of the business of insurance. The vagueness of the amendment's proscriptions will, at the very least, have a "chilling effect" on legitimate underwriting.

The importance of sound underwriting to insurer solvency has been recognized by the NAIC and eloquently expressed in your amicus brief in the case of St. Paul Fire and Marine Insurance Co. v. David Barry, M.D. It was there stated:

> Implicit in the underwriting process of risk assessment is the insurance company's prerogative not to insure particular risks. This prerogative exists to protect the insurance company against the phenomenon of 'adverse selection':
>
> > Whenever a large group of potential insureds are treated alike irrespective of some factor that differentiates them as insurance risks, a disproportionately high percentage of applications for such insurance trends to come from the less desirable applicant because they got the better bargain.

> Since there will always be selection in insurance, the only question which must be answered is whether the selection will be done by the insurance company or by the insurance buyer. In the absence of massive government subsidies to insurers, the only feasible answer to this question is to allow insurance companies to be selective in choosing the risks which they wish to insure; otherwise coverage would be provided at a loss – a result which would ultimately lead to either the financial impairment of insurers or a broad-scale unwillingness of insurers to write only business, i.e. insurance unavailability. (emphasis added).

While the task force was charged with addressing the problem of redlining, the broad general amendment will cast doubt on legitimate underwriting decisions in all lines of property and casualty insurance.

The vagueness of the standard for regulation of underwriting practices contained in the task force general amendment may lead to regidities in underwriting detrimental to insurance consumers. Fear that individualized selection decisions may be characterized as "unfair discrimination" may lead companies to adopt and follow rigid, easily defended underwriting policies. Underwriting judgment, however, often favors the insurance applicant. A seasoned underwriter may accept a risk, in an exercise of judgment, which would be rejected under a rigid formula. The Advisory Committee proposals maintain underwriting flexibility while curbing arbitrary redlining practices.

Another serious problem of the task force general amendment is its unfairness in penalizing individual acts rather than a general business practice of redlining. The most responsible agent and insurer could be subject to serious fines and other penalties due to the single, inadvertent act of an inexperienced employee. The NAIC recognized this unfairness when it placed a "general business practice" qualification in the NAIC Model Unfair Trade Practice Act. The Advisory Committee avoids this unfairness by also including the "general business practice" clause in its proposed amendment.

In conclusion, the Advisory Committee recommendations provide specific, effective remedies to arbitrary redlining practices without imposing unrealistic duties on regulators, unfair penalties on insurers, or unduly restrictions upon underwriting flexibility. The Alliance strongly urges the NAIC to adopt the recommendations of the Advisory Committee and to reject the proposals adopted by the NAIC Redlining Task Force.

****

To: The Property and Casualty (D) Committee

From: Jeffrey M. Yates, General Counsel
Independent Insurance Agents of America, Inc.
85 John Street
New York, N.Y. 10038

Re: Recommendations of the NAIC Redlining Task Force

Date: June 7, 1979

My name is Jeffrey M. Yates and I am General Counsel of the Independent Insurance Agents of America, Inc., (IIAA). IIAA is a national association representing approximately 125,000 independent property-casualty agents throughout the United States, as well as fifty state independent agents associations, plus the District of Columbia, and over 1,200 local associations.

Recognizing that redlining severely limits availability of insurance which results in the decline of neighborhoods, IIAA has consistently opposed redlining practices.

IIAA heartily applauds those companies which have addressed the redlining problem by encouraging agents to forward applications for insurance from inner city areas. This position is a change from past practice and is a step in the right direction. However, the key to resolving the redlining problem is the appointment by companies of more agencies in the inner city area. For example, Boston has approximately 200 brokers located in or near the inner city area, who do not have any company affiliation and who would be more than willing to service an inner city area for a company. With more agents representing companies in the inner city areas there will be a large scale increase in the availability of insurance in the inner city areas. It is also important to realize that agents in the inner city will not be able to survive writing just property insurance, but must be given the opportunity to write automobile insurance and other coverages for their companies as well.

With regard to the proposed legislation before you, our association has great concern about certain provisions of the proposed NAIC Property Insurance Declination, Termination and Disclosure Model Act that make it impossible for us to support that bill in its current form. We are deeply concerned about how Section VI C, imposing civil liability on agents and brokers, will work in actual practice. This provision allows a prospective applicant who was denied insurance in violation of the act to seek indemnification from the agent for the loss which would have been insured had the policy not been terminated or declined.

In practice, we believe this provision will invite frivolous suits by applicants whose insurance is turned down for whatever reason, putting an impossible burden on the agent who is not in a financial position to defend against a series of these suits, nor to assume the position of an insurer of such losses. The provision would invite a suit in any case where an applicant has been turned down for insurance for whatever reason and subsequently incurs a loss which is not insured because the individual did not follow up and attempt to secure insurance from another source. Since such a suit would be based upon alleged intentional acts, the agent's errors and omissions coverage would not protect him. This new liability could drive existing agents in inner city areas out of business, leaving even fewer sources for insurance in depressed areas.

Equally troubling is that this act could subject the agent to civil liability for turning down business that is outside the market area in which he does business. He may not have the personnel to inspect a piece of property, as may be required by the company, or to properly service the insured, if the property is located a great distance away from his place of business.

In addition, the loose wording of the section invites further abuse. If a prospective applicant is turned down for insurance from a source, what obligation does he have to mitigate his damages by making a reasonable attempt to effect insurance through another agent or company within a reasonable time after his original application is declined? As the section is currently worded, the applicant could be turned down once for insurance; do nothing further; pay no premium; and then receive indemnity if he has a loss. We believe this is totally unfair. In addition, as the provision is currently worded, there could be civil liability even if there has been an innocent violation of the act – it is not limited to "willful and knowing" violations.

We just do not believe this indemnification provision will work. On the contrary, it could have a devastating effect on existing insurance agencies in inner city areas who are not in a financial position to defend against a series of such suits – which will be brought no matter what the reason for the declination is if the property owner suffers a loss – nor, in a position to assume the position of an insurer of such losses. We believe the other sanctions provided in Section VI of the act providing up to $5,000 fine for violation of the act will fully protect the public against demonstrated cases of redlining as far as agents and brokers are concerned. Accordingly, we strongly believe Section VI C, the civil liability section, should be deleted, at least insofar as it applies to agents or brokers.

Our members are also troubled by Section VI B(2)(b) which provides for up to a $500 fine for any violation of the act and believe it should be deleted. This section should be stricken because it would penalize a party for mere errors or inadvertence resulting in unintentional violations of this act. A fine should only be imposed upon a showing of a willful and knowing violation which is covered in Section VI B(2)(c).

We also believe Section III of the act providing for procedures for notification of declination and termination should be amended. This provision fails to consider the practical aspects of the agent's business. Commonly, when an applicant is turned down by a company the agent will attempt to place the prospective insured with another company. Under this provision the company must inform the applicant directly of the adverse decision rather than through the agent. This would cause confusion, embarrassment and erode the applicant's confidence in the industry, if at the time the original company turns him down, the agent successfully places the applicant with another company. The language should be amended so that the company informs the agent of the adverse decision, and the agent informs the applicant if he is unable to place coverage. I have attached our proposed revision of Section III A to the copy of the comments submitted to you.

With respect to the proposed general amendment to Section 4(7) of the Unfair Trade Practices Act and accompanying regulation, IIAA believes that the broad scope of this regulation could be used to restrict the companies' ability to underwrite. The ability to underwrite is an important aspect of competition and should be maintained. Accordingly, this amendment should be revised in order to address insurance redlining practices specifically.

I respectfully urge you to consider IIAA's suggested revisions to the NAIC Property Insurance Declination, Termination and Disclosure Model Act and to the proposed general amendment to Section 4(7) of the Unfair Trade Practice Act and accompanying regulation. We appreciate this opportunity to submit our views on this matter.

****

IIAA Suggested Additional Paragraph to Section III A of the Proposed NAIC
Property Insurance Declination, Termination, and Disclosure Model Act

In the event of a declination by an insurer of a risk submitted by an agent or broker on behalf of the applicant, the insurer shall provide the agent or broker with an explanation of the reasons for the declination, in writing if requested by the agent or broker, and the agent or broker shall submit this explanation to the applicant in the event the agent or broker is unable to effect insurance for the applicant through another insurer, in writing if requested by the applicant.

****

To: The Property and Casualty (D) Committee of the NAIC

From: Gregory D. Squires
U.S. Commission on Civil Rights
230 S. Dearborn St., Room 3280
Chicago, Illinois 60604

Date: June 7, 1979

Re: Proposed Model Unfair Trade Practice Amendments to Prohibit Redlining

Substantial progress has been made toward resolving the issue of insurance redlining in recent years. One reason for that progress is that the various parties to the debate have begun sitting down and talking to each other, and trying to understand each other's interests. Neighborhood groups have become extremely sophisticated in their knowledge of the insurance industry, and sensitive to the concerns of that industry. At last a substantial minority of insurers have demonstrated a genuine desire to eliminate unavailability problems. Several companys, agents, and trade associations have launched activities in serious attempts to do so. As evidence of the greater communication and cooperation which has occurred, and one of the clearest signs of progress is the fact that community groups, regulators, and insurers all agree first, that there is a serious problem of insurance redlining and secondly, that there is a need for an amendment to the NAIC model unfair trade practices act or comparable legislation to eliminate the redlining problem.

Differences remain, however, in the precise language of such an amendment. I fully support the Advisory Committee's rejection of the general, broad-in-scope approach taken by the Redlining Task Force and in the committee's preference for an amendment that addresses geographic discrimination directly. But there is a major defect running throughout all the proposed amendments and bills. That defect is the inclusion of the phrase "unless (the prohibited practice in question) is for a business purpose which is not a mere pretext for unfair discrimination." By including such language this legislative approach amounts to little more than fitting regulations comfortably around current practices rather than curtailing certain abusive practices. What is called for is a model law which expressly prohibits specific redlining practices.

The basic defense of the current proposals by some members of both the task force and the Advisory Committee is that they provide commissioners with authority most currently do not have to investigate redlining charges and to determine within the limits of their authority and discretion to take what they see as appropriate action. The industry is concerned that a vague amendment which does not specify precisely what is unfair discrimination may result in some commissioners attempting to exercise more authority than was intended by the act to the detriment of the industry and the public. On the other hand some nonindustry observors are concerned about the lack of independence of some commissioners in relation to the industry and the possibility they will use their discretion not to act at all. While it is true that in some states community groups have organized and have been able to exercise some influence on regulatory activities, in general the industry is far more effective in communicating its perspective with public officials. To rely on community group pressure as a check on recalcitrant regulators is inadequate particularly when confronted with a well paid, knowledgeable, ever

present army of industry lobbyists. The solution to this problem is to minimize the extent to which commissioner discretion will affect the regulatory effort. In other words, specify what the prohibited practices are, what sanctions are available to the regulator, and what remedial actions can be ordered.

The industry has a right to know specifically what it can and cannot do. The public also has a right to know precisely what kind of activities are prohibited. If there are to be any exemptions from generally prohibited practices, these should be individually and expressly stated. The vague exemption for a "business purpose" raises serious questions about the intentions and credibility of the authors, and it does so needlessly. This language should be eliminated. In virtually every discussion of what legitimate business purposes can be served by permitting geographic discrimination, the same ones come up time and again, and they are purposes that even most industry critics would accept! The basic industry concerns are that: (1) specialty companies not be required to suddenly write property insurance in inner city markets if they have never written such business before; (2) no insurer be overexposed to a particular risk or in a particular market; and (3) no insurer be required to assume a risk near a natural hazard that could result in a catastrophic loss. Such exemptions could easily be specifically written into a model unfair trade practices amendment.

In our report, "Insurance Redlining: Fact, Not Fiction," we offered two versions of a proposed model unfair trade practices amendment. Attached to this statement is the appendix of that report which contained this language. It is language which the Advisory Committee and task force has seen and rejected. We urge you to consider the above comments and the draft proposals in your deliberations.

Even a strong unfair trade practices amendment would represent but one step in an overall effort to eliminate redlining. Some states, of course, have already enacted such legislation. Others are considering creation of a reinsurance facility, the establishment of a single rating territory for the entire state, affirmative marketing requirements, and other approaches. So far the NAIC has chosen to take no official action on what has been a controversial public issue. For the NAIC to acknowledge what is now generally recognized as a social reality, that redlining is unfair, would represent one small but important progressive act.

I believe the members of the Advisory Committee and the Redlining Task Force are genuinely committed to the elimination of redlining, and are making good faith efforts toward that end. But for the vast majority of consumers, and particularly those who live in redlined neighborhoods who have not had the opportunity to work closely with these individuals, the proposals under consideration will raise serious questions regarding the integrity of the NAIC and the insurance industry itself, one which by its own admission already has serious public relations problems. Furthermore, the NAIC's dilatory conduct in finalizing a model redlining amendment means that more and more states are enacting their own versions of anti-redlining legislation. Rather than being a leader in the area, the NAIC is quickly placing itself in a catch-up position.

Current proposals being considered by the NAIC are not credible responses to insurance redlining. They are a slap in the face to the victims of the practice. If these proposals represent the best results of 18 months of study by the nation's top insurance law enforcement officers working in close cooperation with the insurance industry, we can expect a flood of litigation and federal legislation if not outright federal regulation, in the near future to end insurance redlining.

****

Appendix

Recommended Model Unfair Trade Practices Amendments

Section 1

1. It is an unfair trade practice for an insurer of residential property (i.e., one to four family dwellings) and, unless otherwise stated, of personal lines auto to:

(a) vary the availability of insurance products or services because of the age of the residential property risk;

(b) refuse to insure a risk because an individual was previously denied insurance by another insurer;

(c) ask in an insurance application whether or not an applicant was previously insured in an involuntary market plan. This subsection shall not be interpreted to preclude an insurer from asking the name of the previous insurer in an insurance application;

(d) refuse to insure a risk because an individual was previously insured in an involuntary market plan;

(e) fail to state the precise reason for an insurer's decision to decline, nonrenew, or terminate an insurance policy;

(f) fail to state prior to issuing a notice of termination or nonrenewal or at the time of issuing a notice of declination what corrective action, if any, the applicant or insured must take in order to obtain insurance;

(g) fail to reinspect a risk, upon request of the applicant or insured, where an inspection report has been used in part or in whole to decline, nonrenew, or terminate a residential property insurance policy;

(h) refuse to renew policies placed by an agent or broker if the insurer terminates its contract with the agent or broker for one year from the date of termination of the insurer's contract with the agent or broker;

(i) fail to provide an applicant or insured, upon request, with any information the insurer has received on that individual, the source of the information, the names of all organizations and individuals with whom the insurer has shared the information, and the opportunity for the applicant or insured to correct or delete any incorrect information or to add a statement indicating his or her disagreement with any information;

(j) fail to correct or delete any incorrect information of which the insurer has knowledge and which the insurer is maintaining in the applicant's or insured's records or on which the insurer has in part or in whole based an adverse underwriting decision.

Section 2

2. It is an unfair trade practice for an insurer of residential property (i.e., one to four family dwellings) and of personal lines auto to refuse to insure or refuse to continue to insure, or to limit the amount or type of coverage available to a risk or to require special facts as a condition to acceptance or renewal of such insurance because of the geographic location of the risk, unless

(a) such insurer not less than sixty (60) days previous to such refusal or limitations shall have filed with the commissioner:

1) a written concentration of risk plan which the risk exceeds. Such a plan shall be applied by the insurer uniformly across all geographic areas in the State;

2) a written statement limiting its business to specific counties in which the risk is not located;

3) a written statement that, with respect to the geographic location, a natural hazard exists which would subject the insurer to an extraordinary loss exposure;

provided, that such filings shall be based on credible data and the standards and practices shall not be arbitrary or unreasonable; or

(b) the risk is located close to a particular and immediate hazard. The insurer's standards and practices in regard to such hazard shall be applied uniformly throughout the state; provided, that such standards and practices shall not be arbitrary or unreasonable.

****

Regulations Under Section 2 of the Recommended Unfair Trade Practices Amendments

Conduct which constitutes unfair trade practices under Section 2 of the Unfair Trade Practices Amendments and is prohibited by these regulations. (These regulations are intended to supplement Section 2 of the Unfair Trade Practices Amendments. If Section 1 is also enacted into law, Regulations 1a through h, below, become redundant and should, therefore, not be promulgated.)

1. Varying the application of any or all of the following standards and practices because of geographic location:

   a. Age of the risk;

   b. Previous denial of coverage or termination by another insurer;

   c. Use of insurance application questions concerning whether the applicant was previously denied coverage or was terminated by another insurer;

   d. Previous coverage under an involuntary insurance plan;

   e. Use of insurance application questions concerning whether the applicant was previously covered in an involuntary insurance plan;

   f. Statement to applicants and insureds of the reasons for insurer's declination, termination, or nonrenewal of an insurance contract;

   g. Statement to applicants and insureds before issuing notices of declination, termination, or nonrenewal what corrective action, if any, the applicant or insured must take to obtain or continue coverage;

   h. Requiring inspections or ascertaining the accuracy of inspection reports on which a decision to decline, terminate, or nonrenew an insurance contract is based;

   i. Services including but not limited to the speed with which claims are settled, access to information about insurance availability, inspections where required for obtaining or continuing insurance, terms of premium payment;

   j. The use of deductibles;

   k. Appointing or terminating a contractual relationship with an agent or broker.

2. Refusing to enter into or continue a relationship with an agent or broker because of the geographic location of the agent or broker or because of the geographic location of agent's or broker's business.

****

To: The Property and Casualty (D) Committee

From: Hans Dieter Meyer

Date: June 7, 1979

Re: Consumer Statement

My name is Hans Dieter Meyer; I am a Lawyer, insurance expert and "consumerist" from Hamburg, Germany. I have observed the procedures in the insurance field of the USA for about three years by reading the National Underwriter, studying in the Library of the High School of Insurance in New York and taking part in several meetings. Let me say, the problems of insurance are international.

You are talking about insurance as a "product," which companies "produce" and agents "sell" to the consumers for the premium as a "product price." The payments for losses shall be costs and the premium shall be priced according to the "economical theory of cost based pricing." Classification of risks and insureds shall be possible according to "statistical group criteria." The "insurance industry" shall be "competitive structured." The commission of the agents shall be a certain percentage of "product-price" (the premium). Regulation shall be restriction of competition and of the free enterprise system.

Let me give you some generally accepted definitions of all that you are talking about:

Insurance is common provision of money by the insureds with a view of a common loss pooling. Thus insurance is the economic performance of the group of insureds (like saving) but not a product of a company.

Economical and legal theories and the National Underwriter accounts say that insurance is no product, because the losses are paid with extraneous money. The companies only bring forth a service to achieve insurance as a performance of the insureds in an efficient way (like banks do for saving.)

You say, the premium is a price for a product insurance. Economical and legal theories say a price can only be quoted for a product or a service, according to the calculation of costs and profits. Since insurance is not a product and only a certain part of the premium is for the expenses of the companies' and agents' services, the premium must be broken down in the contribution for loss pooling (that is the money of the insureds) and a price for the companies' and agents' services (like banks do, separating the consumers' money and their fees).

You say the payments for losses are "costs." The definition of costs says, costs are payments for the employment of work and material to produce a product or a service. According to this the payments for losses are no costs, because they are distributing the insured's money provided for the common loss pooling. It is the same procedure like the paying out of money to the savers by banks. These payments are not costs, either -- only extraneous money is employed. This money is not created through the companies by the employment of work or material. Thus the payments for losses are neither a product nor a part of it.

You say the premium can be priced according to the economical theory of cost based pricing. This economical theory says it cannot, because the payments for losses are no costs. Only the services of the companies for collecting, administrating, investing and distributing the insureds' money can be priced according to the economical theory of cost based pricing, because only for these services own work capacity and material are employed by the companies and agents. But a price for the services of the companies and agents is not quoted!

You say the insurance industry is "competitive structured." The definition of competition says it isn't. The primary prerequisite of competition is, that performances are described and prices are quoted. Since the performances of the companies and agents – their services – are not described and prices are not quoted, there cannot be a competitive structure in the one and only competition area of the insurance field. Insurance as a performance of the insureds, as common loss pooling, as common saving for mutual help, is no area for competition. No one can be so foolish as to believe that competition in this sphere could reduce the payments for losses or can have any other economical effects. But through the teaching of insurance and services, a wrong "competition" takes place in this area, which leads to the well known selection fight for good or clean risks. Thus the classification of the individual risk was replaced by the selection of risk groups.

You say, classification can be done according to statistical group (selection) criteria, but it cannot. According to the social idea of insurance as mutual help, classification must be a generally accepted principal of insurance to achieve a fairness of contributions as far-reaching as possible by establishing contribution classes for particular risks with homogeneous risk and danger criteria. Risk and danger criteria as classification criteria can be only those characteristics which influence damage and loss and which can be ascertained definitely for the particular risk. But statistical group criteria do not have any influence in damage and loss.

You say the commissions of the agents can be priced as a percentage of the premium. By this you allow commission differences of more than 1,000% for the same procedure. The economical theory of cost based pricing says this is wrong! – A service can only be priced according to the costs, the employment of work and material.

You say, regulation of insurance is restriction of competition and of the free enterprise system. All legal and economical theories say that insurance as a performance of the insureds cannot have anything to do with competition and profit-making – like the saving. Only the companies' and agents' services are a competition area and should be kept off from state regulation by dividing the premium.

This is not a vision. This is already reality in the Japanese automobile insurance, where uniform premiums and commissions are enforced and selection fight is hindered by allowing the companies to keep a certain percentage of the premium for their expenses. But 100% of the net premium must be "reinsured" by the state, which gives the money back to the companies according to their loss payments. Thus the financial interest of the companies in the insureds' money, loss pooling and selection is avoided and full insurance availability achieved.

This is not nationalization of the "insurance industry." This is only the adaptation of the procedures in the insurance field to all legal and economical theories and to the National Underwriter accounts. The banking sector, for example, never complained that since our legal and economic system does not allow banks to take in the money from their customers' accounts as profits at the end of the year, the banking industry was nationalized.

Through the issuing of insurance as a performance of the insureds and the companies' services and through the undivided premium, there are a lot of misunderstandings with far-reaching consequences, especially for the consumers who suffer unequal treatment socially and financially. The more the NAIC tries to achieve premiums for the individual insured, the more the selection fight of the companies and discrimination of the insureds increases and automobile and FAIR Plans become more and more populated. Finally the companies will accept only risks which will not suffer losses according to their statistics.

Let me say that you are at the end of a dead end street and running in a circle. You must go back to the cross roads, investigate the basis of insurance, separate insurance and regulation on the one hand and companies's services and competition on the other hand. That requires separating the premium and keeping the financial interests of the companies away from the insureds' money for loss pooling. Only in this way will you establish a competitive structure, a free enterprise system and competition as to the services in the insurance field. Only in this way will you solve the already hundred years old problems of insurance.