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[New Rights; New Responsibilities - How Federal Health Standards
Have Impacted State Health Insurance Markets](#)

By Wayne B. Cotter, New York Department of Insurance

This article is reprinted by permission from the March/April 1998 issue of The Bulletin, a newsletter published by the New York Department of Insurance. The article discusses the implementation of the Health Insurance Portability and Accountability Act.

[HMO Regulation Update](#)

By NAIC Staff

This article provides a brief update on current regulatory issues that affect HMOs. Included in the discussion is information regarding 1997 annual financial data collected on the NAIC financial database, annual financial reporting formats, guidelines and education, and a Managed Care Organizations Risk-Based Capital update.

[NAIC Update: Financial Database Re-engineering \(FDR\)](#)

By Denise Lozano (NAIC/SSO)

This article provides an update on the Financial Database Re-engineering (FDR). The FDR project, which began as the Annual Statement Re-engineering (ASTR) project in May 1996, was initiated to resolve database concerns.

[The NAIC Insurance Regulatory Information System](#)

By NAIC Staff

A summary of the NAIC Insurance Regulatory Information System (IRIS) ratios and the uses for the IRIS results are discussed in this article. Tables are included that provide statistics from the 1997 IRIS results.

[A Demonstration of Market Concentration Measurements Using
Automobile Insurance Markets](#)

By Davin Cermak (NAIC/SSO)

This article employs auto insurance market data to examine four common measures of market concentration: concentration curves, the Lorenz curve/Gini coefficient, concentration ratios, and the Herfindahl Index. Concentration curves and Lorenz curves present a visual representation of the market concentration. Concentration ratios and Herfindahl Indices provide numerical data for examining market concentration.

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The views expressed in these articles do not necessarily represent the view of the NAIC members, individually or collectively.

New Rights; New Responsibilities

How Federal Health Standards Have Impacted State Health Insurance Markets

by Wayne B. Cotter, Director of Research, New York Department of Insurance

Editor's Note: The following is reprinted by permission from the March/April 1998 issue of The Bulletin, a news letter published by the New York Department of Insurance.

The Health Insurance Portability and Accountability Act, enacted in 1996, is currently being implemented throughout the country. In February 1998, the U.S. General Accounting Office (GAO) issued a report, "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators" (GAO/HEHS-98-67) that addresses the strengths and weaknesses of the Act and assesses its initial impact on the states. The following article summarizes some of the major findings of that report, discusses the Act's impact on New York and other states, and clarifies how the federal Act interweaves with existing New York State Law. The article should not be used as a replacement for the full text of either the federal or state law.

Although the Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, introduced several important safeguards into the health insurance marketplace, its impact has varied considerably from state to state. In some states, relatively few statutory changes were needed to implement the new law because similar protections had already been in place.

In New York, for example, open enrollment, community rating, and portability laws¹ were enacted in the early 1990s in the small group and individual marketplace. A few years later, Governor Pataki signed into law legislation that mandated that all New York State HMOs offer comprehensive coverage to individuals.²

Other States that had not addressed the issues of access, portability and renewability in the health insurance marketplace needed far more detailed legislation in order to conform to federal standards, while some states have yet to pass conforming legislation.³ In these states, the Department of Health & Human Services (DHHS) must actively regulate health insurance plans, including policy forms, monitoring insurer practices, handling consumer complaints and imposing disciplinary actions, to ensure compliance with HIPAA.

Contrary to popular perception, HIPAA does *not* require all health insurers in the individual market to offer coverage to all applicants, but it does mandate that insurers in the individual market write any individual who loses his or her group coverage and meets all other eligibility criteria, a requirement often referred to as "group-to-individual guaranteed access." The group-to-individual mandate has not presented major difficulties in states that chose to implement the mandate through an "alternative mechanism" approach (such as New York), but has presented some severe affordability problems in many of the 13 states that adopted the "federal fallback" approach.⁴ This is why the impact of HIPAA reforms has varied so widely from state to state.

New York's health insurance reform efforts over the past few years have focused on the individual and small group markets. Because so many large employers choose to self-insure,⁵ a sizable percentage of large group members are unaffected by any statutory changes initiated by the states. The federal government, however, is in a position to mandate basic protections to insureds in small and large groups—both self-insured and fully insured—and create a level playing field.

For example, HIPAA does not permit any small or large group plan, including self-insured plans, to exclude any member of the group from coverage based on that individual's health status or medical history, nor does it allow any group plan to charge one enrollee more than another similarly situated enrollee based on factors such as health status or medical condition. These requirements ensure that self-insured enrollees are provided the same nondiscrimination protections as fully insured enrollees.

Basic Health Insurance Protections, U.S. & N.Y., by market, 1998						
	Individual		Small Group		Large Group	
	U.S.	N.Y.	U.S.	N.Y.	U.S.	N.Y.
Guaranteed Access	No ^a	Yes ^b	Yes	Yes	No	No
Guaranteed Renewability	Yes	Yes	Yes	Yes	Yes	Yes
Limitations on Pre-Existing Condition Waiting Periods	No ^c	Yes ^d	Yes ^d	Yes ^d	Yes ^d	Yes ^d
Credit for Prior Coverage	No	Yes	Yes	Yes	Yes	Yes

^a Only group-to-individual guaranteed access is mandated under HIPAA. HIPAA requires that at least two different coverage options be made available to eligible individuals. An individual is determined to be eligible if he or she (1) has had at least 18 months of prior group coverage with no significant gap (63 days or more) between termination of the group policy and the commencement of the individual policy; (2) has exhausted any Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) benefits or similar continuation coverage benefits; (3) is not eligible for any group coverage or Medicare or Medicaid; and (4) did not lose group coverage because of nonpayment of premium or fraud.

^b As of April 1, 1993, New York residents applying for individual health insurance coverage must be accepted, without regard to health status, at all times throughout the year by insurers in the individual market. As of 1/1/96, all health maintenance organizations operating throughout New York State must offer two standardized comprehensive managed care options to individuals.

^c A person eligible under group-to-individual guaranteed access would not be required to serve a pre-existing condition waiting period. All other individuals are subject to pre-existing condition waiting periods. Limitations on such waiting periods are those that have been established by the individual states.

^d For those without prior creditable coverage (see Endnote No. 6), no pre-existing condition waiting period can exceed 12 months. Those with full creditable coverage would not be subject to any new pre-existing condition waiting period. However, if an enrollee's previous plan did not cover a "category of benefits," such as prescription drugs, the new insurer could elect to apply a pre-existing condition waiting period for that category of benefits. Those qualifying under HIPAA's group-to-individual guaranteed access provisions would not be subject to such a waiting period.

The above table indicates some basic protections that apply in the individual, small group and large group markets in the U.S. and New York. As the table indicates, New York provides far greater protections for individuals than those required under HIPAA; however, it should be noted that the large group protections now available in New York for the fully insured and the self-insured were implemented as a result of HIPAA.

Guaranteed Access

In New York, every HMO must offer two standard plans to all individuals on an open-enrollment basis. Both plans include drug coverage, but one provides a point-of-service option which allows an enrollee to obtain treatment from a physician outside the plan for an increased co-payment. In contrast, HIPAA affects only those individuals who lose group coverage and meet all other eligibility requirements. The

small group market is the only market in which HIPAA offers guaranteed access to all prospective enrollees, which means that any health insurer in the small group market must offer its products to all small groups (New York has provided small group guaranteed access since 1993). Because large groups typically do not face the same access problems as small groups and individuals, they are not subject to the guaranteed access provisions of either HIPAA or New York State Insurance Law.

Guaranteed Renewability

Under HIPAA, all health plan policies, with limited exceptions, must guarantee renewals regardless of the health status or claims experience of the enrollees. Insurers that seek to withdraw from the market must submit a plan to the Superintendent of Insurance designed to minimize market disruptions, must provide at least 180 days notice to policyholders, and are not

permitted to re-enter the marketplace for at least five years.

Limitations on Waiting Periods

Most states do not permit pre-existing condition waiting periods to exceed a certain time period, e.g., 12 months. HIPAA, however, does not impose such limitations on pre-existing condition waiting periods in the individual market (one important exception: those exercising their group-to-individual guaranteed access rights are not subject to pre-existing condition waiting periods). Thus, the state-mandated limitations have continued to apply in the individual market. In New York, this means that waiting periods in the individual market cannot exceed 12 months and that New Yorkers are not subject to such waiting periods if they had previous creditable coverage⁶ through another employer or group. Group insurance pre-existing condition waiting periods have been subject to the same limitations as New York's individual market since 1993, while limitations for self-insured groups (12 months except for late enrollees) were introduced as a result of HIPAA.

Credit for Prior Coverage (Portability)

Since 1993, individual and group policyholders have had portability rights in New York State, i.e., a New Yorker that has had previous coverage can receive credit for the time covered under the previous plan (thereby reducing or eliminating any new waiting period under the new policy). HIPAA provides similar protections for group policyholders, including the self-insured. Under both HIPAA and current New York State Law, a policyholder cannot receive credit for prior coverage if more than 63 days elapses between policies.

Summary & Conclusions

Although the large group, small group and individual health insurance markets share some common characteristics, the impact of the federal HIPAA reform efforts have varied widely from market to market. For example, guaranteed access and guaranteed renewability rights are far more meaningful to those in the small group and individual markets (where choices are limited) than to those in large groups where employers

typically can choose among many competing plans or self-insure.

The impact has also varied widely on a state-by-state basis. In the 13 states that chose the "federal fallback" approach to comply with HIPAA's group-to-individual guaranteed access mandate, some former group members (especially those with pre-existing conditions) are confronting hefty premium hikes. In New York, affordability problems persist, but the health care financing system—in which New York's HMOs are mandated to offer coverage to all individuals—spreads the risks associated with serious illnesses over a far more disparate mix of enrollees than the systems that exist in the "federal fallback" states.

HIPAA has provided new protections to millions of New York large group policyholders, while introducing more modest changes in the State's individual and small group markets. In the early-to-mid-1990s, market reforms in New York focused on the State's individual and small group markets, and New York still provides far broader guaranteed access and portability protections than HIPAA in the individual market. But in New York's large group market, few changes were introduced prior to HIPAA, primarily due to the proliferation of self-insurers in that market.

In states that lacked individual and small group protections, HIPAA has ushered in major changes. It is important to recognize, however, that HIPAA primarily addresses the *availability* of health insurance in a state's marketplace, not its *affordability*. Guaranteed access and other mandated protections generally enhance affordability for high-risk enrollees, while raising costs for other policyholders.

Lastly, it is essential that consumers and regulators fully understand this new federal legislation. Although consumers seem generally aware that federal health insurance legislation was recently enacted, misunderstandings are commonplace. For example, many believe all individuals are guaranteed access under HIPAA, while others—who are legitimately entitled to coverage under HIPAA's group-to-individual guaranteed access provisions—may be unaware of their rights under HIPAA. Since HIPAA provides a relatively narrow 63-day window in which to

exercise portability rights, it is important that accurate, timely information be conveyed to the public.

Moreover, the consumer services divisions of state regulatory agencies can now play a larger role in helping their residents deal with self-insurers. Self insurers have specific obligations under HIPAA and although these entities are unlicensed, a well-informed state consumer services staff is well positioned to provide meaningful assistance to state residents who encounter difficulties with their self-insurers.

Although HIPAA impacts millions of Americans, its provisions are not easy to understand or communicate. Thus, it is imperative that state insurance departments train their consumer services representatives on the nuances of HIPAA and how this new law interacts with existing state statutes. In addition, departments should make every effort to educate state residents about their rights under the new federal guidelines through publications, web sites, public service announcements, and other forms of communication.

Endnotes

¹ New York's open enrollment, community rating, and portability laws, which took effect in 1993, require all health insurers of small groups and individuals to offer products to any applicant regardless of age, sex, occupation or prior health history. Pre-existing condition waiting periods are permitted, but enrollees can receive credit for the time previously covered under other health plans. Rates do not vary by age, sex, occupation or prior health history.

² The legislation, which took effect January 1, 1996, requires HMOs to offer two standardized, comprehensive health insurance products, including a point of service option which allows enrollees to choose physicians outside the usual network of HMO physicians.

³ California, Massachusetts, Michigan, Missouri and Rhode Island had not enacted appropriate conforming legislation as of December 1997.

⁴ States have two options under HIPAA when implementing group-to-individual guaranteed access mandates. The majority of states have

opted for the so-called "alternative mechanism" approach, which allows them to establish high-risk pools or other mechanisms that ensure guaranteed access. New York qualifies as an "alternative mechanism" state because individuals are guaranteed access to the individual health insurance market through HMOs, whether or not they were formerly covered by group policies. Problems have arisen in the 13 states that have chosen the mechanism known as the "federal fallback" approach. Under this approach, individual health insurers are mandated to provide guaranteed access to individuals meeting the group-to-individual guaranteed access standards. However, many of these insurers have set premiums that are 140% to 600% above standard rates, while steering the healthiest applicants to other, more affordable plans. Such efforts appear to be in compliance with the new law, but have incurred the wrath of federal legislators, consumer groups and eligible state residents who have been priced out of the market.

⁵ An employer may provide group coverage to its employees by purchasing a group policy from a licensed insurance company (fully insured coverage) or by funding its own plan (i.e., self-insured coverage). Plans that are self-insured are under the jurisdiction of the U.S. Department of Labor (pursuant to the Employee Retirement Income Security Act of 1974 (ERISA)) and are not subject to state regulation.

⁶ In order to ensure that the plan for which an enrollee receives credit meets certain minimum standards, both HIPAA and New York State Law require that the previous plan meets the definition of "creditable coverage." The term is defined in both the federal and New York state statutes.

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HMO Regulation Update

by NAIC Staff

The regulation of health maintenance organizations (HMOs) continues to move forward at a fast pace. This article provides a brief update on current regulatory issues that affect HMOs. Included in the discussion is information regarding 1997 annual financial data collected on the NAIC financial database, annual financial reporting formats, guidelines and education, and a Managed Care Organizations Risk-Based Capital update.

Annual Financial Data Reporting

Data year 1997 marked the second year for HMO annual financial data to be added to the NAIC financial database. There were 402 HMOs added to the NAIC database for data year 1996, and to date 481 HMO annual statement filings were loaded to the NAIC financial database for the 1997 data year. This represents a nearly 20 percent increase in the number of HMOs filing with the NAIC from 1996 to 1997.

Tables 1 through 3 show aggregate amounts reported to the NAIC on the Assets, Liabilities and Income Statement pages of the 1997 HMO annual statement. This data was taken from the NAIC financial database and may contain reporting anomalies that have not yet been addressed or corrected. The aggregate data is not representative of the entire HMO industry since

not all HMOs file annual financial data with the NAIC.

Table 4 presents 1996 and 1997 premiums and number of HMOs filing with the NAIC. As a means of comparison, the number of domestic HMOs reported by state insurance departments at the end of 1996 is also included. The reported number of companies from the state insurance departments is taken from the *Insurance Department Resources Report*. This report is compiled by the NAIC, based on an annual survey that is completed by each state insurance department.

1998 HMO Annual Statement Changes

HMO staff members have been challenged by the continuing changes that have been made to the HMO annual statement blanks. The 1998 statement will again have several changes from the 1997 statement.

The major changes include:

- Investment Schedules A through DB have been added to the HMO statement. These schedules are consistent with the property/casualty and life/health annual statements. Previously the HMO annual statement contained only Schedule B for reporting all investments held at year-end. These schedules will allow detail information to be reported regarding the purchase or sale of investments throughout the year.
- New exhibits for reporting underwriting information have been added. This was done to capture data according to categories needed for the risk-based capital calculation. These exhibits include areas for reporting details of expenses incurred.

Education Programs

During 1998 the NAIC is offering two opportunities to attend educational workshops for those responsible for the preparation, analysis or auditing of HMO annual statements. The first opportunity will be August 17-19 at the Omni Parker House in Boston. The second is August 31-September 2 at the Hyatt Regency in Dallas.

In these three-day workshops the NAIC staff and insurance regulators will provide a complete "how to" preparation of the HMO annual statement, discuss statutory accounting procedures, and provide guidance on adapting to the new reporting format. This workshop is especially valuable since the 1998 HMO statement has undergone dramatic changes. Included in the training is instruction on the Risk-Based Capital for Managed Care Organizations. The workshops will begin on a very elementary level, but quickly progress to more complicated reporting and accounting issues.

A case study of a model company will be used to assist participants in tracking the flow of information throughout the annual statement. Participants are encouraged to bring a copy of their own company's annual statement for reference and comparison. This will be especially useful in determining where new procedures should be implemented to accommodate the 1998 reporting format. Examples in the case study will use the 1998 reporting forms. Participants will receive a copy of the 1998 HMO annual statement blank.

The insurance regulators who will be presenting at these workshops are Louis S. Felice, Principal Insurance Examiner for the New York State Insurance Department, and Jacqueline Gardner, CFE, FLMI, Chief Insurance Examiner at the Insurance Division Minnesota Department of Commerce. Special topics that will be discussed include:

- Statutory Accounting
- Regulating of HMOs
- Annual Statement Preparation
- Other Required Filings
- Accounting for Assets and Liabilities
- Mergers
- Reinsurance
- Accounting for Revenue and Expenses
- Diskette Filing Problems
- Risk-Based Capital

For registration information call the NAIC Education Department at (816) 374-7192 or e-mail to etrainin@naic.org.

Managed Care Organizations Risk-Based Capital

Beginning with year-end 1998, HMOs will be required to complete the Managed Care Organizations Risk-Based Capital formula. During the past few years, HMOs have been asked to complete sample formulas in order for the regulators to adjust the formula to best fit the managed care organizations industry. For those companies that have been completing the sample formulas, the introduction of the risk-based capital requirement will not be a new endeavor. However, those companies completing the formula for the first time might find that they have several questions about the specific data that is requested.

Conclusion

With the continued growth and changes in the HMO industry, it is not surprising that the regulation of these entities would also be on the move to keep up. The implementation of the Managed Care Organizations Risk-Based Capital and the ongoing changes to the HMO annual statement are signs that state regulators are dedicated to continuing the high level of quality oversight of the HMO industry.

Table 1
Aggregate Assets Page for 481 HMOs

Description	Assets	Assets Not Admitted	Net Admitted Assets	Prior Year Net Admitted Assets
CURRENT ASSETS:				
Cash and Short-Term Investments	5,560,947,083	1,704,135	5,559,242,948	5,075,849,142
Premiums Receivable	2,501,228,926	180,600,032	2,320,628,892	1,986,008,840
Investment Income Receivables	114,832,943	626,143	114,206,800	113,048,170
Health Care Receivables	483,856,500	94,385,154	389,471,346	351,251,175
Amounts Due from Affiliates	1,524,006,775	183,548,129	1,340,458,647	1,048,370,167
Reinsurance Recoverable on Paid Losses	99,361,225	11,936,619	87,424,605	35,453,600
Aggregate Write-ins for Current Assets	1,421,374,244	253,299,538	1,168,074,707	600,452,395
TOTAL CURRENT ASSETS	11,709,054,750	729,546,779	10,979,507,968	9,210,433,491
OTHER ASSETS:				
Restricted Cash and Other Assets	864,051,576	37,557,112	826,494,464	609,012,933
Bonds	5,797,755,518	30,014,799	5,767,740,719	4,633,450,465
Stocks:				
Preferred Stocks	66,410,162	-3,021,644	69,431,806	97,973,546
Common Stocks	570,711,601	36,892,381	533,819,220	337,847,147
Other Long-Term Invested Assets	375,495,967	31,833,892	343,662,075	505,478,279
Receivable for Securities	7,916,190	0	7,916,190	4,309,228
Amounts Due from Affiliates	95,407,444	16,034,233	79,373,211	116,890,274
Aggregate Write-ins for Other Assets	696,115,458	540,757,887	155,357,571	130,018,267
TOTAL OTHER ASSETS	8,473,863,916	690,068,660	7,783,795,256	6,436,980,440
PROPERTY AND EQUIPMENT:				
Land, Buildings and Improvements	1,389,135,767	75,008,064	1,314,127,703	1,332,419,248
Furniture and Equipment	729,354,598	216,991,482	512,363,115	535,400,158
Leasehold Improvements	86,978,698	49,574,952	37,403,746	76,564,307
Other Property and Equipment	42,282,991	17,792,630	24,490,361	59,206,174
TOTAL PROPERTY AND EQUIPMENT	2,247,752,052	359,367,125	1,888,384,925	2,003,589,887
TOTAL ASSETS	22,430,670,712	1,778,982,565	20,651,688,144	17,651,003,516

Table 2
Aggregate Liabilities Page for 481 HMOs

Description	Covered	Current Year Uncovered	Total	Prior Year
CURRENT LIABILITIES:				
Accounts Payable	558,602,929	32,975,713	591,578,642	566,289,530
Claims Payable	7,961,890,077	368,073,910	8,329,963,986	6,742,756,632
Accrued Medical Incentive Pool	362,399,301	719,293	363,118,594	341,404,572
Unearned Premiums	1,809,305,400	117,204,837	1,926,510,237	1,154,717,906
Loans and Notes Payable	13,666,036	524,490	14,190,526	23,585,666
Amounts Due to Affiliates	1,036,721,967	84,724,763	1,121,446,730	870,210,471
Unauthorized Reinsurance	0	0	0	0
Aggregate Write-ins for Current Liabilities	1,817,828,658	130,253,671	1,948,082,329	1,600,732,284
TOTAL CURRENT LIABILITIES	13,560,414,370	772,776,679	14,294,891,048	11,260,367,062
OTHER LIABILITIES:				
Loans and Notes Payable	213,757,887	0	213,757,887	219,982,326
Amounts Due to Affiliates	146,815,169	1,110,557	147,925,726	160,844,995
Payable for Securities	0	0	0	0
Aggregate Write-ins for Other Liabilities	392,715,371	31,882,489	424,597,860	357,006,338
TOTAL OTHER LIABILITIES	753,288,427	32,993,046	786,281,473	737,833,659
TOTAL LIABILITIES	14,313,702,796	767,469,725	15,081,172,523	11,998,200,751
NET WORTH:				
Common Stock	0	0	340,827,585	281,461,851
Preferred Stock	0	0	60,595,386	44,999,167
Paid in Surplus	0	0	3,565,558,978	2,689,758,509
Contributed Capital	0	0	1,194,492,588	565,322,534
Surplus Notes	0	0	1,201,139,420	826,175,188
Contingency Reserves	0	0	496,663,561	371,135,368
Retained Earnings/Fund Balance	0	0	-1,131,284,423	896,824,650
Aggregate Write-ins for Other Net Worth Items	0	0	-145,850,444	-6,806,783
TOTAL NET WORTH	0	0	5,563,291,690	5,653,097,162
TOTAL LIABILITIES AND NET WORTH	14,313,678,986	767,469,725	20,644,464,213	17,650,297,884

Table 3
Aggregate Income Statement Page for 481 HMOs

Description	Current Year		Prior Year
	Uncovered	Total	
MEMBER MONTHS	XXX	494,744,036	420,213,983
REVENUES:			
Premium	XXX	46,595,367,214	40,648,255,897
Fee-For-Service	XXX	1,224,515,740	1,372,106,211
Title XVII-Medicare	XXX	13,728,613,223	9,274,658,347
Title XIX-Medicaid	XXX	4,943,387,810	4,772,316,446
Investment	XXX	727,115,539	668,474,536
Aggregate Write-ins for Other Health Care Related Revenues	XXX	698,777,280	565,184,725
Aggretage Write-ins for Other Revenues	XXX	432,609,526	439,536,407
TOTAL REVENUES	XXX	68,350,386,332	57,039,954,712
EXPENSES:			
Medical and Hospital:			
Physician Services	353,174,522	22,890,583,368	18,948,163,547
Other Professional Services	100,195,461	6,430,130,292	5,643,877,234
Outside Referrals	389,080,625	2,586,992,164	1,931,868,710
Emergency Room and Out-of-Area	91,059,249	1,582,259,540	1,320,150,141
Occupancy, Depreciation and Amortization	421,967	375,382,198	386,713,500
Inpatient	492,678,732	16,364,179,603	13,216,232,459
Incentive Pool and Withhold Adjustments	46,578	89,665,023	135,710,347
Aggregate Write-ins for Other Medical and Hospital Expenses	279,181,844	11,052,025,838	8,591,997,719
Subtotal	1,676,437,260	61,074,509,938	49,859,788,851
LESS:			
Net Reinsurance Claims Incurred	3,755,060	502,820,938	311,730,493
Copayments	1,494,473	309,713,193	363,932,516
COB and Subrogation	1,408,996	507,787,269	514,115,236
Subtotal	6,653,871	1,023,613,125	856,857,072
TOTAL MEDICAL AND HOSPITAL	1,699,185,108	60,347,768,001	49,315,118,171
Administration:			
Compensation	266,946,289	3,201,978,686	2,499,467,068
Interest Expense	3,601,451	42,090,663	43,200,063
Occupancy, Depreciation and Amortization	54,801,279	713,060,709	517,319,578
Marketing	152,842,887	1,660,276,656	1,425,576,072
Aggregate Write-ins for Other Administration Expenses	278,692,557	3,761,502,183	3,407,963,485
TOTAL ADMINISTRATION	756,884,463	9,378,909,050	7,723,526,270
TOTAL EXPENSES	2,456,069,571	69,726,687,044	57,038,644,420
INCOME (LOSS)	XXX	-1,376,290,683	31,310,275
Extraordinary Item	0	-7,979,557	-995,348
Provision for Federal Income Taxes	XXX	-160,866,540	107,230,178
NET INCOME (LOSS)	XXX	-1,207,046,585	-74,798,525

Table 4
Number of HMOs & Direct Premiums Earned by State of Domicile

State	Number of HMOs			Direct Premiums Earned**	
	NAIC Database		IDRR*	1996	1997
	1996	1997	1996		
Alabama	5	9	14	68,136,667	97,446,450
Alaska	0	0	0	0	0
American Samoa	0	0	N/A	0	0
Arizona	2	7	8	674,534,766	1,994,575,923
Arkansas	4	4	6	46,875,015	248,553,381
California	0	0	0	0	0
Colorado	9	11	18	830,956,116	1,142,836,795
Connecticut	11	15	15	784,215,251	1,534,314,848
Delaware	5	5	5	141,802,567	111,697,524
District of Columbia	0	0	0	719,191,025	919,773,943
Florida	8	13	40	2,181,951,040	3,327,415,374
Georgia	14	15	16	382,169,209	1,240,145,669
Guam	0	0	N/A	0	0
Hawaii	0	1	9	0	6,555,145
Idaho	0	3	4	24,065,554	97,838,737
Illinois	14	13	19	1,144,439,643	1,692,219,141
Indiana	4	9	25	299,122,124	771,514,620
Iowa	2	2	4	154,552,670	351,549,754
Kansas	4	6	7	128,899,972	341,851,809
Kentucky	10	11	13	485,312,026	879,000,442
Louisiana	12	11	23	167,912,559	278,052,974
Maine	0	1	3	0	123,195,569
Maryland	11	11	14	1,394,112,125	1,947,621,670
Massachusetts	3	7	14	679,328,687	2,006,776,005
Michigan	10	11	21	1,155,303,664	1,586,443,806
Minnesota	1	0	9	0	0
Mississippi	2	6	12	2,465,128	71,129,124
Missouri	18	25	26	1,098,764,650	2,078,818,643
Montana	0	0	2	0	0
Nebraska	4	6	5	158,281,927	264,871,957
Nevada	3	7	8	439,116,708	604,871,454
New Hampshire	2	2	5	237,601,935	22,141,982
New Jersey	10	13	21	3,041,664,913	3,129,285,523
New Mexico	2	2	6	123,454,196	175,575,684
New York	21	22	37	3,153,486,815	3,837,739,388
North Carolina	22	22	23	754,292,766	781,063,308
North Dakota	0	0	2	0	0
Ohio	20	25	37	953,519,031	2,528,690,457
Oklahoma	3	3	10	255,004,907	291,373,383
Oregon	10	9	10	2,163,020,380	2,364,922,002
Pennsylvania	26	26	29	5,105,947,248	6,290,668,598
Puerto Rico	0	1	N/A	0	0
Rhode Island	3	4	4	452,380,046	230,791,017
South Carolina	9	9	9	362,518,249	238,091,497
South Dakota	2	2	2	28,594,748	35,748,075
Tennessee	4	7	23	226,470,197	299,590,951
Texas	50	58	62	4,302,162,895	4,704,573,214
U.S. Virgin Islands	0	0	0	0	0
Utah	13	14	13	711,773,460	728,363,301
Vermont	0	1	1	5,745,029	160,219,902
Virginia	17	17	18	983,403,452	1,534,234,258
Washington	8	9	10	1,456,907,976	1,499,743,438
West Virginia	1	4	5	4,550,888	187,087,767
Wisconsin	22	21	25	1,788,439,508	2,297,453,377
Wyoming	1	1	1	7,603,837	10,981,595
Countrywide	402	481	693	39,280,051,569	55,067,409,474

NAIC Update: Financial Database Re-engineering (FDR)

by Denise Lozano (NAIC/SSO)

The Beginning . . .

The NAIC Financial Database mission has always been to provide the foremost source of quality, timely and useful financial information to support solvency and other insurance needs. The financial database was developed and is currently maintained to serve, primarily, the regulatory requirements of the members of the NAIC and, secondarily to serve public information needs. It is essential that the database is useful, accurate, and available on a timely basis.

Since the beginning, the financial database has grown dramatically to hold most of the extensive data reported in the annual and quarterly statements for an increasing number of insurers and types of statements. There has also been a significant increase in the volume of data reported in the financial statements, such as Schedule P (loss reserving schedules) in the Property & Casualty statement and Schedule D (investment schedules) in most of the statements.

This expansion and development of the database has occurred without the existence of a long-range system design plan. Timeliness and

accuracy of the information contained in the database have been issues of concern from the beginning. With the passage of time, other concerns have been raised about the efficiency and effectiveness of current practices and procedures related to the financial database process and systems that support that process.

Among the financial database concerns were:

- Evolution and growth of database (500%+)
- Timeliness, quality and completeness of data
- Effectiveness and efficiency of current systems and procedures
- Cost of IS support and maintenance
- Database structure

In 1996, the membership conducted a study of the NAIC's financial database to determine the user needs and requirements of the database and its primary purpose, to see how well the database currently served those needs and requirements, and, assuming there were unfulfilled needs and requirements, determine a high-level set of recommendations for moving forward with a re-engineering effort. This was all finalized in December 1996 with the adoption of the recommendations for moving the initiative forward.

The FDR Task Force

To uphold the objectives of the NAIC Financial Database in a changing world, the Financial Database Re-engineering (FDR) project, which began as the Annual Statement Re-engineering (ASTR) project in May 1996, was initiated to resolve the database concerns. On March 17, 1997, the Financial Database Re-engineering Task Force was created, a group of regulators from 13 state insurance departments, responsible for the oversight of the FDR project, ensuring that resources of the NAIC are deployed in such a manner as to re-engineer the financial systems to:

- Meet or exceed business requirements not currently being met;
- Improve the flexibility, efficiency and cost effectiveness of current systems; and
- Reduce the cost of regulatory compliance in the area of financial reporting.

This would include:

- Providing the technical infrastructure to facilitate and promote the sharing and communication of financial information and knowledge among insurance entities;
- Providing economies of scale for state insurance departments by developing tools and services that help insurance departments regulate solvency more effectively and efficiently; and
- Prioritizing and monitoring the scope of FDR information technology projects that result in developing and delivering systems/products in a rapid and cost/beneficial manner.

The specific charges to the FDR Task Force are:

- Explore alternative methods of achieving higher quality filings of financial statements. Alternatives may include the filing of financial data via telecom-munication lines (i.e., interactively), changes in database structure, or changes in filing format specifications;
- Guide the support and development of the Financial Database Re-engineering auto-mation initiative; and
- Make recommendations to the EX7 committee in regard to policy and the development and implementation of guidelines related to financial data capture issues.

The Task Force met at the NAIC's Support and Services Office (SSO) on May 29, 1997, to review the analysis of the business processes done by NAIC staff in the first quarter of 1997. This served to provide the framework within which the NAIC moved forward with the project. The Task Force meets monthly via conference call and at each NAIC Quarterly National Meeting to carry out its charges.

An all day meeting of the FDR Task Force was held in Kansas City on May 18, 1998. The purpose of the meeting was to provide the task force members with a detailed status of the FDR project and to ensure that the direction the task force has provided to the project team was still valid and has been followed.

At this meeting the task force adopted the following standards for a filing to the NAIC Database once FDR is implemented:

Diskette Processing Minimum Standards:

1. A filing must be for a complete data year.
2. A filing must represent data for an active company as of the date of filing.
3. The quarter sequence and data year must be correct.
4. The Jurat must be present on every filing.
5. Each diskette must be in NAIC specified data format.
6. Each diskette must be machine readable.
7. The company code on the diskette label must match the diskette data.
8. The filing must not contain all zeroes.
9. All tables in a filing must balance (within accepted tolerances).

Internet Processing Minimum Standards:

1. The filing must meet all of the requirements listed for Diskette Processing.
2. The user ID/password must have permission to submit for this company code.
3. The company code on the submit form must match the company code in the file being submitted.
4. The company code and FEIN (Federal Employers Identification Number) must match per the NAIC financial database demographic information.
5. The company code being submitted must be active per the NAIC financial database demographic information.
6. The original filing must not have already been submitted – duplicate originals.

Loading Hold Area Minimum Standards:

1. The filing must not contain an excessive number of missing records (single lines or complete tables).
2. The filing must not contain invalid characters (March data on an April diskette, for example).
3. The filing must correctly be identified with specified codes (a Separate Accounts diskette with a Line 19 identifier AND a file name extension indicating a March filing, for example).

Crosschecks – Data Quality Review:

Property

1. Assets Line 22 (Total Assets) must agree to Liabilities, Surplus & Other Funds Line 26 (Total Liabilities plus Surplus as regards Policyholders).
2. Underwriting and Investment Exhibit, Statement of Income, Line 32 (Surplus as regards Policyholders, December 31 current year) must agree to Liabilities, Surplus & Other Funds Line 25 (Surplus as regards Policyholders).

Life

1. Assets Line 25 (Total Assets) must agree to Liabilities, Surplus & Other Funds Line 29 (Total Liabilities plus Surplus).
2. Summary of Operations Line 48 (Capital and Surplus, December 31, current year) must agree to Liabilities, Surplus & Other Funds Line 38 (Total of Common Capital Stock, Preferred Capital Stock and Surplus).

Title

1. Assets Line 19 (Total Assets) should agree to Liabilities, Surplus & Other Funds Line 27 (Total Liabilities plus Surplus as regards policyholders).
2. Operations and Investment Exhibit Line 30 (Surplus as regards Policyholders, December 31, current year) should agree to Liabilities, Surplus & Other Funds Line 26 (Surplus as regards Policyholders).

HMO

1. Assets Line 22 (Total Assets) should agree to Liabilities and Net Worth Line 25 (Total Liabilities and Net Worth).
2. Statement of Revenue, Expense and Net Worth Line 43 (Net Worth End of Year) should agree to Liabilities and Net Worth Line 24 (Total Net Worth).

Fraternal

1. Assets Line 23 (Total Assets) should agree to Liabilities, Surplus & Other Funds Line 32 (Total Liabilities plus Surplus).

2. Summary of Operations Line 42 (Surplus December 31, current year) should agree to Liabilities, Surplus & Other Funds Line 31 (Total Surplus).

FDR Applications

To achieve the objectives of the project, more specific applications have been identified to implement the recommendations adopted by the membership. In general, they will “meet or exceed ...requirements not currently being met” by improving the database structure to improve quality and speed of access to information (data warehousing); providing more flexible systems that allow for capturing additional data faster; providing systems that facilitate compliance and quality; providing more information about the status of the filing and any action taken; providing new state applications utilizing new information about the financial filings; and providing “public access” to assist states in fulfilling public information obligations.

The FDR applications will “improve flexibility, efficiency and cost effectiveness....” by reducing maintenance costs associated with maintaining the yearly blanks cycle; streamlining processes facilitated by more user friendly applications; and migrating to newer, more efficient client/server technologies.

Last, they will “reduce the cost of regulatory compliance.....” by providing an efficient method for data submission, by allowing for more timely feedback for a most cost effective response, by providing for status information regarding the filing, and by reducing the dependency on hard copy filings.

More specifically the applications for Phase I and Phase II have been identified as:

Internet Filing – This is FDR’s first production application. It was piloted in May 1997 and moved into production for the third quarter project in November 1997. This successful production release received positive feedback from both the insurers who participated as well as the NAIC staff on the receiving end of the exchange.

Internet Filing is a faster, more convenient, easier to use, more reliable, secure, and traceable

system. It will significantly reduce the time it takes to get financial data to the NAIC financial database. Internet Filing starts with a company sign-up process. Each company that wants to submit its financial data through the Internet must first sign up for a user ID and password. Once companies have successfully logged in to the system, they can select several functions:

- Submit Filing – submit one quarterly filing for the selected company.
- View Status – View Internet filing status for the selected company.
- Administration – Perform administrative functions, such as change passwords, create new users, grant and revoke authorizations, and add and remove companies. This is a “one size fits all” solution to company concerns regarding access and security. Companies may take advantage of whatever options they choose, depending on their particular desires regarding security and level of sophistication regarding user ID and password administration.

In addition, the Web site provides:

- FAQs – Frequently Asked Questions: sign up, filing and browser questions.
- Online User’s Guide – documentation of procedures to follow when using Internet Filing.
- Online Help – documentation for a specific function.
- Link to Help Desk – direct line to the NAIC’s Help Desk.

As of July, 1998, at the end of the first quarter project, 483 companies signed up for Internet Filing and 276 companies filed their first quarter statement through the Internet.

Data Staging and Loading – This application basically accepts the filing from the Internet Filing application and makes the data available in both the Online Transaction Processing (OLTP) database as well as the Decision Support System (DSS).

Data Validation – This application is responsible for all of the validations performed on any of the following filings submitted by the company: data file submission, company demo-

graphic information, results file, explanation file, and any text file where appropriate. It validates form and format of the electronic filing, ensures that the filing is complete, validates basic demographic information, validates text fields, and performs financial data “crosscheck” validations. This is a very comprehensive validation tool. This application is also responsible for providing an interface to end users to maintain the validation rules and formulas.

Work Flow/Work Track – This application consists of four parts. The first part, “Scheduler,” is a rigid set of processes that a filing goes through, such as loading the data, validating the data, and performing additional calculations on the data (filing fees, IRIS results, etc.). “Work flow,” the second part, is based on business rules and directs traffic and moves work on to the next appropriate work queue or process. Work flow encompasses another part called “Filing Prioritization.” This part prioritizes the work for an analyst in a work queue, based on failed validations or incoming correspondence, in the order in which the work should be reviewed, as defined by the FDR Task Force. The last part, “Work Track,” accepts and stores information sent to it from other processes that indicate the process was performed and when it was completed. Work Track basically tracks where the filing is in the process.

Financial Data Update & Inquiry – This is a financial data update tool that will allow the NAIC internal users the ability to update company financial data. It allows the analyst to run real time validations and tracks any changes that were made to an audit trail, listing when and why the change was made.

Specification Generator – The specification generator is a tool that promulgates changes to data dictionary or blank support tables, other support tables, hard copy filing specifications and other applications based on changes to the printed blank. It will create the information necessary to actually create the physical database tables.

Internal Data Access Tool (IDAT) – This tool will provide internal users access to view only or view/update information on the database, such as company demographic information, based on their security clearance. The application will also

provide the ability to query and generate reports. There will be a set of "canned" queries available to the users based on a "most wanted information" list. However, there will also be a means to run adhoc queries by the users. The application will provide the users with a place to input 'analyst notes' on the database. It is somewhat of a "dumping ground" for internal end user interfaces. It may be desirable to make components of IDAT available in the State and Public Access application. IDAT will be designed with that in mind.

Correspondence – Correspondence will generate form letters, faxes and e-mail triggered by the Work Flow application and based on results of other applications that will be fed to Work Track. Correspondence will also provide a mechanism for feeding records to the Work Track application, based on free form generated letters, faxes or e-mail, and providing the structure for storing that correspondence for future retrieval by the Analyst Notes function in IDAT or interfaces for viewing information. This tool will be flexible enough to allow correspondence through different media (written letters, e-mail, Internet web-postings, faxes, etc.) and formats (Excel, Word, etc.).

Common Application Access Tool – This tool will basically be the internal user's menu for accessing all of the different applications that each user has the authority to use.

Security Module – This will allow users the ability to control and maintain the appropriate security level for each user of financial database applications.

Audit Trail – The Audit application records all changes (edits, inserts and deletes) to FDR tables that are necessary to track. These include company demographic, financial and status tables as well as system tables (tables maintaining data on formulas, the contents of blanks, and miscellaneous tables). One of the purposes of the Audit Trail is to be able to trace the evolution of a filing from its original state to its present condition. The business requirements for audit trails are currently being documented by the business analysts in cooperation with the application developers and the data modeler.

Data Warehousing – Staff is currently prototyping a new data warehouse database structure as well as various OnLine Analytical Processing (OLAP) tools that are designed to give users a high degree of flexibility and performance in analyzing data.

The following applications have been identified as Phase III, or 1999, initiatives. The analysis phase of the development life cycle is scheduled for completion by October 1998.

Supporting Calculations – IRIS, Nationally Significant, RBC Recalculations, Filing Fee, Examiner Team selection, etc. Various calculations performed on the financial data.

Metrics Scoring – To communicate to the states and companies the timeliness, completeness, accuracy, and the integrity of financial filings. Metrics Scoring is a calculated "score" for both the individual filings and the database in aggregate to provide a measurable indicator of the quality of the data at any point in time.

State and Public Access – The interface to the Decision Support Systems (DSS) for the states and other external users.

FDR Implementation Plan

Gary Gummig, NAIC Director of Information Systems, presented an implementation plan for the Financial Database Re-engineering (FDR) project at the May 18 meeting of the FDR Task Force in Kansas City. The plan was well received by the task force members, who agreed that this was the direction NAIC staff should take in implementing FDR.

As expected, changes may be forthcoming, especially if issues surrounding Year 2000 system changes warrant higher priority.

Highlights of the implementation plan are as follows:

1999 Calendar Year

- Internet Filing will be available for ALL filings.
- Development and testing of all FDR applications will be completed.

2000 Calendar Year

- Life, Property, LRBC, PRBC, and Combined filings will be processed in the old data file format through AST systems.
- The new Health blank, HRBC, Title, and Fraternal filings will be processed in the new data file format through FDR systems.
- All “core” FDR applications will be ready for production.

2000 Calendar Year Quarterly

- Property and Life quarterly statements will be processed in the old data file format through AST systems for all quarters.
- By summer, for testing purposes, second quarterly statements, already submitted in the old data file format by insurance companies, will be converted to the new format by NAIC staff for processing through FDR systems.

2001 Calendar Year Annual

- All business types will be processed through FDR systems and submitted in the new data file format.

2001 Calendar Year Quarterly

- All business types will be captured for quarterly data.
- All business types will be processed through FDR systems in new data file format.

The plan takes into consideration the importance of this critical function and the strong need to minimize any risk that might jeopardize the NAIC’s ability to continue to provide a high level of service to its membership in the financial database area.

Summary

What is provided in this document does little but “scratch the surface” of the depth and breadth of the FDR project. FDR is not a project to change the business taking place at the NAIC. FDR will address the volume of data, the short timeframe for processing the data, the quality standards that

must be achieved in that timeframe, the follow-up with companies that did not file, and handling other exception processing.

The NAIC Insurance Regulatory Information System

by NAIC Staff

Each year on March 1, insurance companies are required to submit annual financial statements to state regulators and to the NAIC. State financial analysts and examiners quickly review and prioritize exams and reviews based on the most current financial data that is given to them. To assist the state regulators in this prioritization process, the NAIC established a set of ratios that can be used to indicate which insurers may be in need of financial review. These ratios are called the Insurance Regulatory Information System (IRIS).

The IRIS consists of a series of ratios that are calculated for property and casualty, life and health and fraternal insurance companies. The ratios are calculated based on data entered into the NAIC financial database from the insurers' annual financial statements. It is not intended that the IRIS ratio results alone be used in prioritizing insurers. It is possible for an insurer to have unusual values for several ratios and not be in need of review. Based on the company's individual circumstances, state regulators may already be aware of the individual company situation causing unusual ratio results. However, in many cases, unusual IRIS results indicate that a company has areas of financial weakness.

Ratio Formulas

Following is a listing of the financial ratios used in calculating the 1997 data year IRIS ratios. Also included are the criteria used for determining if a ratio result is usual or unusual. (An unusual

result may indicate that further review or an explanation is needed.)

Life and Health

Ratio 1: Net Change in Capital and Surplus

The net change in capital and surplus ratio is a general measure of the improvement or deterioration in a company's financial condition during the year. The ratio is calculated by dividing the change in capital and surplus between the prior and the current year (net of any capital and surplus paid in, including net increases in surplus notes) by the prior year capital and surplus. This ratio is not calculated for a newly formed company because of the lack of prior year data. The usual range includes all results greater than minus 10 percent and less than 50 percent.

Ratio 1A: Gross Change in Capital and Surplus

The gross change in capital and surplus is also a measure of improvement or deterioration in the company's financial condition during the year. This ratio is also not calculated for a newly formed company. The gross change in capital and surplus ratio is calculated by dividing the change in capital and surplus from the prior year to the current year by the prior year capital and surplus. The usual range includes all results greater than minus 10 percent and less than 50 percent.

Ratio 2: Net Income to Total Income (Including Realized Capital Gains and Losses)

Net income (including realized capital gains and losses) is a measure of the company's profitability. The calculation consists of dividing net income from operations (including realized capital gains and losses) by total income (including realized capital gains and losses). The usual range for this ratio includes all results greater than zero.

Ratio 3: Commissions and Expenses to Premiums and Deposits

This ratio has been discontinued as a regular ratio.

Ratio 4: Adequacy of Investment Income

This ratio indicates whether an insurer's investment income is adequate to meet the interest requirements of its reserves. The ratio result is obtained by dividing net investment

income by interest required. The usual range includes all results greater than 125 percent and under 900 percent.

Ratio 5: *Non-Admitted to Admitted Assets*

This ratio measures the degree to which a company has acquired nonadmitted assets that may represent either nonproductive assets or risky investments. To calculate this ratio, total nonadmitted assets are divided by total assets. The usual range includes all results less than 10 percent.

Ratio 6: *Total Real Estate and Total Mortgage Loans to Cash and Invested Assets*

This ratio reflects the percentage of cash and invested assets invested in real estate and mortgage loans. Total mortgage loans; BA mortgages; total real estate, including properties occupied by the company, properties acquired in satisfaction of debt and investment real estate, less encumbrances; and BA real estate are divided by cash and invested assets minus amounts payable for securities. Results less than 30 percent are included in the usual range for all companies.

Ratio 7: *Total Affiliated Investments to Capital and Surplus*

This ratio is determined by dividing the receivable from parent, subsidiaries and affiliates plus the amount invested in a parent, subsidiaries and affiliates by total capital and surplus. The usual range includes all results less than 100 percent.

Ratio 8: *Surplus Relief*

The ratio is calculated by dividing net commissions and expense allowances on reinsurance by capital and surplus. Results greater than minus 10 percent and less than 10 percent are included in the usual range for those companies with capital and surplus of \$5 million or less. For companies with capital and surplus in excess of \$5 million, the usual range includes those results which are greater than minus 99 percent and less than 30 percent.

Ratio 9: *Change in Premium*

This ratio represents the percentage change in premium from the prior to the current year. The change in total premiums, annuity considerations and other fund deposits from the prior year to the

current year is divided by total premiums, annuity considerations and other fund deposits for the prior year. This ratio is not calculated for a newly formed company because of the lack of prior year data. The usual range includes all results less than 50 percent and greater than minus 10 percent.

Ratio 10: *Change in Product Mix*

To calculate this ratio result, the percentage of premium from each product line is first determined for the current and prior years. Next, the difference in the percentage of premium between the two years is determined for each product line. Finally, the total of these difference –without regard to sign–is divided by the number of product lines to determine the change in the percentage of premium for the average product line. The usual range includes all results less than 5 percent.

Ratio 11: *Change in Asset Mix*

This ratio result represents the average change in the percentage of total cash and invested assets for the classes of assets in column 4 on lines 1 through 10 on page 2 of the annual statement, less the amount reported on page 3 line 24.8 column 1. The usual range includes all results less than 5 percent.

Ratio 12: *Change in Reserving Ratio*

The change in reserving ratio represents the number of percentage points of difference between the reserving ratio for current and prior years. For each of these years, the reserving ratio is equal to the aggregate increase in reserves for individual life insurance taken as a percentage of renewal and single premiums for individual life insurance. The usual range of the number of percentage points of difference between the reserving ratios for current and prior years includes all results less than 20 percent but greater than minus 20 percent.

Fraternal

The IRIS ratios used for fraternal insurance companies are very similar to the ratios used for life and health companies. The differences are listed here:

- Ratio 1 is calculated as the change in surplus and other funds for fraternal companies.

- Ratio 1A is not calculated for fraternal companies.
- Ratio 7 is calculated as total affiliated investments to surplus and other funds for fraternal companies.

Property and Casualty

Ratio 1: Gross Premium to Surplus

The gross premium to surplus ratio is calculated by dividing gross premium written by surplus as regards policyholders. The usual range for this ratio includes results up to 900 percent.

Ratio 1A: Net Premium to Surplus

The net premium to surplus ratio is calculated by dividing net premium written by surplus as regards policyholders. The usual range includes results up to 300 percent.

Ratio 2: Change in Net Writings

The change in net writings ratio reflects the increase or decrease in net premium written reported as a percentage of net premium written in the prior year. The usual range includes percentages greater than minus 33 percent and less than 33 percent.

Ratio 3: Surplus Aid to Surplus

Surplus aid, as calculated in this ratio, consists of commissions on unearned ceded reinsurance premium. Since this amount cannot be determined exactly from the annual statement, it must be estimated. This estimate is made by multiplying the ratio between ceding commissions and ceded premium for all reinsurance ceded by the amount of unearned premium on reinsurance ceded to non-affiliated companies. This estimated surplus aid is calculated as a percentage of surplus as regards policyholders to obtain the ratio result. The usual range includes ratios less than 15 percent.

Ratio 4: Two-Year Overall Operating Ratio

The overall operating ratio is a measure of the profitability of an insurance company. The ratio is a combination of three ratios: the loss ratio, plus the expense ratio, minus the investment income ratio. The usual range includes results less than 100 percent.

Ratio 5: Investment Yield

The investment yield provides an indication of the general quality of the company's investment portfolio. The ratio is calculated as net investment income as a percentage of the average amount of cash and invested assets during the year. The usual range includes results greater than 4.5 percent and less than 10 percent.

Ratio 6: Change in Surplus

The change in surplus is the difference between surplus as regards policyholders at the end of the current year and surplus as regards policyholders at the end of the prior year calculated as a percentage of policyholders surplus at the end of the prior year. The usual range includes results less than 50 percent and greater than minus 10 percent.

Ratio 7: Liquidity Ratios

The ratio of liabilities to liquid assets is a measure of the company's ability to meet the financial demands that may be placed upon it. The ratio reflects liabilities as a percentage of liquid assets. The usual range includes results below 105 percent.

Ratio 8: Agents Balances to Surplus

This ratio reflects the amount of agents' balances in course of collection as a percentage of surplus as regards policyholders. The usual range for the agents' balances to surplus ratio is less than 40 percent.

Ratio 9: One-Year Reserve Development to Surplus

The most up-to-date estimate of the losses that were outstanding a year prior to the current statement date is the sum of the current reserves for those losses still outstanding plus the payments on those losses made during the past year. The difference between this current estimate and the reserves that were established at the end of the prior year is the one-year reserve development. The usual range includes results that are less than 20 percent.

Ratio 10: Two-Year Reserve Development to Surplus

The two-year reserve development is the sum of the current reserve for losses incurred more than two years prior plus payments on those losses during the past two years minus the reserves that had been established for those losses two years

earlier. The usual range includes results which are less than 20 percent.

Ratio 11: Estimated Current Reserve Deficiency to Surplus

In this ratio the estimated current reserve deficiency or redundancy is calculated as a percentage of surplus as regards policyholders. This estimated deficiency is the difference between the estimated reserves required by the company and the actual reserves maintained. The estimated reserves required are the current net premium earned multiplied by the average ratio of developed reserves to earned premium for the last two years. For each of those years the reserves as reported in that year are adjusted by the one-year or two-year reserve development as reported in the Schedule P - Part 2 - Summary and used in Ratios 9 and 10. These amounts are then divided by the net premiums earned in each appropriate year to obtain the developed reserves to premium ratios. The usual range includes ratios with results less than 25 percent.

1997 IRIS Results

Table 1 shows the number and percentage of companies failing each of the IRIS ratios calculated using the year-end 1997 data. The IRIS ratios are not calculated for all property and casualty, life and health and fraternal insurers. Some insurers are exempted by their state of domicile or may have individual reasons for not participating in IRIS. For those companies, state regulators must rely on their own data calculations and regulatory processes. In reviewing Table 1, it can be seen that some ratios have much higher failure rates than other ratios.

Table 2 shows the distribution of the number of unusual values. So, for example, 39.62 percent of all property and casualty companies with calculated IRIS ratios had no unusual IRIS ratio results. Even though the number of unusual results that are calculated for a company does not determine financial soundness or unsoundness, it is a place for beginning the review process. A company with eight unusual values would no doubt catch an analysts eye before a company that had only two unusual values. However, it could be the case that the company with only two unusual values was in greater need for review than the company with eight unusual values.

Conclusion

IRIS can be traced back to the Early Warning System that was used in the 1970s. Through the years, the ratios have been updated and the data processes improved to develop into the IRIS system that is used today. IRIS ratio results are kept confidential through the period when the ratios are calculated. After the ratios are calculated for an individual company, they are made available only to the company and to the state insurance department where the company is domiciled. After the period when the ratios have been reviewed by company and state officials, then the ratio results are published by the NAIC. Information about the IRIS ratios and the published ratio results can be obtained through the NAIC publications department.

Table 1
1997 IRIS Ratio Unusual Value Results

Property/Casualty IRIS Ratios	Number of Unusual Values	Unusual Values As a % of Total
1 Gross Premium to Surplus	119	4.39%
1A Net Premium to Surplus	89	3.29%
2 Change in Net Writings	698	25.78%
3 Surplus Aid to Surplus	132	4.87%
4 Two-Year Overall Operating Ratio	530	19.57%
5 Investment Yield	586	21.64%
6 Change in Surplus	428	15.81%
7 Liabilities to Liquid Assets	181	6.68%
8 Agents' Balances to Surplus	152	5.61%
9 One-Year Reserve Development to Surplus	102	3.77%
10 Two-Year Reserve Development to Surplus	167	6.17%
11 Estimated Current Reserve Deficiency to Surplus	169	6.24%
<i>(1997 IRIS ratios were calculated for 2,708 property/casualty companies)</i>		
Life/Health IRIS Ratios		
1 Net Change in Capital and Surplus	291	19.85%
1A Gross Change in Capital and Surplus	273	18.62%
2 Net Income to Total Income	325	22.17%
3 Commissions and Expenses to Premiums and Deposits	(Discontinued)	
4 Adequacy of Investment Income	548	37.38%
5 Non-Admitted to Admitted Assets	70	4.77%
6 Total Real Estate & Mortgage Loans to Cash & Invested Assets	43	2.93%
7 Total Affiliated Investments to Capital and Surplus	55	3.75%
8 Surplus Relief	199	13.57%
9 Change in Premium	543	37.04%
10 Change in Product Mix	104	7.09%
11 Change in Asset Mix	131	8.94%
12 Change in Reserving Ratio	402	27.42%
<i>(1997 IRIS ratios were calculated for 1,466 life/health companies)</i>		
Fraternal IRIS Ratios		
1 Change in Surplus and Other Funds	16	12.50%
2 Net Income to Total Income	54	42.19%
3 Commissions and Expenses to Premiums and Deposits	(Discontinued)	
4 Adequacy of Investment Income	4	3.13%
5 Non-Admitted to Admitted Assets	3	2.34%
6 Total Real Estate & Mortgage Loans to Cash & Invested Assets	17	13.28%
7 Total Affiliated Investments to Surplus and Other Funds	0	0.00%
8 Surplus Relief	1	0.78%
9 Change in Premium	50	39.06%
10 Change in Product Mix	32	25.00%
11 Change in Asset Mix	1	0.78%
12 Change in Reserving Ratio	50	39.06%
<i>(1997 IRIS ratios were calculated for 128 fraternal companies)</i>		

Table 2
Percentage of Companies with the Listed Number of Unusual Values
By Company Type

Number of Unusual Values	<u>Property/Casualty</u>	<u>Life/Health</u>	<u>Fraternal</u>
0	39.62%	20.12%	21.88%
1	28.32%	24.49%	27.34%
2	16.58%	22.78%	18.75%
3	7.87%	13.37%	18.75%
4	3.36%	9.21%	10.16%
5	1.88%	5.87%	2.34%
6	1.40%	2.66%	0.78%
7	0.52%	0.89%	0.00%
8	0.22%	0.48%	0.00%
9	0.15%	0.14%	0.00%
10	0.07%	0.00%	0.00%
11	0.00%	0.00%	<u>0.00%</u>
12	<u>0.00%</u>	<u>0.00%</u>	
	100.00%	100.00%	100.00%

A Demonstration of Market Concentration Measurements Using Automobile Insurance Markets

By Davin Cermak (NAIC/SSO)

One of the areas of concern to regulators in insurance markets is the question of market concentration. Making assumptions about market concentration based solely on the number of companies can lead to incorrect assumptions about the structure of a market and, even worse, turn legislative or regulatory policies intended to improve the marketplace into an impediment. A particular state may have hundreds of companies selling automobile insurance, but if a handful of companies, say three for four, write a majority of the premiums, little competition exists in that market. Several methods exist to examine market concentration and market structure in a meaningful way. Using these tools together can provide a more comprehensive understanding of market structures.

This article employs auto insurance market data to examine four common measures of market concentration: concentration curves, the Lorenz curve/Gini coefficient, concentration ratios, and the Herfindahl Index. Concentration curves and Lorenz curves present a visual representation of the market concentration. Concentration ratios and Herfindahl Indices provide numerical data for examining market concentration. The data used in the measures comes from the 1997 NAIC Prop-

erty/Casualty Annual Statement, Exhibit of Premiums and Losses. Lines from this exhibit used are:

- Private passenger auto no-fault (personal injury protection)
- Private passenger auto liability, other
- Commercial auto no-fault (personal injury protection)
- Commercial auto liability, other
- Private passenger auto physical damage
- Commercial auto physical damage

Where needed, the auto insurance market is represented by the summation of these six lines.

Concentration Curves

Simple to create, concentration curves show the relationship between size of companies, measured by sales, employees, assets, etc., and the number of companies in an industry. Beginning at the origin of the graph (see Chart 1), the concentration curve for a theoretical purely competitive market, where all companies have identical market share, would be a 45-degree line beginning at zero. All industries not purely competitive would appear above this 45-degree line. A shorter, steeper concentration curve indicates a highly concentrated market where a few companies have a large market share in the industry.

The example in Chart 1 develops three concentration curves for nationwide auto insurance: private passenger, commercial and the total auto market (sum of all six lines listed in the previous section). All three lines exhibit comparable market concentration curves, indicating similar market structures. Visual inspection of the graph indicates that the top 200 insurers ranked by direct premiums written (around 13 percent of the companies writing auto insurance) represent approximately 80 percent of the industry auto direct premiums written.

Regulators can utilize concentration curves to examine markets in relation to other markets or other industries, which can be used as benchmarks. The curves also allow comparisons of markets over time to look for changes in market structure as a result of regulation policies or market changes because technology, companies entering or leaving the market, etc.

The Lorenz Curve and the Gini Coefficient

A second tool for examining market concentration is actually a combination of visual and numerical data. Since the Gini coefficient is relatively difficult to calculate, focus on the visual portion will be emphasized. The Lorenz curve (see Chart 2) uses the same data as the concentration curves, but presents it in a different form. The differences lay in the development of the horizontal axis. First, instead of using the total number of companies, the Lorenz curve uses the cumulative percentage of companies represented in the industry. It also sorts companies so those with the smallest market share are closest to the origin, which is opposite of the concentration curves.

The curve and ratio provide information about how companies in an industry are distributed by their relative size, which complements the concentration curves. The 45-degree diagonal line represents companies that are all identical size in the market regardless of the number of companies comprising the market. The further the Lorenz curve is from the diagonal, the greater the inequality of market share across companies in the industry. The Gini coefficient is calculated as the area between the two curves divided by the area of the triangle to the right of the diagonal (AREA X/AREA OBC). A Gini coefficient of zero indicates that all companies have identical market share, whereas a coefficient approaching one indicates that one company among many in the market has virtually all the market share.

Although the Gini coefficient is not calculated for Chart 2, visual examination of the graph shows the coefficient is a significantly large portion of the AREA OBC. This indicates once more that a handful of companies write a large portion of nationwide auto insurance premiums.

Concentration Ratios

Concentration ratios offer a quick and simple way to examine market concentration through numerical data. Market percentages are calculated for all companies in the industry and ranked in descending order (highest concentrations first). The top companies are taken separately and their market shares are added together, providing a concentration ratio for the market or industry.

The U.S. Bureau of the Census calculates market concentration ratios for industries based on either four or eight of the largest companies by market share. However, using groups of 20 companies is not uncommon in other calculations, especially when a large number of companies operate in a market or industry.

This method of examination provides information about whether there are a few large companies capturing a large share of the market. Again, the concentration ratios can be calculated for comparison across markets or industries or for comparisons over a period of time to examine market structure changes. The ratio itself, however, yields little information about the market structure of the companies included in the ratio, which may be an indicator of what the overall market structure looks like.

Table 1 shows market concentration ratios for all six lines of auto insurance as well as the total national auto market for the largest eight companies in terms of direct premiums written. The data indicate again that auto market concentrations are high among a few insurers. Commercial lines exhibit a smaller concentration ratio compared to private auto insurance lines. Commercial lines have a more even dispersion of market share among the eight largest companies. It is interesting to note that initially the commercial insurance concentration curve from Chart 1 does not increase as steeply as the other two curves. Eventually it intersects and becomes steeper than the total auto market curve and shadows the private auto curve. This stresses the point, once again, that this measure of market concentration alone cannot provide the whole of the concentration picture, but only a piece of it.

Herfindahl Index

This index is the most comprehensive and descriptive of the tools discussed. It provides information about the number of companies in a market or industry and information about the inequality in size of the companies. The Herfindahl Index (HI) is calculated by squaring the market share of each company in the market and adding them together. A common convention for presenting the HI, which is used here, is to multiply the calculation by 1,000. This format makes the HI easier to view. A market or industry with a

HI of 10,000 is a monopoly - one company producing all the goods and services available. At the other end of the spectrum, the market becomes more competitive (more companies with a smaller share of the overall market) as the HI approaches zero.

The HI will become smaller indicating a more competitive market as the number of companies grows or as the distribution of market share become more evenly distributed. The HI is also unaffected by minor changes in the market structure as smaller companies enter and exit and as smaller companies expand and contract. A drawback with the HI calculations is the way it assigns differences to values between industries, making comparisons across different industries difficult to interpret in many cases, although its degree of importance is unknown. The differences generally occur when comparing industries with differing numbers of companies or differing degrees of market share distribution among companies.

Table 2 shows Herfindahl Indices calculated for all lines of auto insurance, by state. In general, the data shows that states with lower HI scores tend to have more companies writing premiums, indicating that competition in these markets is strong. Auto no-fault lines, where fewer companies write business than other lines, exhibit large variations in the Herfindahl Indices, whereas the auto liability lines have more companies writing business and relatively low HI scores. Commercial auto lines tend to have lower HI scores than do private auto lines.

Although there is no precise point at which the Herfindahl Index indicates that a market or industry is highly concentrated enough to restrict competition, the Department of Justice has developed guidelines with regard to corporate mergers.¹ Under these guidelines, if a merger of companies in a given market cause the Herfindahl Index to rise above 1,800, the market is considered highly concentrated. If the HI after the merger is between 1,000 and 1,800, the market is considered moderately concentrated and a HI less than 1,000 is considered not concentrated. Since these numbers are guidelines, judgement on the part of

regulators must be used to interpret what information the HI's provide for a particular market.

Conclusion

Using these measurements of market concentration together provide a better understanding of an industry's market structure than any singular measure allows. Knowledge about the number of companies *and* the distribution of market share are essential components in developing the market structure of an industry. This information will then allow regulators to determine what actions stand the best chance of improving the functionality of the marketplace and to gauge the effectiveness of actions over time.

¹ U.S. Department of Justice, 1984, Merger Guidelines, Washington, D.C.

Chart 1
Concentration Ratios for Private and Commercial Auto Insurance

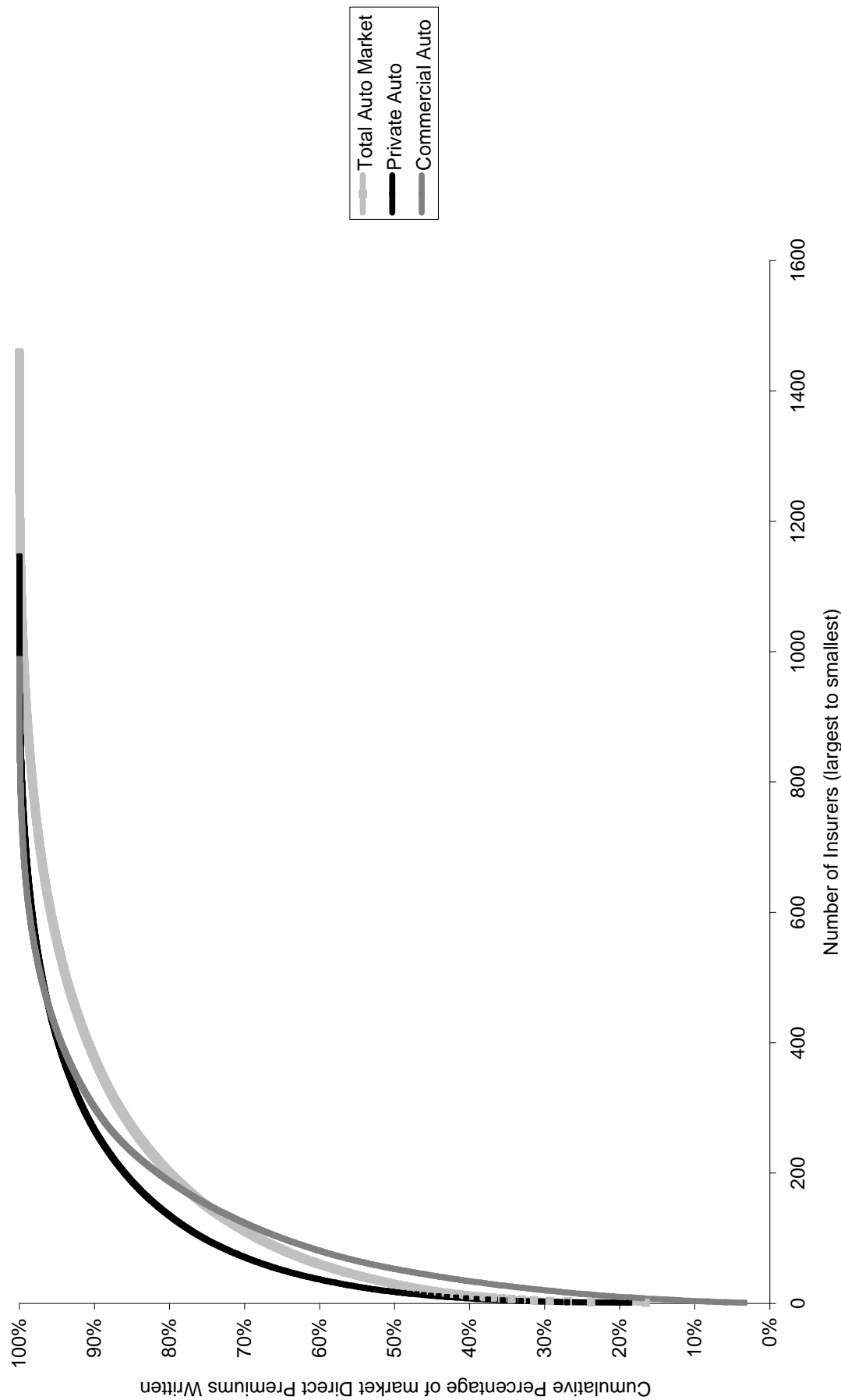


Chart 2
Lorenz Curve - Visual Representation
of the Gini Coefficient

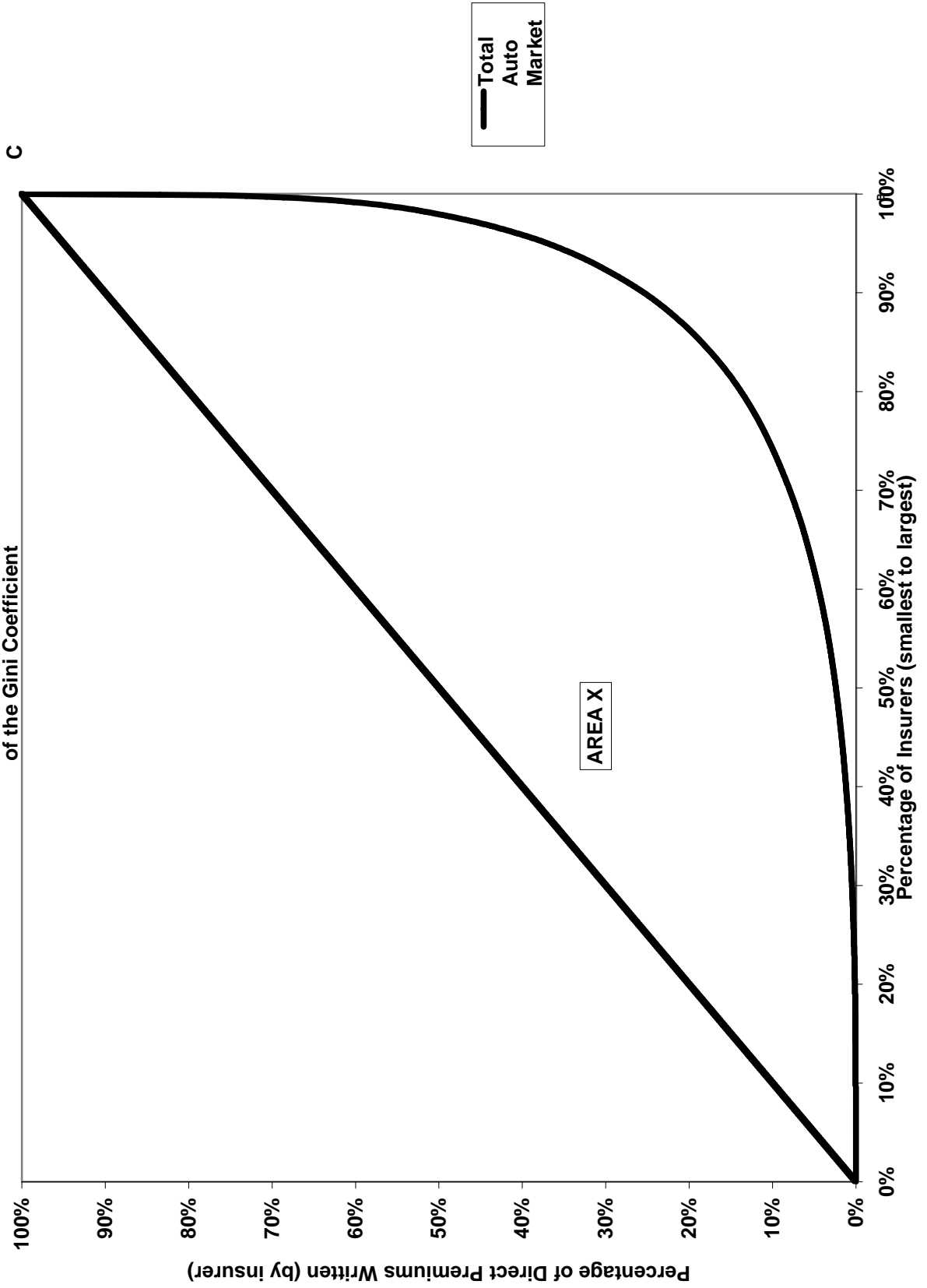


Table 1
Concentration Ratios for the Eight Largest Insurers in the Auto Market

Private Passenger Auto No-Fault		Private Passenger Auto Liability (Other)		Commercial Auto No-Fault	
Firm	Market Share	Firm	Market Share	Firm	Market Share
1	15.8%	1	18.7%	1	8.3%
2	9.5%	2	7.8%	2	4.3%
3	4.1%	3	3.4%	3	4.2%
4	2.5%	4	2.7%	4	3.6%
5	2.0%	5	2.4%	5	3.5%
6	2.0%	6	1.9%	6	2.0%
7	1.7%	7	1.5%	7	1.7%
8	1.6%	8	1.4%	8	1.6%
(of 729 insurers) 39.3%		of 1,085 insurers 39.9%		(of 650 insurers) 29.2%	

Commercial Auto Liability (Other)		Private Passenger Auto Physical Damage	
Firm	Market Share	Firm	Market Share
1	2.5%	1	19.3%
2	2.5%	2	8.8%
3	2.4%	3	3.5%
4	2.0%	4	2.6%
5	1.8%	5	2.5%
6	1.8%	6	2.0%
7	1.7%	7	1.6%
8	1.5%	8	1.4%
(of 991 insurers) 16.2%		of 1,148 insurers 41.6%	

Commercial Physical Damage		Total Auto Market	
Firm	Market Share	Firm	Market Share
1	5.2%	1	16.6%
2	2.5%	2	7.3%
3	2.1%	3	3.1%
4	2.0%	4	2.4%
5	1.7%	5	2.1%
6	1.7%	6	1.6%
7	1.6%	7	1.4%
8	1.5%	8	1.2%
(of 974 insurers) 18.4%		of 1,459 insurers 35.7%	

Table 2
Herfindal Indices

State	Private Passenger Auto No-Fault (Personal Injury Protection)		Other Private Passenger Auto Liability	
	Number of Companies	Herfindahl Index	Number of Companies	Herfindahl Index
Alabama	2	10,000	194	1,269
Alaska	1	10,000	54	1,315
Arizona	6	5,350	227	675
Arkansas	49	4,667	169	955
California	10	8,242	209	696
Colorado	170	1,017	184	878
Connecticut	96	620	160	314
Delaware	129	885	130	835
District of Columbia	74	966	92	984
Florida	233	644	257	874
Georgia	7	5,299	240	665
Hawaii	45	1,017	51	972
Idaho	10	8,953	168	717
Illinois	36	5,280	297	1,176
Indiana	2	5,303	286	675
Iowa	3	9,916	208	599
Kansas	184	874	191	770
Kentucky	193	811	202	805
Louisiana	3	9,903	166	1,275
Maine	3	5,180	128	482
Maryland	136	971	148	820
Massachusetts	40	963	48	923
Michigan	108	865	115	889
Minnesota	181	1,035	190	839
Mississippi	-	-	161	1,071
Missouri	3	5,200	242	850
Montana	2	6,841	120	980
Nebraska	2	10,000	182	775
Nevada	7	8,777	132	804
New Hampshire	-	-	114	446
New Jersey	103	737	112	663
New Mexico	1	10,000	136	979
New York	218	531	231	520
North Carolina	3	9,516	156	678
North Dakota	126	699	135	648
Ohio	3	9,425	278	546
Oklahoma	2	10,000	178	893
Oregon	168	898	181	737
Pennsylvania	180	713	208	851
Rhode Island	2	10,000	125	450
South Carolina	32	4,641	70	1,505
South Dakota	22	2,364	139	577
Tennessee	3	10,000	236	934
Texas	211	1,417	228	845
Utah	141	1,058	150	867
Vermont	2	7,797	121	508
Virginia	33	4,091	235	637
Washington	176	782	190	555
West Virginia	3	9,788	124	1,464
Wisconsin	3	9,996	236	751
Wyoming	-	-	104	1,115
Median	10	4,641	168	820

Table 2 (con't)
Herfindal Indices

State	Commercial Auto No-Fault (Personal Injury Protection)		Other Commercial Auto Liability	
	Number of Companies	Herfindahl Index	Number of Companies	Herfindahl Index
Alabama	10	5,108	290	170
Alaska	2	9,991	165	426
Arizona	8	5,300	287	171
Arkansas	31	3,803	278	171
California	15	3,022	308	124
Colorado	244	238	289	148
Connecticut	74	1,589	243	198
Delaware	185	252	215	176
District of Columbia	133	3,669	176	506
Florida	273	472	330	157
Georgia	34	2,808	334	130
Hawaii	83	695	120	544
Idaho	5	5,456	233	219
Illinois	38	1,992	377	139
Indiana	7	3,640	353	197
Iowa	5	9,357	296	285
Kansas	232	474	273	214
Kentucky	235	213	288	149
Louisiana	9	4,321	292	198
Maine	4	3,744	189	369
Maryland	247	245	286	153
Massachusetts	129	526	174	429
Michigan	247	562	288	318
Minnesota	243	511	293	258
Mississippi	7	5,159	267	185
Missouri	10	5,380	325	165
Montana	2	5,313	225	223
Nebraska	5	8,714	252	376
Nevada	14	8,862	238	183
New Hampshire	2	9,961	202	239
New Jersey	213	316	255	189
New Mexico	3	8,587	239	191
New York	259	1,068	298	177
North Carolina	10	4,865	293	164
North Dakota	179	349	211	467
Ohio	16	4,032	368	202
Oklahoma	2	9,494	279	181
Oregon	212	588	279	173
Pennsylvania	272	288	334	168
Rhode Island	2	8,383	191	211
South Carolina	176	544	258	190
South Dakota	6	8,457	237	355
Tennessee	8	7,371	322	166
Texas	306	248	372	105
Utah	207	241	248	170
Vermont	2	9,370	190	290
Virginia	27	4,567	316	150
Washington	181	570	268	186
West Virginia	6	9,766	213	497
Wisconsin	17	3,107	317	214
Wyoming	2	8,800	200	336
Median	22	3,655	276	190

Table 2 (con't)
Herfindal Indices

State	Private Passenger Auto Physical Damage		Commercial Auto Physical Damage	
	Number of Companies	Herfindahl Index	Number of Companies	Herfindahl Index
Alabama	198	1,144	286	255
Alaska	59	1,322	151	681
Arizona	233	744	276	205
Arkansas	176	1,150	273	218
California	205	753	283	201
Colorado	192	1,093	281	230
Connecticut	167	347	232	245
Delaware	135	1,008	206	563
District of Columbia	86	1,083	156	331
Florida	273	706	328	178
Georgia	253	966	327	174
Hawaii	47	1,027	102	609
Idaho	168	781	226	559
Illinois	301	1,305	362	223
Indiana	292	777	346	198
Iowa	213	666	281	315
Kansas	199	933	271	286
Kentucky	203	873	276	148
Louisiana	180	1,308	282	233
Maine	128	534	183	348
Maryland	156	962	278	180
Massachusetts	49	912	157	453
Michigan	118	948	281	440
Minnesota	196	954	267	464
Mississippi	160	1,016	264	202
Missouri	248	944	309	221
Montana	124	1,041	214	280
Nebraska	182	928	242	428
Nevada	139	790	230	199
New Hampshire	111	459	190	204
New Jersey	112	656	249	156
New Mexico	142	916	235	284
New York	232	566	284	114
North Carolina	172	675	282	203
North Dakota	137	712	200	480
Ohio	281	627	356	211
Oklahoma	180	955	277	209
Oregon	181	930	264	301
Pennsylvania	219	850	-	-
Rhode Island	118	481	186	180
South Carolina	78	1,552	249	422
South Dakota	143	578	224	453
Tennessee	243	956	322	182
Texas	233	801	358	248
Utah	160	976	228	514
Vermont	123	497	183	240
Virginia	236	698	298	172
Washington	193	605	258	242
West Virginia	135	1,794	205	357
Wisconsin	236	864	302	235
Wyoming	105	1,100	189	448
Median	174	914	264	240

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