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[Problems Found In HMO Annual Statement Reporting for Year-End 1996](#)

By Colleen Gingrich, AIAS

Year-end 1996 was the first year Health Maintenance Organization (HMO) annual statement information was captured on the NAIC database. During the NAIC staff's first review of the HMO annual statement data, common reporting anomalies were noted. This article discusses the noted reporting anomalies and ways of avoiding similar problems in coming years.



[1995 Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance](#)

By NAIC Staff

This article offers a preview of the 1995 Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance report (the homeowners report) that is published by the NAIC. The data contained within the homeowners report is explained along with graphs and charts for a full understanding of the contents of the report.



[State Average Expenditures & Premiums for Personal Automobile Insurance in 1996](#)

By NAIC Staff

Each year the NAIC publishes the State Average Expenditures & Premiums for Personal Automobile Insurance report. The report shows estimated state average expenditures and average premiums per insured vehicle for private passenger automobile insurance. This article provides a preview of the 1996 report.



[What About Fraternal Insurance Companies?](#)

By NAIC Staff

This short article gives an overview of the fraternal insurance industry. Included in the article is a brief description of the fraternal insurance industry along with the national distribution of these companies and a discussion of the state regulation of fraternal insurers.

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Address correspondence to:
Editor
NAIC, 120, W. 12th St., Suite 1100, Kansas City, MO 64105-1925
(816) 842-3600

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The National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico and the Virgin Islands. The NAIC provides its members with a forum for discussing common interests and for working cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions.

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Problems Found in HMO Annual Statement Reporting for Year- End 1996

by Colleen Gingrich, AIAS

Year-end 1996 was the first year Health Maintenance Organization (HMO) annual statement information was captured on the NAIC database. During the first year of capture, the NAIC added 399 HMOs to the database. In reviewing the HMO annual statement filings, it was apparent that the NAIC *Annual Statement Instructions* and NAIC *Accounting Practices and Procedures* were lacking in guidance. The development of Managed Care Organizations Risk-Based Capital (MCO RBC), Codification, and the move for consistency of supporting schedules among the different insurer types should assist in correcting some of the problems found in the reporting guidance. As shown in Figure 1, there were many new HMOs commencing business in 1996. Therefore, as with any new undertaking, there is a learning curve on proper annual statement reporting.

Colleen Gingrich is an Insurance Accountant at the NAIC, where she specializes in HMO financial reporting and risk-based capital. She also lectures on annual statement reporting for the NAIC Education Department.

A common problem many HMOs face is that they are unfamiliar with differences between statutory accounting principles (SAP) and generally accepted accounting principles (GAAP). SAP follows the practices or procedures prescribed or permitted by the laws and regulations of an insurer's domiciliary state. New HMOs face different accounting rules when preparing the statutory statement. These new HMOs were confused by the definition of a non-admitted asset. Many did not reduce assets on the balance sheet by any nonadmitted assets. When companies reported non-admitted assets, some did not calculate the change in non-admitted assets directly against the fund balance account. Instead, the HMOs recorded the change through the income statement.

Cash

The definition of cash is confusing to many companies. Outstanding checks should be subtracted from the amount of cash reported and should not be reclassified as a liability. Therefore, companies may find that they are reporting a negative cash amount on the asset page.

Invested Assets

Another common problem among HMOs was the definition of short-term and long-term investments. Unlike GAAP, SAP defines a short-term investment as one that has a maturity date of one year or less from the date of purchase instead of from the statement date. Therefore, an investment would not be reported as a long-term investment one year and be reported as a short-term investment the following year. In addition, companies need to report the investments acquisition and maturity dates in Schedule B. This helps companies determine whether investments have been classified properly as either short-term or long-term investments.

Investments were also misclassified in the investment schedule and on the asset page. Many bonds and investments in subsidiaries were classified in the "Other Invested Asset" section instead of the appropriate bond or stock line. Some companies may feel that it does not make a big difference in the classification as long as they are reported as assets. However, the classification does make a difference when looking at individual

state restrictions on investments. It will also make a difference when the Managed Care Organizations Risk Based Capital is applied to the items reported in the annual statement. Each type of asset has a unique factor assigned to it in the MCORBC formula.

In addition to the above reporting problems found on the invested assets schedule, 14 percent of the companies reporting to the NAIC did not complete the detail portion of the invested asset schedule. The detail portion includes the purchase and maturity dates, market value, cost and book value of the listed investment. The exclusion of the detail information posed a problem in determining if the invested assets were properly reported within the financial statement.

Notes To Financial Statements

Several companies completed the Notes to Financial Statements incorrectly and some companies failed to complete them at all. Others only referred to Notes that were prepared by their auditor in a separate document. Many times only a portion of the Notes were addressed. This was because the company had outdated *Annual Statement Instructions* or because the HMO failed to indicate every Note whether it applied to the HMO or not. In any case, every Note should be addressed and companies should make sure they have updated *Annual Statement Instructions* every year.

Many companies use separate word processing software to complete the Notes. This is acceptable for the hard copy; however, the diskette that is produced will not contain the Notes unless the company enters them into the annual statement software. It is important that HMOs use the annual statement software package to complete the financial amounts that are required in some of the Notes in order for them to be captured on the NAIC database. Reports are often generated from the information that is reported in the Notes. In addition, the MCORBC formula will use amounts from the Notes that receive a risk-based capital charge. Therefore, it is important that these amounts be disclosed both on the diskette and hard copy.

Premium Enrollment and Utilization Table

When cross-checking data within the HMO annual statements, the NAIC detected several problem areas. The largest was the completion of the Premium, Enrollment and Utilization table. The schedule was completed incorrectly by 149 companies out of the 399 that filed. That means 37 percent of the companies that filed with the NAIC failed some type of cross-check within this schedule. The most common problem with the schedule was confusion on the definition of incurred losses within a calendar year. Incurred losses include losses paid during the year plus the change in reserves set up for losses incurred over the year. The appropriate cross-check is the following:

Page 8, Line 15, Column 1 (Amount Paid for Provision of Health Care Services)	
	+
Page 8, Line 16a, Column 1 (Amount Unpaid for Provision of Health Care Services Current Year-End)	
	-
Page 8, Line 16b, Column 1 (Amount Unpaid for Provision of Health Care Services Prior Year-End)	
	=
Page 8, Line 17a, Column 1 (Amount Incurred for Provision of Health Care Services Current Year-End)	

Another common cross-check problem was the validation of the premium amounts reported in the Premium Enrollment and Utilization table. This is cross-checked by adding the premium collected to the change in premium receivable and to the change in unearned premium to figure the amount of premium earned. The following is the cross-check:

Page 8, Line 11, Column 1 (Premium Collected)	
	+
Page 8, Line 12a, Column 1 (Premium Receivable Current Year-End)	
	-
Page 8, Line 12b, Column 1 (Premium Receivable Prior Year-End)	
	-
Page 8, Line 13a, Column 1 (Unearned or Advanced Premiums Current Year-End)	

+

Page 8, Line 13b, Column 1 (Unearned or
Advanced Premiums Prior Year-End)

=

Page 8, Line 14, Column 1 (Premiums Earned)

Even though there were many companies that had problems with these cross-checks, there were also several companies that did not complete the schedule at all. A grand total Premium Enrollment and Utilization table is to be completed as well as a separate table for each state where the company has written direct business, or has amounts paid, incurred or unpaid for provisions of health care services. Some companies completed the individual state pages but failed to complete the grand total page, and others completed the grand total page and failed to complete the individual state pages. In either case, both the state pages and the grand total page should be completed even if the HMO is licensed in only one state. Completing the grand total page makes it more efficient for state regulators to generate reports from the information on the database.

Schedule M

Another table with a high error rate was Schedule M, Part 2. This schedule captures information on affiliated company transactions in the same format as Schedule Y, Part 2 for Life & Health and Property & Casualty companies. Schedule M, Part 2 only needs to be completed if the reporting HMO is part of a holding company system. Each insurer within the holding company system will prepare a common Schedule M, Part 2. Each company reported in Schedule M, Part 2 should be listed only once. The companies should be listed in the same order as they appear in the organizational chart. In addition, this schedule should contain only financial transactions between holding company members for the portion of the year in which the companies were affiliated. Therefore, if a member is sold on June 30 of the calendar year, only report the transactions between affiliates that took place January 1 through June 30.

The biggest problem with reporting within Schedule M, Part 2 is that companies exclude themselves when reporting the transactions. Schedule M, Part 2 shows the increase in net

worth in one affiliate from the transaction by reporting a positive amount. The decrease is shown with a negative amount. Both sides of the transactions should be seen in this schedule. Therefore, the reporting company would also be shown giving a subtotal of zero at the bottom of the schedule. When looking at all the insurers reported in Schedule M, Part 2, state regulators should see the same amounts and same companies reported for each insurer that is a part of the same holding company system.

Schedule M, Part 1 posed several problems this year for HMOs. Most companies produce their organizational chart using software other than their annual statement software. This is fine for the hard copy. However, the diskette filing does require the companies to be listed in order of the organizational chart with their NAIC company code (insurers and HMOs only), federal employer identification number, and group code. Many times, companies left out this part of the procedure. It is important to use the annual statement software to list the companies that are part of the holding company system. This allows the information to load onto the diskette filing. For large holding company systems, many software packages allow Schedule M, Part 1 to be produced once, and then copied into the different reporting insurers' software packages.

Schedule C

Another area of concern was the aging schedules. Many companies did not complete the aging of accounts receivable recorded in Schedule C. This schedule allows examiners to ensure that companies are receiving prompt payment for services. There are also many state regulations that prohibit the admission of accounts receivable that are overdue by a specified period of time. This schedule helps assure state regulators that companies are complying with these regulations.

Schedule H

Several HMOs did not complete the aging of claims payable recorded in Schedule H - Section I. Many states have regulations regarding the timing of payments for health care services rendered. This aging schedule allows regulators to monitor the time it takes for an HMO to pay its health care providers.

Claims reported to the HMO and unpaid as of the statement date should be aged in Schedule H - Section I. The unreported reserve is added to the reported amount to come up with the total claims payable. There is also a separate line to age the accrued medical incentive pool. The total will tie back to the liability page.

Schedule H - Section II breaks out the claim payable amounts between inpatient, physician, referral and all other claims. The total of these amounts should agree with amounts reported in Schedule H - Section I.

Schedule H - Section III shows an analysis of unpaid claims of the prior year. It first looks at the amounts paid in the current year for the prior year unpaid claims. Any amounts that were reported as payable at the end of the prior year and still unpaid at the end of the current year are added to the payment amount. The total is then compared to the liability set up for the claims at the end of the prior year. If the total is greater than the original reserve set up, the HMO is not reserving enough. If the total is less than the original reserve set up, the HMO is reserving too much. Of course, the goal is to have the amounts in columns 5 and 6 as close as possible. See Figure 2 for a more visual view of the logic described above.

Other

HMOs need to keep in mind that claim reserves reported on the liability page should be net of reinsurance. This includes stop loss agreements. HMOs will benefit from reporting the reserves in this manner when risk based capital is implemented. Therefore, companies should reduce the unpaid losses by the excess amounts that are subject to a stop loss contract. This in turn will increase the companies' net worth.

For year-end 1997 reinsurance schedules were added to the HMO statement. Stop loss agreements should be included in these schedules. This information will be used in the future risk-based capital calculation.

Conclusion

With upcoming changes in annual statement reporting for HMOs, it is important for the companies to understand the current reporting requirements. Once there is an understanding of the current reporting requirements, it will assist HMOs in understanding the future changes. HMOs should make sure that they are on top of the changes in the future. This will allow them to ensure that systems are able to produce the amounts that are required in their financial statements. As with any major changes in procedures, the more education provided to the preparers, the easier the transition.

Figure 1

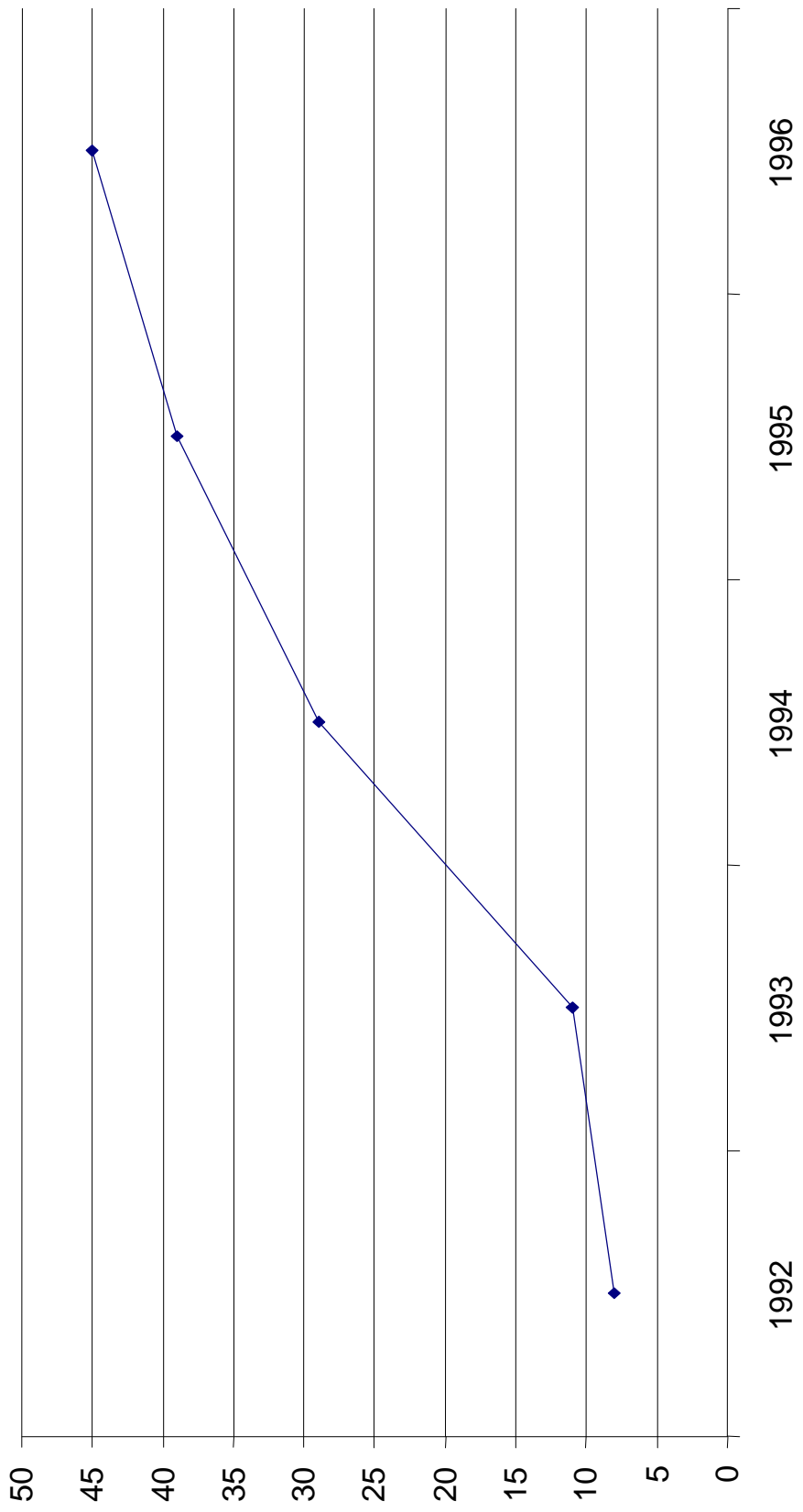


Figure 2

If
 Claim Payments in current calendar year on claims incurred in prior calendar years
 Claim Reserve at the end of the current calendar year on claims incurred in prior calendar years
 >
 Claim Reserve reported at the Prior Year-End
 then the HMO under reserved initially

If
 Claim Payments in current calendar year on claims incurred in prior calendar years
 +
 Claim Reserve at the end of the current calendar year on claims incurred in prior calendar years
 <
 Claim Reserve reported at the Prior Year-End
 then the HMO over reserved initially

Figure 3
Crosscheck Failures Found within Specific Annual Statement Tables

Table Failures	Number of Companies Failed	Percentage of Failures to Total Companies Filed with NAIC
Premium, Enrollment and Utilization Table	149	37%
Schedule B	59	14%
Schedule C	39	9%
Schedule D – Part 1	29	7%
Schedule H – Section 1	24	6%
Schedule M – Part 2	43	10%

1995 Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance

Market Distribution and Average Cost By Policy Form and Amount of Insurance

by NAIC Staff

The *1995 Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance* report (the homeowners report) is published by the NAIC. The following information outlines the data found within the homeowners report by providing definitions and graphical illustrations. References to specific tables within the following text are referring to actual tables found within the homeowners report. These tables are not a part of the following article. To order the homeowners report, call the NAIC Publications Department at (816) 374-7259.

Purpose of Report

The purpose of the homeowners report is to provide information about premium and exposure data for dwelling fire insurance policies and for homeowners insurance package policies, which include both owner-occupied and tenants and condominium/cooperative unit owners policy forms. The report contains descriptions of the data and a discussion about how the data may be associated with certain economic, demographic and natural phenomenon that may impact premiums and coverage amounts. Since this is the first published version of this report, market trends cannot yet be identified.

Data

The data compiled for the publication consist of written exposures, calculated in house-years, and aggregate written premiums by state and countrywide for the 1995 data year. Premium and exposure information was collected for all states, except California,¹ and for the District of Columbia. The data are displayed in five tables. Three tables show individual state and countrywide² exposures grouped by policy form, policy type and by amount of insurance coverage, divided into ranges, with percentages of total exposures provided. The last two tables display by-state and countrywide average premiums, calculated by dividing premiums by exposures, for each policy form and range of insurance coverage. Percentages of totals are provided.

Policy forms included in the report are described in detail in the following section. The amount of coverage ranges for the dwelling fire and homeowners owner-occupied policy forms differ from those for the homeowners tenant and condominium insurance because the premium data for the latter two forms do not include coverage for the residential structure.

Data for all states, except Texas, are provided by the American Association of Insurance Services (AAIS), the Insurance Services Office, Inc. (ISO),

¹ In 1998, the California Insurance Department will begin compiling dwelling and homeowners insurance premium and exposure data for the state. 1996 data should be available for next year's report.

² In this report, the term "countrywide" will refer to all states in the U.S. except California.

the National Association of Independent Insurers (NAII) and the National Independent Statistical Service (NISS). Texas data were obtained from the Texas Department of Insurance. In 1995, the Texas department developed its own home insurance policy forms that were similar, but not identical, to homeowner policy forms used countrywide. Beginning in 1997, however, home insurers writing in Texas were permitted to use the same forms used in other states. State Farm Insurance Company, the largest home insurance writer in the state of Illinois, provided its own premium and exposure data for that state as it does not report its Illinois business to a statistical agent. The cooperation and assistance of these providers is greatly appreciated.

Limitations on the Data

Average premium is an imperfect measure of the relative “price” of insurance because of wide variations in economic conditions and real estate values from state to state. Even when comparing identical policy forms and amounts of insurance, the property being insured may significantly differ by state. These market differences are explored in more detail in a later section.

Policy Forms/Types

Data for the report was collected for eight policy forms that are grouped into three broad categories (policy types) for comparison purposes:

Dwelling fire policy (one family, owner occupied, non-seasonal buildings)

- Indicated by DW: Protects building only; covered perils include fire and may customarily include “extended coverage;” however, premium data collected for dwelling fire policies in this report include only the dwelling fire coverage.

Homeowners package policies for owner-occupied dwelling (1-4 family units)

- HO-1: Basic “named-perils”³ coverage on buildings and personal property.
- HO-2: Broad named-perils coverage on buildings and personal property; provides coverage for more perils than HO-1 package.
- HO-3: Provides “all-risks”⁴ coverage on buildings, broad named-peril coverage on personal property; most common package written.
- HO-5: Provides all-risks coverage on buildings and personal property; form not in common use.
- HO-8: Repair cost coverage for a dwelling whose replacement cost greatly exceeds its market value. Personal property, theft and additional coverages provided are similar to coverages provided under an HO-1 policy.

Homeowners package policies for tenants, condominium and cooperative unit owners

- HO-4 (Renter’s Insurance): Broad named-perils coverage for the personal property of tenants.
- HO-6 (Condo/Co-op Insurance): Broad named-perils coverage for personal property of condominium or cooperative unit owners, as well as certain building items in which the unit owner may have an insurable interest.

Premium data for the dwelling fire policies in this report do not include an amount for extended coverage (allied lines). Also, unlike homeowners policies, dwelling policies do not provide coverage for contents or liability unless additional contents

³ Insures against any loss incurred by the insured due to a peril named in the policy (i.e., fire, lightning, hail, etc.)

⁴ Insures against risks of direct loss except losses specifically stated in the policy as exempt from coverage.

coverage is purchased. Premium data for owner-occupied homeowners policies represent a "package" of coverages for buildings, contents and liability. Accordingly, in each coverage range the average premium for the dwelling fire policy represents less coverage than the corresponding homeowners policies. Homeowners tenants and condominium policies are similar to owner-occupied policies with respect to covered perils, content coverage and liability. However, there is no building coverage other than the condo/co-op owner's insurable interest.

Analysis of the Data

Table 1 provides exposure data in house years by policy type. In 1995, homeowners owner-occupied policy exposures accounted for 82.9 percent of overall exposures countrywide. Tenant and condominium policy exposures accounted for 14.5 percent of the total, while dwelling fire exposures made up the remaining 2.6 percent. Exposure data for the eight individual policy forms is provided in Table 2. The HO-3 accounted for 71.1 percent of all policy exposures, making it the most common policy sold by far.

Figure 1 shows the percentage breakdown of exposures for owner-occupied homeowners policy forms. Countrywide, 85.7 percent of these exposures were written on the HO-3 form.

Figure 2 shows the percentage breakdown of countrywide exposures for the tenant and condo/co-op policy forms. Of these, 68.6 percent were written on the HO-4 form.

Table 3 presents data for the three types of policies by amounts of insurance. Countrywide, 72.2 percent of dwelling fire and owner-occupied policies are written for insurance coverage amounts between \$50,000 and \$150,000. Close to the same percentage, 69 percent, represents tenant and condominium insurance written in amounts below \$32,000. When comparing dwelling fire and owner-occupied policies by form (Table 4), HO-3 exposures represent more than 85 percent of the total in each coverage range except \$500,000+, where the HO-5 form accounts for 22 percent of the total. Except for the dwelling policy at coverage between \$0-\$24,999, and the HO-5 form at coverage of \$500,000+, no other policy

form accounts for more than 20 percent in any coverage range.

Figure 3 provides a comparison of dwelling fire and homeowners owner-occupied policy exposures by amounts of insurance coverage. The comparison shows that dwelling fire policies were most prevalent in the lower coverage ranges. At insurance coverage amounts between \$0-\$24,999, dwelling fire exposures accounted for 58.7 percent of the countrywide total, the largest percentage for all dwelling and owner-occupied forms.

Between \$25,000-\$49,000 dwelling fire policies represent 18.7 percent of total exposures then drop to 2.4 percent at insurance amounts of \$50,000-\$74,999. At coverage amounts above \$75,000 dwelling fire exposures account for less than 1 percent of the total for these forms.

Figure 4 compares HO-4 and HO-6 policy forms by coverage amounts. Countrywide, the HO-4 (tenants) form represents more policies written at lower coverage amounts. At coverage amounts above \$26,000 the majority of exposures are written on the HO-6 (condo/co-op) form.

Tables 4 and 5 display by-state average premiums for each policy form. Examining the average premium data countrywide for dwelling fire and owner-occupied homeowners policies, some expected results occur. In general, the average premium increases as the amount of coverage increases for all policy types. Dwelling fire premiums are lower in all coverage ranges when compared to homeowners premiums. This is influenced, in part, by the exclusion of contents, other perils, etc., that homeowners packages cover.

Some counterintuitive results also appear in the data. The HO-2 package might be expected to have a higher average premium than the HO-1 since it provides more extensive coverage. However, Figure 5 shows that for coverage amounts of \$25,000 through \$99,999, HO-1 average premiums are higher than HO-2 premiums. Presumably, this is a result of differences in the types of properties that tend to be insured on HO-1 forms versus those that tend to be insured on HO-2 and HO-3 forms.

Another counterintuitive result, displayed in Figure 6, is that for coverage of \$125,000 and above, HO-2 policies, usually had higher average premiums than the more common HO-3 package. As the number of HO-2 policies written in high price ranges is relatively small, this result presumably occurs due to differing mixes of business.

Factors Affecting the Cost of Insurance

Many factors impact the cost of home insurance. These factors affect wide differences in average premiums throughout the United States. A primary reason for this countrywide variation is the value of real estate and, as a subset of this, construction costs. In general, real estate values and construction costs tend to be higher in areas of greater population densities, where scarcity of land puts upward pressure on land and property values. Other areas with relatively higher real estate values include tourist areas, where there is an influx of money from outside the community and areas of rapid economic development. Construction costs vary based on the type of residence being built, availability of building materials and input factors driven by local climate and regulations, such as value added designs to reduce damages to the structure from earthquakes or hurricanes. As shown in Figures 7 and 8, these variations in costs are reflected in the wide range that exists throughout the United States in the median amounts of insurance purchased.

Catastrophe Exposure

Degree of exposure to catastrophe also affects the cost of insurance to homeowners. Brush and forest fires, tornadoes, high winds, hail, freezing rain, snow storms, hurricanes, earthquakes and civil disturbances are some common types of catastrophes that occur in the United States. Although exposure to catastrophe exists in all areas, some communities are more prone to certain types than others. Brush and forest fires are more common in the West. Hurricane exposure is greater in areas near the Gulf of Mexico and the Atlantic and Pacific Oceans. Exposure to tornado damage is greatest in the central and southeastern United States even though tornadoes can and do occur in nearly every state. Earthquake exposure also exists throughout

the country since faults are located in all regions. Most recently there have been catastrophic earthquakes in the West, yet there are predictions that even greater earthquakes will occur in the New Madrid area in the Midwest. Civil disturbances, also, are not specific to any geographic area, but have typically occurred in larger urban areas.

Since 1989, catastrophes have been occurring with greater frequency and severity, and, in the last decade, have become an even greater consideration in the pricing of home insurance. For the five-year period 1984-1988, total insured losses for catastrophes (in 1993 dollars) were just under \$10 billion. In the following five-year period, 1989-1993, total catastrophe losses spiraled to nearly \$37.5 billion.⁵ In fact, of the ten most costly insured catastrophes, only one occurred prior to 1989. Figure 9 shows, in chronological order, major catastrophes from 1989 to 1995 (in dollar values at time of loss): even when all catastrophes in U.S. history are converted to 1995 dollars, the Oakland fire, the Los Angeles riot and the California brush fires rank in the top ten worst fire catastrophes in U.S. history.⁶ Between 1967 and 1988, the number of tornadoes in the United States exceeded 1,000 in only two years. However, the number of tornadoes has exceeded 1,000 in each year from 1990 through 1995.⁷ It is possible that the numbers have increased from better reporting rather than from an actual increase in the number of tornadoes, but these figures serve to emphasize the variability and unpredictability of catastrophe losses. The impact that the various catastrophes described above have on rates from state to state must be considered in any evaluation of average premiums.

Other Variables to Consider

There are several other variables that impact the frequency and severity of home insurance

⁵ Property Claim Services Division of the American Insurance Services Group, Inc.; Insurance Information Institute

⁶ Source: National Fire Data Center (United States Fire Association)

⁷ Source: National Climatic Data Center, NESDIS, NOAA, U.S. Department of Commerce, and Insurance Information Institute

losses and contribute to its cost. Loss experience and premiums among states and regions will vary considerably due to unique combinations of these variables. The following are some of the more significant variables to consider in understanding these differences.

Building Structures: Recent losses from natural disasters, especially hurricanes and earthquakes, have increased awareness of the importance of minimizing the potential for damage to both new and existing structures. This is one reason why many municipalities in high-risk areas are implementing more stringent building codes. The types of building materials used in construction also impact premiums due to an increased cost to repair or replace expensive materials or an increased risk of loss inherent in structures, such as wood-frame houses. Specialized building features, such as the wood shingle roof which is prone to hailstorm and lightening damage, can ultimately impact premiums in areas where they become increasingly popular.

Urban/Rural Issues: When trending data over several years, it is important to consider the impact of urbanization. Large cities often have burglary or crime rates that are higher than those of the states in which they are located. Some have crime rates higher than the countrywide rate.⁸ Catastrophic riots are generally an urban phenomenon and arson is the leading cause of residential fires in many metropolitan areas.⁹ In rural areas, heating system malfunctions are the principal causes of residential fires.¹⁰ Also, an area's level of fire protection is a major criterion in home insurance rating and it is rarely cost-feasible for rural areas to maintain the level of fire protection available to urban residents.

⁸ Source: U.S. Bureau of the Census.

⁹ Source: National Fire Data Center (United States Fire Association)

¹⁰ Source: National Fire Data Center (United States Fire Association)

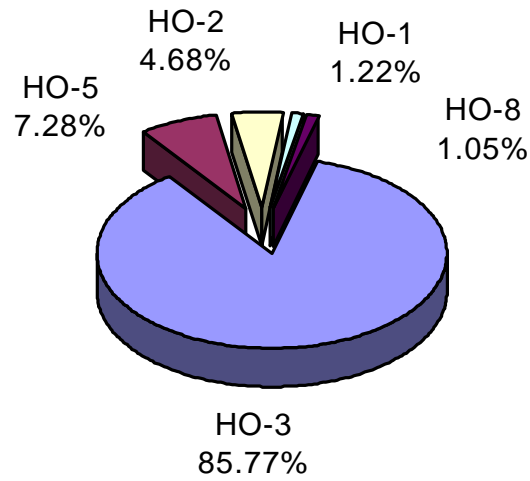
Economic Considerations: Economic phenomena have a significant impact on home insurance premiums. Mortgage and consumer interest rate and inflation have an effect on the values of real estate, property and contents (as consumers purchase more expensive durable goods), which in turn affects the required amount of insurance. Additionally, inflation increases the dollar amount of insurance premiums over time.

Other: Since heating systems are a principal cause of residential fires, warmer climates tend to minimize that particular risk. However, other common causes of fires, such as careless smoking, cooking, electrical problems and children playing with matches are not peculiar to any geographic region. Wood-burning fireplaces, multi-car garages, wood decks, etc., are usually not considered part of the dwelling when determining the value of the residence for insurability; however, there is generally an increased cost to insure home with these kinds of appurtenances. On the other hand, added features that reduce the risk of loss, such as security systems and fire detection devices, will often qualify a home for premium discounts.

Summary

Many factors impact home insurance premiums and losses. Real estate values, building and construction costs, catastrophes, urban/rural issues and economic phenomena result in wide variations in premiums, not only by region or state, but on local levels as well. Although the data in this report does not provide the necessary information for a thorough analysis of the affect of these factors on home insurance premiums, it is important to recognize the connections discussed in this narrative.

**Figure 1 - Percent of Owner-Occupied Written Exposures
By Policy Form
Countrywide**



**Figure 2 - Percent of Tenant and Condominium/Co-op Written
Exposures by Policy Form
Countrywide**

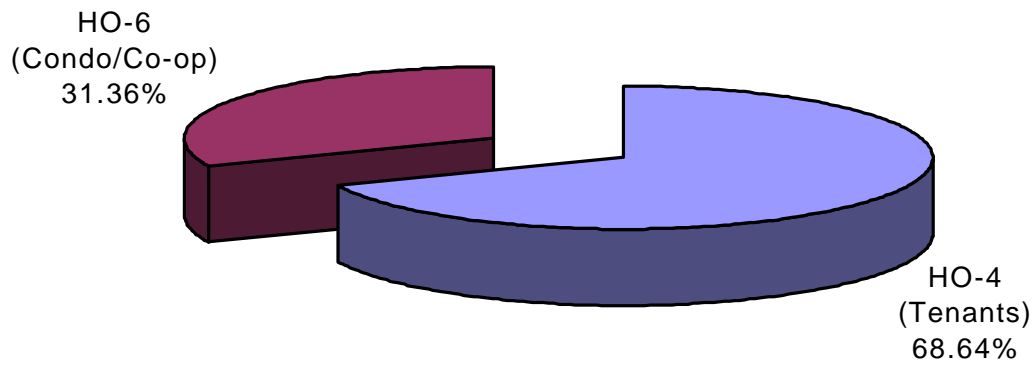


Figure 3 - Percent Comparison of Dwelling Fire and Homeowner Owner-Occupied Written Exposures by Amount of Insurance

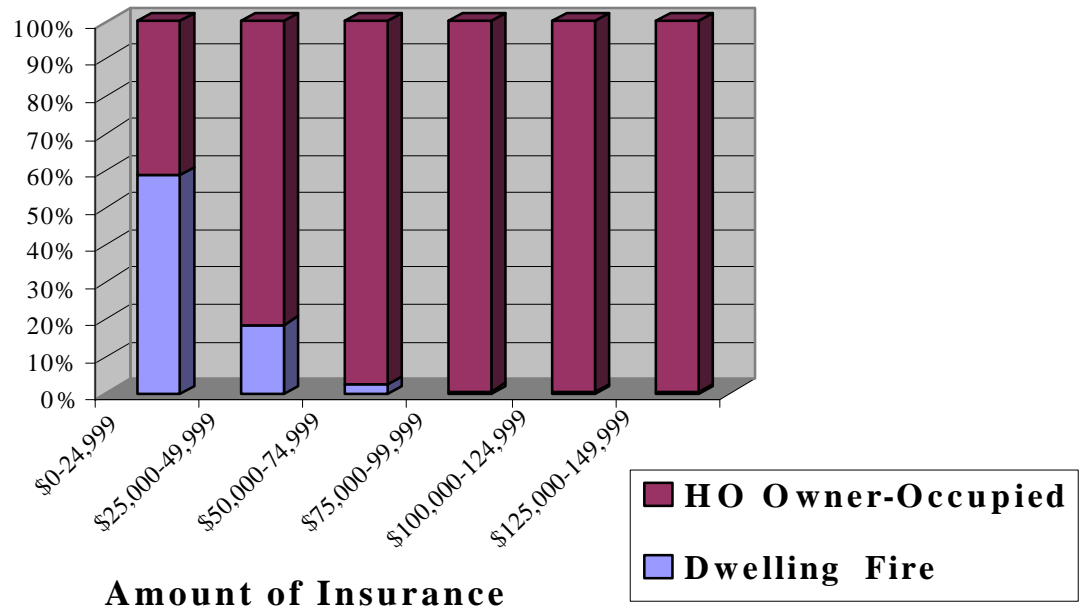


Figure 4 - Percent Comparison of Tenants and Condo/Co-op Written Exposures by Amount of Insurance

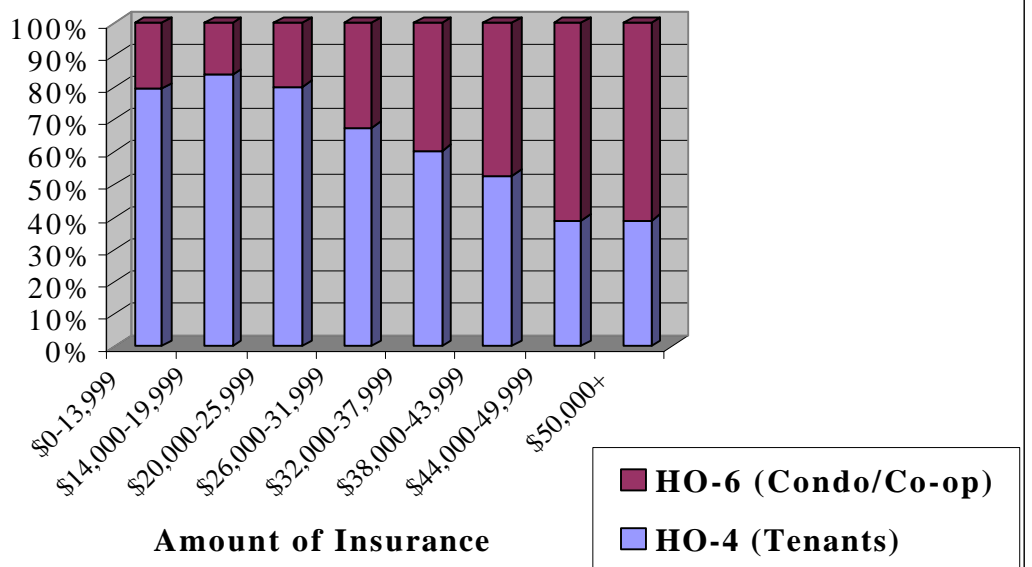


Figure 5 - Average Premium Comparison of HO-1 and HO-2 Policies by Amount of Insurance

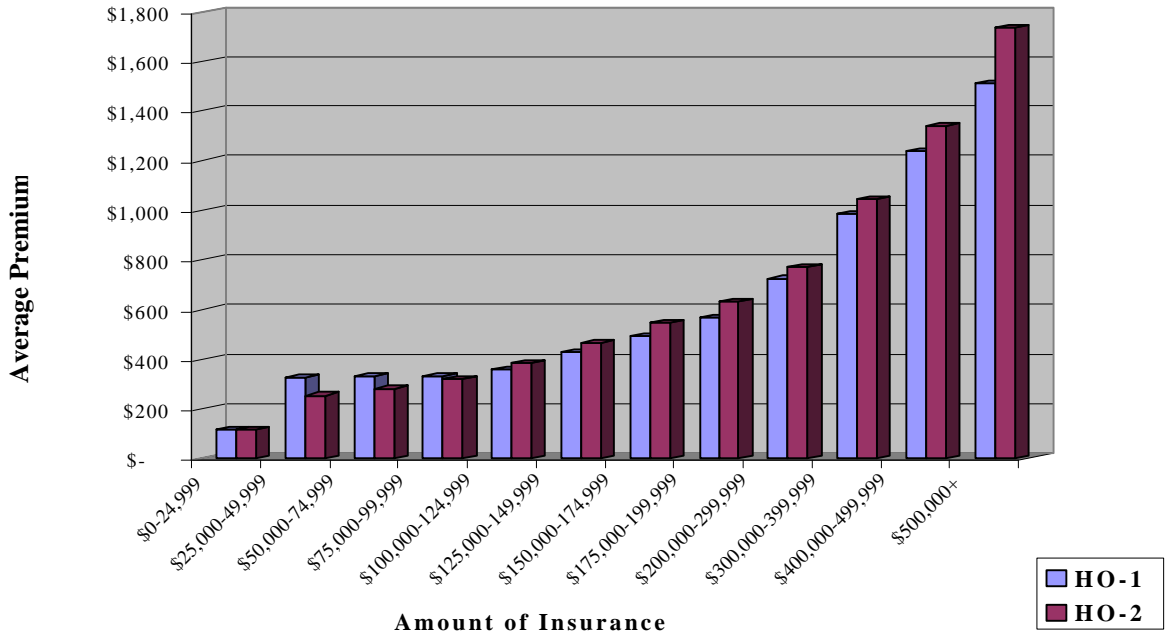


Figure 6 - Average Premium Comparison of HO-2 and HO-3 Policies at Insurance Amounts of \$125,000+

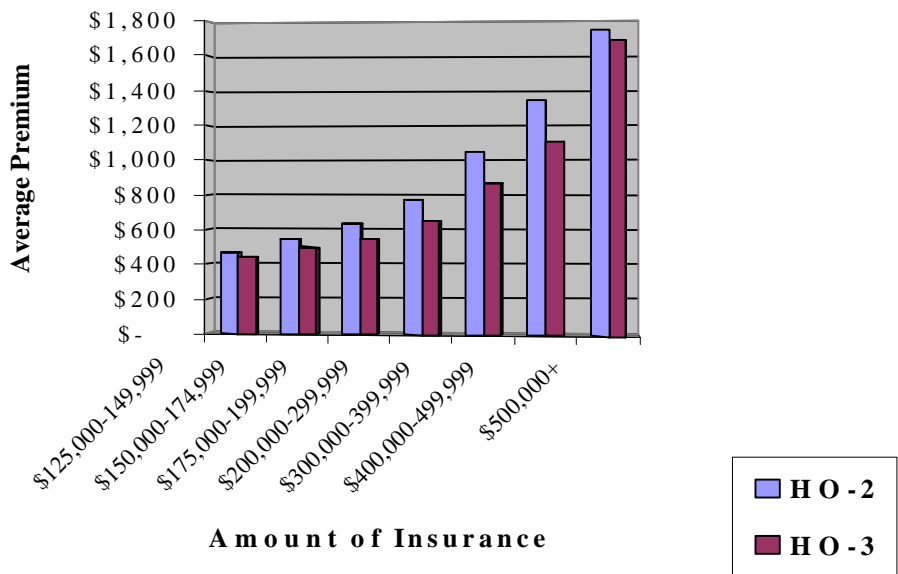
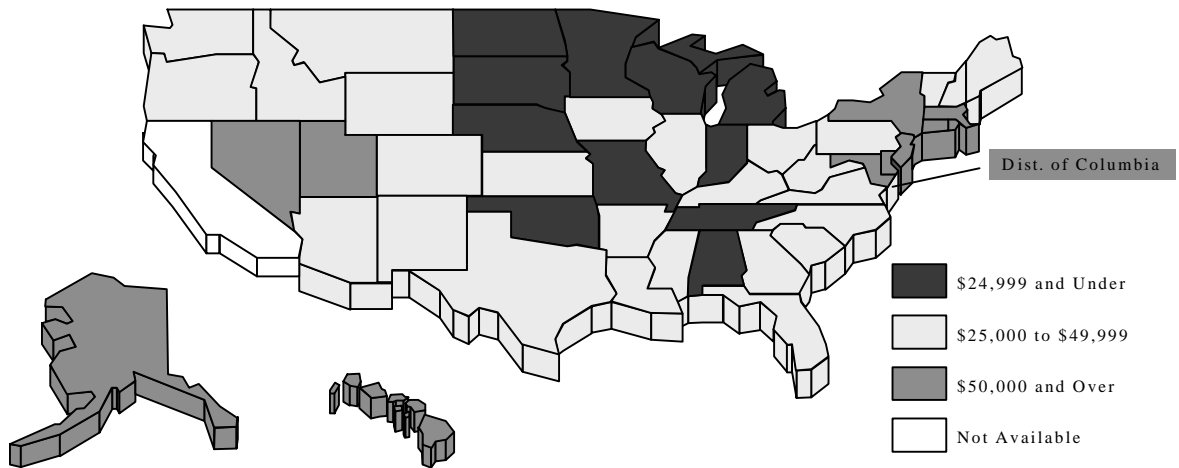


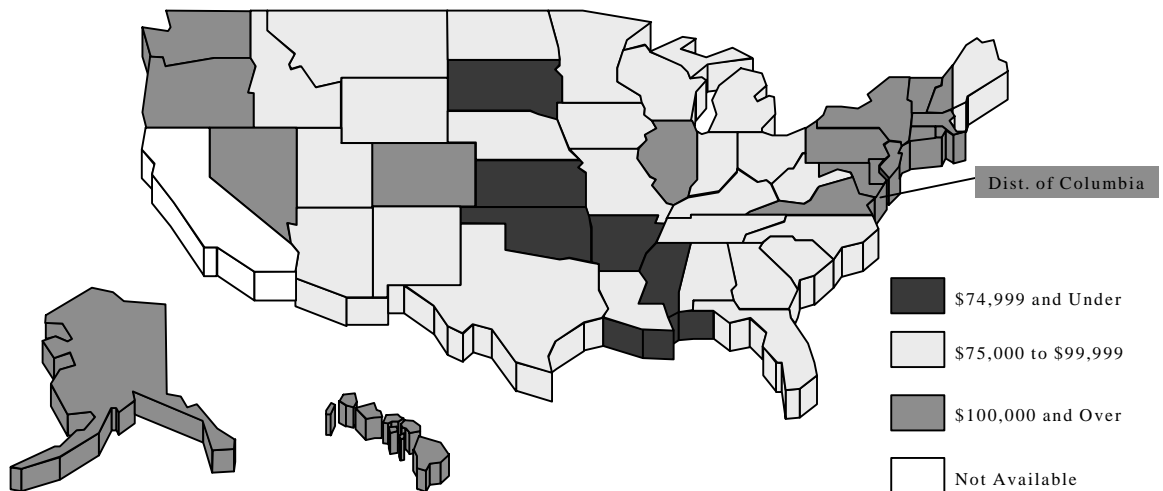
Figure 7 1995 Dwelling Fire Median Amount of Insurance



Source: NAIC

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Figure 8 1995 Homeowners Median Amount of Insurance



Source: NAIC

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Figure 9
Major Catastrophes From 1989 to 1995

<u>Month/Year</u>	<u>Catastrophe</u>	<u>Estimated Insured Loss*</u>
September, 1989	Hurricane Hugo	\$4,195,000,000
October, 1989	Loma Prieta Earthquake	\$960,000,000
October, 1991	Oakland, CA Fire	\$1,700,000,000
April-May, 1992	Los Angeles Riots	\$775,000,000
August, 1992	Hurricane Andrew	\$15,500,000,000
September, 1992	Hurricane Iniki	\$1,600,000,000
March, 1993	20 State Winter Storm	\$1,750,000,000
October-November, 1993	California Brush Fires	\$950,000,000
January, 1994	Northridge Earthquake	\$12,500,000,000
May, 1995	Texas/New Mexico Storms	\$1,135,000,000
October, 1995	Hurricane Opal	\$2,100,000,000

* Property Claim Services Division of the American Insurance Services Group, Inc.; Insurance Information Institute

State Average Expenditures & Premiums for Personal Automobile Insurance in 1996

by NAIC staff

Each year the NAIC publishes the *State Average Expenditures & Premiums for Personal Automobile Insurance* report. The report shows estimated state average expenditures and average premiums per insured vehicle for private passenger automobile insurance. The NAIC gathers the auto expenditures and premiums data primarily from the National Association of Independent Insurers (NAII), Insurance Services Office (ISO), National Independent Statistical Service (NISS) and American Association of Insurance Services (AAIS). Data was also provided by the California, New Jersey, South Carolina and Texas Departments of Insurance and the Massachusetts Commonwealth Automobile Reinsurers.

The 1996 report is divided into several tables. Table 1 shows average expenditures and average premiums in 1996 by state, including separate averages for liability, collision and comprehensive coverages. Tables 2 through 6 show average expenditures and average premium trends by state for the years 1992-1996. Tables 7(a) through 7(e) provide the underlying data on written premiums and written car-years by state. A written car-year is equal to 365 days of insurance coverage for a single vehicle and is the standard measure of exposure for automobile insurance.

The *State Average Expenditures & Premiums for Personal Automobile Insurance* report has become a very popular source for information in recent years. Rising auto insurance premiums have caused the public as well as regulators and politicians to keep a watchful eye on the yearly changes in auto insurance rates. However, it should be noted that using this report to compare the average expenditures and average premiums between states can be misleading. The data within the report does tend to reflect the average expenditures within a state, but it cannot be assumed that the data for each state represents an equal exposure and coverage upon which conclusions can be drawn concerning the relative purchasing power of the insurance dollar in each state.

Many factors affect the prices of insurance within each state. These factors include, but are not limited to the following:

- The relative amounts of the coverages purchased
- The distribution of deductibles and limits selected
- The types of vehicles insured
- Driver demographics
- Traffic conditions
- The proportion of drivers in urban areas
- The cost of living
- Wage and income levels
- Medical costs
- Law enforcement
- Road maintenance
- Vehicle theft and fraud
- No-fault restrictions
- Propensity to sue
- Relative generosity of jury awards
- Premium taxes
- Auto repair costs
- Average underwriting and loss adjustment expense factors
- Socioeconomic factors

Insurance prices are determined primarily by the cost of claims filed by the insured. Many of these cost factors can impact price not only from state-to-state, but from community-to-community as well. Certain broad characteristics contribute to the frequency and severity of loss costs, and hence premiums, in a particular state. For instance, "general economic conditions" can affect

the price of coverage but no direct measure of this phenomenon exists. Although these broad characteristics that affect insurance premiums cannot be measured directly, some measurable variables can be used as imperfect substitutes to approximate the effect of these broad characteristics.

Figures 1 through 3 are presented to demonstrate three variables that are highly correlated with average premiums. These three graphs show data from the 10 highest average expenditure states on the left side of the graph and the 10 lowest average expenditure states on the right side of the graph according to the *State Average Expenditures & Premiums for Personal Automobile Insurance in 1996*.

Figure 1 shows millions of miles driven per mile of roadway for each of the 20 states depicted. This is a proxy for measuring the traffic congestion in a particular state. In general, the states with the highest average expenditures also have a larger number of miles driven per mile of roadway.

Figure 2 displays the percentage of the states' population that lives in metropolitan areas. The average percentage for the 10 largest expenditure states is higher than the average percentage for the 10 lowest expenditure states.

Figure 3 charts the income per capita for the same 20 states. The average per capita annual income can serve as a proxy for the general level of economic activity or wage and price levels in a state. Again, on average the 10 largest expenditure states have a higher income per capita than the 10 lowest expenditure states.

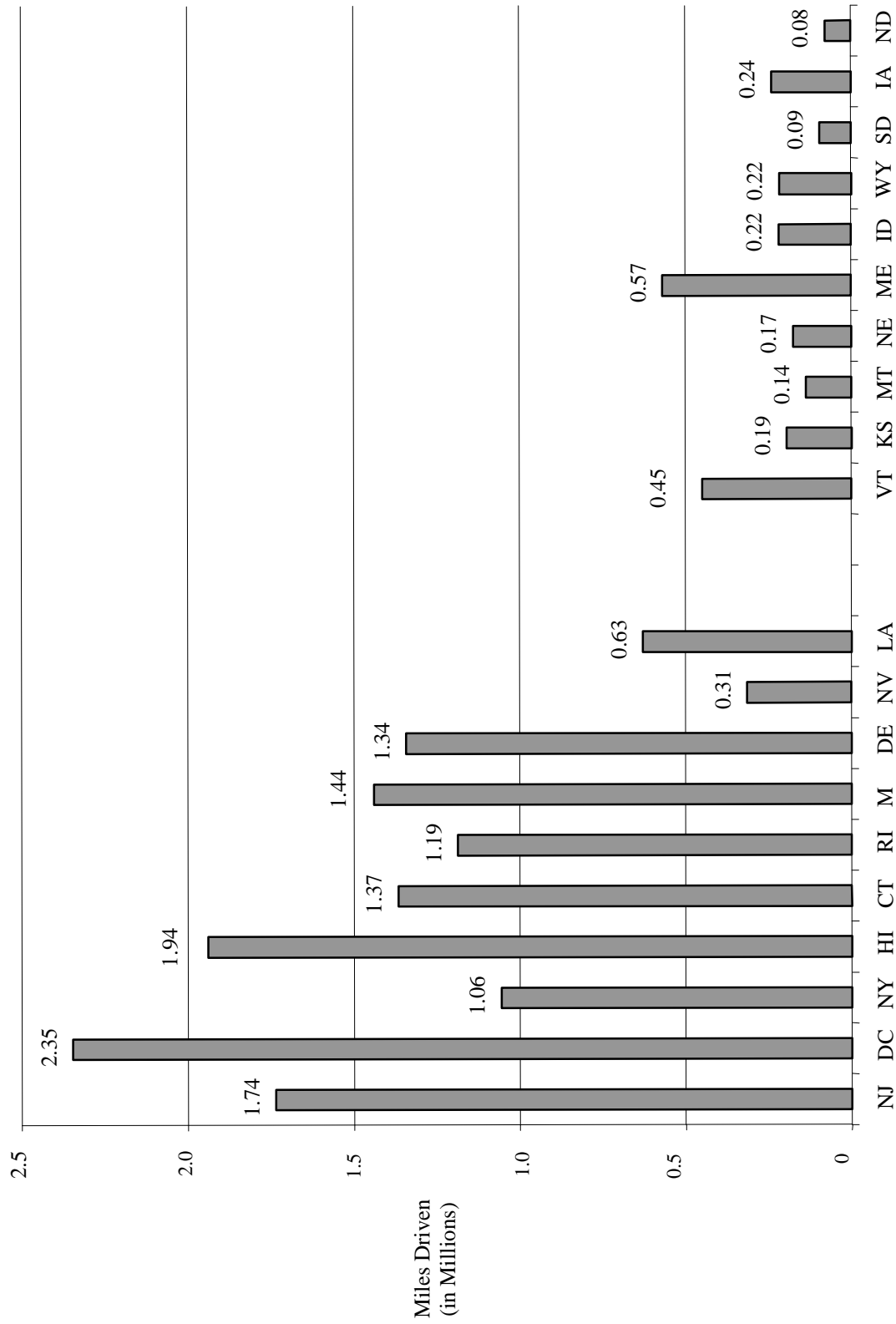
By viewing the charts, a relation is clearly seen between the variables presented and auto insurance premiums. As discussed above, numerous variables affect the prices of auto insurance. New variables are continually being introduced into the complex auto premium calculation. For example, the air bag was introduced, which has caused controversy related to the safety of the mechanisms and insurance safety discounts that are given for autos that have the air bags. More variables are sure to be on the horizon to further complicate the premium calculations.

Figure 4 lists the annual rates of change in consumer price indices along with the average expenditures and premiums for 1992 through 1996. The Consumer Price Index (CPI) for all items measures the cost of a fixed set of consumer goods and services purchased by a set population. Similarly, the CPI for automobile insurance is an index measuring the cost of automobile insurance to consumers over time. The annual rate of change in the average premium and average expenditure will vary from the annual rate of change in the automobile insurance price index. The average premium and average expenditure are affected by changes in insurance prices as well as the choices individual consumers make as to the types and amounts of insurance purchased, whereas the latter holds the amount of insurance constant to measure price changes in a uniform product.

The NAIC will once again begin publication of the *Auto Insurance Database Report* as of year-end 1998 to be published in 1999. This report was last published December 1993. The *Auto Insurance Database Report* contains extensive data on many factors that affect the auto insurance industry. The report contains data on insurance, traffic conditions, medical costs, crime, auto repair costs, legal system, economic/demographics and state laws. The *State Average Expenditures & Premiums for Personal Automobile Insurance* report information is also contained within the *Auto Insurance Database Report*.

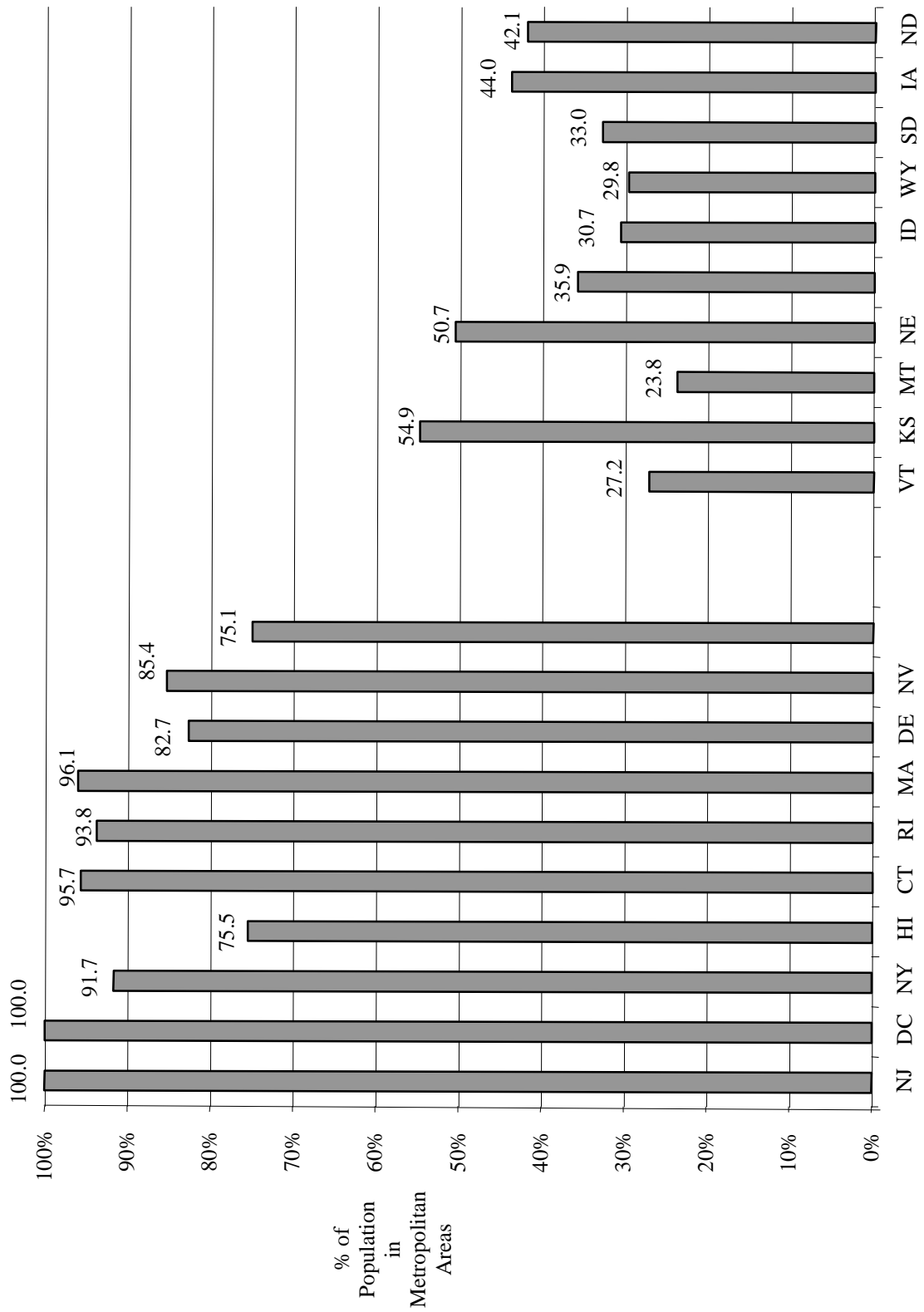
The *State Average Expenditures & Premiums for Personal Automobile Insurance in 1996* is now available for purchase from the NAIC. To order, call the NAIC Publications Department at (816) 374-7259.

Figure 1
Millions of Miles Driven per Mile of Roadway



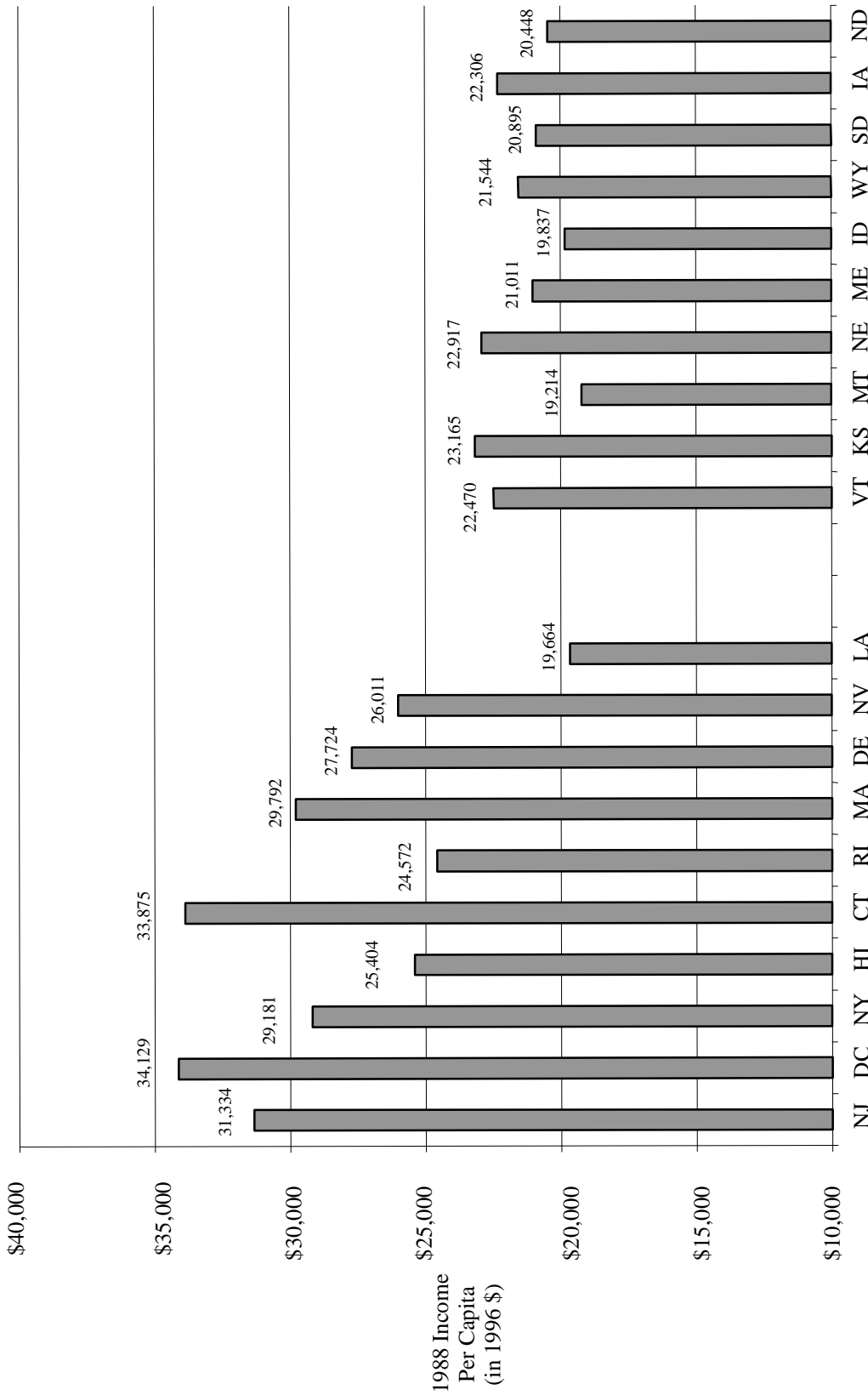
Source: Federal Highway Administration, 1996

Figure 2
Percent of State Living in Metropolitan Areas



Source: U.S. Bureau of the Census Internet Site [<http://www.census.gov/>]

Figure 3
Income Per Capita



Source: Bureau of Labor Statistics Database [<http://stats.bls.gov/datahome.htm>]

Figure 4
Annual Rates of Change in Consumer Price Indices, Average Expenditures and Premiums

	1992	1993	1994	1995	1996	5-Year Average
Consumer Price Index - All Items*	3.0%	3.0%	2.6%	2.8%	3.0%	2.9%
CPI - Auto Insurance*	7.3%	5.5%	3.7%	4.2%	4.1%	5.0%
CPI - Total Medical Care*	7.4%	5.9%	4.8%	4.5%	3.5%	5.2%
CPI - Auto Maintenance and Repair*	3.9%	3.3%	3.0%	2.5%	2.9%	3.1%
CPI - Legal Service Fees*	2.5%	2.7%	3.7%	2.5%	2.0%	2.7%
CPI - New Vehicles*	2.5%	2.7%	3.7%	2.5%	2.0%	2.7%
CPI - Used Vehicles*	4.3%	8.7%	5.8%	10.4%	0.3%	5.9%
Average Expenditure**	3.6%	2.8%	2.4%	2.6%	2.4%	2.8%
Combined Average Premium**	3.8%	2.5%	1.7%	2.3%	2.0%	2.5%
Average Liability Premium**	5.1%	4.1%	2.4%	1.9%	0.6%	3.9%
Average Collision Premium**	0.7%	-0.1%	-0.2%	3.3%	4.3%	1.6%
Average Comprehensive Premium**	5.5%	1.7%	2.7%	2.0%	3.0%	3.0%

* U.S. Bureau of Labor statistics [<http://www.bls.gov>]
** NAIC

What About Fraternal Insurance Companies?

by NAIC Staff

The following article is provided to give a brief overview of the fraternal insurance industry and its purpose.

What is a Fraternal Insurance Company?

Fraternal insurance companies are established to provide group insurance benefits for a fraternal corporation, society, order or voluntary association. These types of insurers offer only life and health insurance contracts and usually operate on a non-profit basis. Most fraternal companies have a lodge system and a ritualistic form of operation. The fraternal companies are normally established by groups of people with religious, ethnic or trade commonalties.

Number and Distribution of Companies

As can be seen in Figure 1, the number of fraternal insurance companies indicating that they are required to file annual financial data with the NAIC has decreased over the last several years. This decline is a result of several different situations, including: mergers and consolidations, companies voluntarily going out of business or companies no longer being required by their state of domicile to file with the NAIC. In Figure 1, the data years represent the year for which data was filed. So, for example, data year 1996 represents

data reported for the calendar year ending December 31, 1996.

Fraternal companies are domiciled in states all across the United States. Figure 2 shows the number of fraternal companies domiciled within each of the states for data year 1996. The companies represented within Figure 2 are those companies that have indicated that they are required by their state of domicile to file annual financial data with the NAIC. This information was taken from the NAIC database.

Fraternal insurers represent only a small portion of the life insurance market. These companies only seek to meet the insurance needs of the members within their fraternal organization and, therefore, are not competitive for market share percentages. Also, the non-profit status of the fraternal insurers indicates the non-competitive goals of the organizations.

Regulation of Fraternal Insurers

Fraternal insurance companies are regulated by state insurance departments as are other life insurance companies. They are required to undergo financial examinations and reviews and to meet certain state requirements based on their state of domicile's laws and regulations. The fraternal companies report annual and quarterly financial data to the states where they are licensed and to the NAIC. However, the annual and quarterly forms used to report their financial data have been formulated to specifically fit the fraternal business type. These forms are very similar to the life insurance reporting forms and are continually updated to be as consistent as possible with the life insurance forms.

In Summary

As discussed in the previous text, fraternal insurers hold a special niche within the insurance industry. These companies have linked the commonalties of a group of persons with the life and health insurance needs of that group. This approach is not new to the insurance industry as it has been used successfully for many years.

Fraternal Companies Required to File with the NAIC

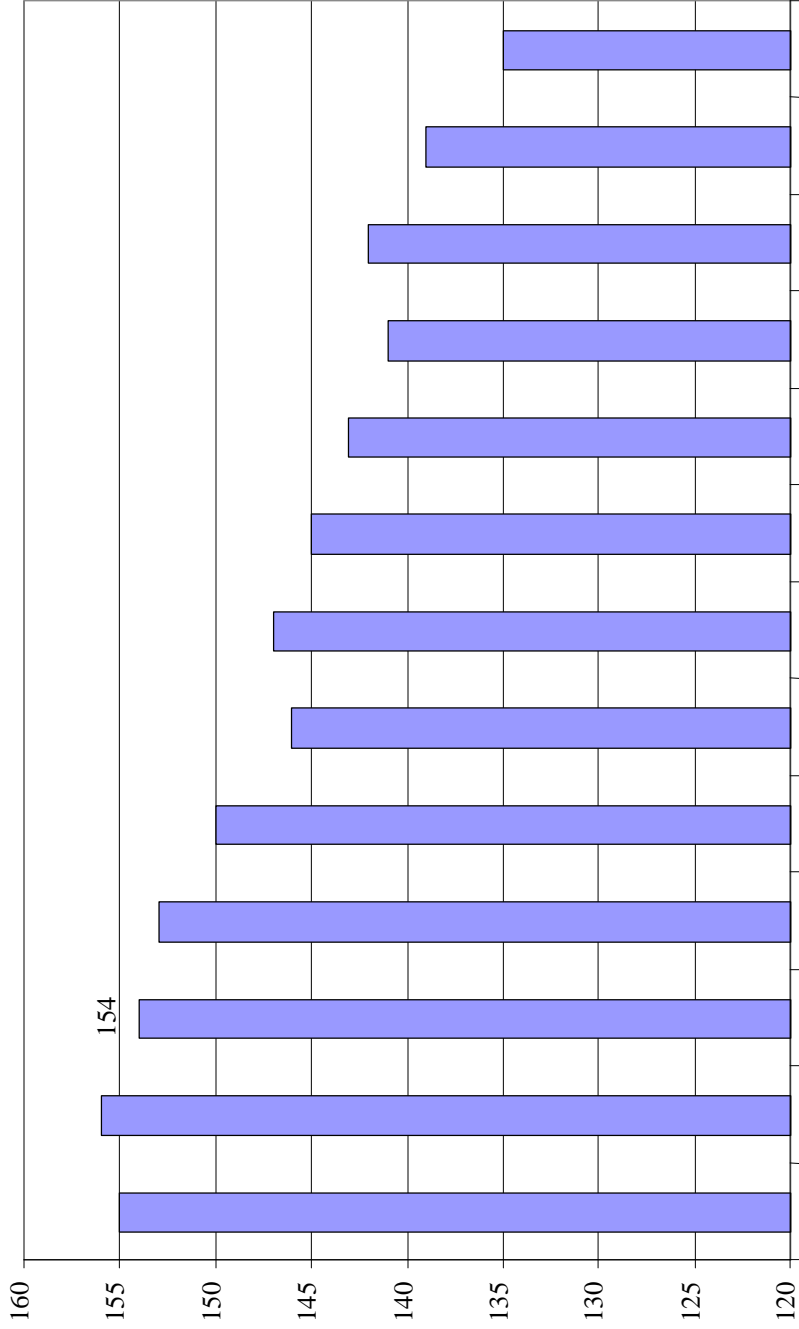


Figure 2
1996 Fraternal Insurance Companies Required to File with the NAIC
Listed by State of Domicile

<u>State</u>	<u>Number of Domestic Fraternal</u>	<u>State</u>	<u>Number of Domestic Fraternal</u>
Alabama	0	Montana	0
Alaska	0	Nebraska	1
American Samoa	0	Nevada	0
Arizona	0	New Hampshire	2
Arkansas	0	New Jersey	4
California	7	New Mexico	0
Colorado	2	New York	9
Connecticut	2	North Carolina	0
Delaware	1	North Dakota	0
District of Columbia	2	Ohio	14
Florida	0	Oklahoma	0
Georgia	0	Oregon	1
Guam	0	Pennsylvania	34
Hawaii	0	Puerto Rico	0
Idaho	0	Rhode Island	0
Illinois	21	South Carolina	0
Indiana	3	South Dakota	0
Iowa	1	Tennessee	1
Kansas	0	Texas	10
Kentucky	0	Utah	0
Louisiana	0	Vermont	0
Maine	0	Virgin Islands	0
Maryland	0	Virginia	0
Massachusetts	3	Washington	0
Michigan	2	West Virginia	0
Minnesota	6	Wisconsin	7
Mississippi	0	Wyoming	0
Missouri	2		