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## A Message to Our Readers

Traditionally, the *RQ* has served as a vehicle to showcase insurance department and NAIC research projects and studies, to share regulator viewpoints and to present insurance topics of global, national and local interest to our readers. Its role is that of “little sibling” to the *Journal of Insurance Regulation* and as such we are seeking to increase its circulation among regulators and other insurance professionals and encourage readers to contribute to its content.

NAIC staff researchers and writers intend to keep you informed through the *RQ*. We will tell you about projects, programs and products developed by NAIC committees and working groups, and we will inundate you with pages and pages of statistical and financial information from the world’s most comprehensive databases. We want the *RQ* to evolve. We want it to become a professional journal for our members. We want regulators to use the *RQ* as a forum to advocate regulatory viewpoints, share regulatory theories and promote regulatory ideas and innovations.

The release of each *RQ* is scheduled approximately one month before each national

meeting: Spring—February; Summer—May; Fall—August and Winter—November. This is intended to associate the distribution of each *RQ* issue with the NAIC quarterly national meetings, which are also designated by season.

Contributing writers can submit articles and other information for publication with the expectation that each *RQ* issue will be exposed to more than 1,000 meeting attendees.

**If you would like to contribute an article(s) of interest on an insurance issue, share a department project or idea, provide written commentary in response to someone else’s project or ideas, advertise an event or special activity or just get your name in print, contact Natalai Hughes, [nhughes@naic.org](mailto:nhughes@naic.org), or Teresa Smith, [tsmith@naic.org](mailto:tsmith@naic.org) for information on getting your article published.**

An annual subscription to the *Research Quarterly* is \$100; individual copies are \$25. Regulators may obtain copies at no charge. Contact the NAIC Insurance Products & Services Division at [prodserv@naic.org](mailto:prodserv@naic.org) for order information.

## Research Quarterly

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

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## A Note from the Editor:

*Auto Insurance.* The 2001/2002 NAIC *Auto Insurance Database Report* was released on September 30<sup>th</sup> and, to borrow the most overused expression of our day, it has undergone “an extreme makeover”. Most notably, the new report format no longer includes the state rankings for any calculated results.

Why? Because it has always been the NAIC’s position that major differences in state requirements for coverages, limits and benefits prevent an “apples-to-apples” comparison of average auto insurance expenditures among the states. Rankings published in previous auto reports appeared to justify comparisons between states and have, therefore, been eliminated as misleading. An excerpt from the report’s narrative along with average annual expenditures and premium for states—listed alphabetically—appears in this issue.

*Asbestos.* Can you say Mesothelioma? It is a type of cancer that has been linked to exposure to asbestos. The lengthy incubation period for development of asbestos-related diseases has resulted in a growing number of recent claims filed on behalf of claimants that have not yet manifested symptoms of asbestos-related diseases.

Find out how insurance regulators are working with Congress, state legislators, U.S. businesses and the insurance

industry to resolve the problem of how to fund the obligations of the business community and the insurance industry in ways that offer a fair settlement to those afflicted with debilitating medical conditions, without bankrupting the system and impeding economic development.

*Data Management.* In the second in a series of three articles on the value of data management to the insurance industry, Aimee Siliato, Information Technology Manager for ISO, Inc. and current Chair of the Insurance Data Management Association Marketing Committee, discusses the importance of specific data management skills, processes and tools to key insurance industry staff positions and business areas.

*Medical Malpractice.* The Market Conditions Analysis (C) Working Group of the NAIC Property and Casualty (C) Committee has completed its study of the medical professional liability insurance market. Highlights of the paper appear in this issue. Despite several indications that paid losses drive the need for premium increases, the specific elements of loss that can be controlled to effect lower rates were less clear due to data limitations.

### Upcoming RQ Features

*Risk Based Capital Results.* A supplement to the Winter 2004 *Research Quarterly* will feature annual risk-based capital results for Life, Property/Casualty and Health insurers.

*Home Insurance.* Dismal trends in home insurance will also be discussed in the next issue. Will hurricanes, wild fires, tornadoes and now volcanoes make this the worst year yet?

*Risk Retention Groups.* Should federal laws that govern them be extended to non-liability lines of coverages? What about personal lines? In a future RQ issue regulators debate the pros and cons of these controversial questions.

*Obesity.* As the government makes some critical observations about Americans’ diet, exercise and weight consciousness, both health and life insurance premiums are escalating. The RQ will explore the role of nutrition and exercise on health and life insurance costs.

### Talk to Us

We want to hear from our readers. Please e-mail your articles, statistical study summaries, comments, questions and suggestions to my attention at [nhughes@naic.org](mailto:nhughes@naic.org). The RQ is a forum for NAIC staff, state regulators and interested parties to discover, debate and review information on current events in insurance regulation. The RQ is a global publication with subscribers in 17 countries. Subscribe today.

Thank you,

Natalai Hughes  
Editor, *Research Quarterly*

# 2001/2002 Auto Insurance Database Report

*By The NAIC Staff*

Throughout the United States, the cost of personal automobile insurance generates a great deal of discussion. Because each state's circumstances are different, the NAIC annually publishes a statistical report that contains by-state premium and loss data for the individual coverage components of a typical auto insurance policy, as well as statistics for many of the factors related to the average costs to consumers for these coverages.

The 2001/2002 Auto Insurance Database Report (Database), was released to insurance departments and NAIC customers in September 2004. It was developed under the direction of the Statistical Information (C) Task Force, to help make information used in the statistical analysis of auto insurance rates readily available to insurance regulators, and to help the public better understand state-to-state differences in the amounts consumers pay for this essential product.

The report's data are divided into the following areas:

1. insurance data;
2. traffic conditions;
3. medical data;
4. crime;
5. auto repair costs;
6. economic/demographic data; and
7. state laws.

The insurance premium data include written premiums and exposures for calendar years 1998-2002 and the combined voluntary and residual market. Insurance loss data for calendar/accident years 1999-2001 are also reported, but separately, for voluntary and residual market business. Loss data include earned premiums, earned exposures, incurred losses and incurred claims.

Results are calculated by state, for average premium and average expenditure, pure premium, loss ratio, claim frequency and claim severity. Auto insurance coverages included are:

- bodily injury and property damage liability (including

no-fault);

- uninsured and underinsured motorist coverages;
- combined single limit
- medical payments;
- collision; and
- comprehensive.

The non-insurance data are for variables that would be expected to have some impact on the cost of personal automobile insurance.

## **State Average Expenditures and Average Annual Premiums**

These statistics measure the relative cost of automobile insurance to consumers in each state.

The Database contains average expenditures and average premiums for bodily injury and property damage liability (including no-fault), collision, and comprehensive coverages—the basic components of a personal auto insurance policy.

The state average expenditure per insured vehicle is the total written premium for the combined

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liability, collision and comprehensive coverages, divided by the liability written car-years (exposures) in that state. This assumes that all insured vehicles carry liability coverage but do not necessarily carry the physical damage coverages—collision and/or comprehensive. The average expenditure estimates what consumers in the state spent, on average, for auto insurance. In 2002, the countrywide average expenditure was \$774, an increase of 7.5 percent over the previous year. The median average expenditure was \$702.

The state combined average premium per insured vehicle, on the other hand, is calculated by summing the average premiums for the three coverages. The result is the average cost of an auto insurance policy in the state that contains all three—liability, comprehensive and collision—coverages. The countrywide combined average premium also increased 7.5 percent in 2002, to \$880. The median combined average premium was \$818.

Aggregate written premiums and aggregate written exposures are used in calculations with no distinction as to policyholder classifications, vehicle characteristics or the selection of specific limits or deductibles. Nor do the results consider differences in state auto and tort laws, rate filing laws, traffic conditions or other demographics. Because of these differences, direct

comparisons between state results are misleading.

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 insurance price index holds the amount of insurance constant to measure price changes in a uniform product.

Between 1998 and 2002, the national average expenditure for automobile insurance increased by 10.09 percent, while the CPI for all goods increased by 10.46 percent. Over the same period, the automobile insurance component of the CPI increased by 19.81 percent. The basic economic law of demand explains the difference between the change in the CPI-auto insurance component and that of the measured average expenditure. As the price of insurance (as measured by the CPI) increases, the amount of insurance demanded

decreases (i.e., dropping coverage or increasing deductibles), leading to a smaller increase in the average expenditure.

The national combined average premium increased 9.91 percent. Average liability premiums increased 5.54 percent over the 1998-2002 period. Premiums charged for a particular coverage and annual changes in those premiums vary based on the changes in the cost of factors that impact the coverage. Bodily injury liability premiums are affected by medical costs, wage loss costs, litigation costs, etc. Property damage liability and physical damage premiums are affected by the cost of vehicles, auto repairs, auto parts, labor, motor vehicle theft rate, windstorms, hailstorms, etc.

### **Factors that Affect State Average Expenditures and Average Premiums**

Many factors affect the state-to-state differences in average expenditures and premiums for automobile insurance including:

- underwriting and loss adjustment expense
- relative amounts of coverages purchased
- driving locations
- accident rates
- traffic density
- vehicle theft rates
- auto repair costs
- population density
- medical and legal costs
- per capita disposable income
- rate and form filing laws
- liability insurance requirements

Table 4

## Average Premiums and Expenditures 1998-2002

STATE	Average Expenditure				
	2002	2001	2000	1999	1998
Alabama	625.95	605.32	593.65	612.44	632.25
Alaska	883.57	826.10	770.11	750.66	771.32
Arizona	877.19	822.35	791.99	788.54	817.68
Arkansas	670.12	620.90	606.05	596.88	589.06
California	777.93	705.01	666.94	665.65	708.61
Colorado	914.06	807.51	754.88	743.84	763.73
Connecticut	964.57	912.19	871.20	860.95	900.60
Delaware	907.12	850.56	848.51	861.41	845.32
District of Columbia	1,040.02	1,011.76	996.39	986.49	1,031.35
Florida	870.35	788.02	746.29	742.43	770.55
Georgia	739.16	703.07	674.12	672.11	672.38
Hawaii	736.43	705.10	701.51	699.99	797.49
Idaho	560.05	523.38	505.16	492.72	493.54
Illinois	725.51	682.59	651.60	646.03	656.30
Indiana	646.38	614.86	570.27	581.98	583.22
Iowa	546.54	512.66	478.75	466.19	459.01
Kansas	585.71	555.90	540.21	541.94	532.16
Kentucky	685.11	645.21	615.69	609.65	617.34
Louisiana	926.03	838.96	806.01	813.02	830.30
Maine	584.67	546.01	528.08	514.14	492.05
Maryland	837.34	783.77	757.41	756.63	769.34
Massachusetts	983.59	936.01	945.61	889.24	815.62
Michigan	839.25	735.12	701.80	704.68	736.71
Minnesota	800.44	735.20	695.55	687.90	679.64
Mississippi	678.75	637.62	654.16	655.23	650.14
Missouri	666.16	633.52	611.73	605.11	611.47
Montana	627.89	572.06	530.43	511.17	509.68
Nebraska	589.09	553.83	532.74	523.25	517.54
Nevada	887.46	851.15	829.28	821.15	842.67
New Hampshire	730.60	685.62	665.47	649.79	621.50
New Jersey	1,112.86	1,027.71	977.07	1,015.00	1,138.28
New Mexico	699.37	662.27	674.27	663.95	675.95
New York	1,087.38	1,014.96	939.43	930.05	959.76
North Carolina	587.69	564.76	563.66	566.85	564.35
North Dakota	532.81	497.79	477.28	468.79	452.10
Ohio	639.43	613.75	579.05	577.88	581.47
Oklahoma	650.00	610.33	602.72	576.22	575.42
Oregon	681.65	642.52	625.37	621.28	629.87
Pennsylvania	783.37	726.41	698.56	691.06	721.93
Rhode Island	937.18	880.06	825.44	823.89	851.79
South Carolina	702.44	636.26	619.57	593.32	655.33
South Dakota	540.45	510.42	481.67	484.08	479.22
Tennessee	631.64	610.65	592.33	582.26	586.65
Texas	791.39	735.46	677.83	696.24	730.66
Utah	700.05	640.12	620.05	615.48	618.88
Vermont	644.16	602.52	568.39	555.76	534.37
Virginia	625.32	610.14	576.08	565.99	563.74
Washington	787.62	749.74	722.48	697.44	710.00
West Virginia	776.23	706.90	680.09	684.01	724.58
Wisconsin	609.46	573.46	545.29	545.29	552.08
Wyoming	580.32	527.63	495.60	490.54	492.45
<b>Countrywide</b>	<b>773.68</b>	<b>719.75</b>	<b>687.06</b>	<b>683.70</b>	<b>702.74</b>

Table 5

## Average Premiums and Expenditures 1998-2002

STATE	Combined Average Premium				
	2002	2001	2000	1999	1998
Alabama	756.51	733.79	718.16	704.99	722.78
Alaska	1,034.00	969.69	912.78	896.12	924.57
Arizona	991.66	914.26	876.38	876.12	905.30
Arkansas	806.27	749.19	721.84	721.14	702.95
California	880.47	805.11	766.90	771.46	821.48
Colorado	1,051.37	935.10	881.74	866.85	876.04
Connecticut	1,057.57	993.50	953.77	952.11	981.96
Delaware	990.91	929.84	927.30	935.93	919.05
District of Columbia	1,191.87	1,156.23	1,143.71	1,138.71	1,192.07
Florida	931.15	835.79	798.59	789.94	817.77
Georgia	883.35	848.21	810.23	805.98	808.46
Hawaii	840.00	811.12	811.15	833.73	919.73
Idaho	669.13	629.68	608.70	596.78	593.35
Illinois	801.75	747.57	725.95	713.77	722.35
Indiana	741.54	698.18	657.68	659.99	664.29
Iowa	638.56	596.44	557.67	543.43	531.14
Kansas	738.35	700.24	682.52	671.31	656.64
Kentucky	815.64	766.76	733.75	731.22	739.36
Louisiana	1,064.54	967.21	928.48	944.40	965.22
Maine	671.25	625.06	599.88	591.25	564.27
Maryland	910.05	853.04	828.22	830.33	843.99
Massachusetts	1,062.39	1,013.46	1,028.62	976.32	889.46
Michigan	986.71	871.98	841.41	836.96	867.59
Minnesota	885.84	808.63	762.84	752.56	742.23
Mississippi	820.10	784.37	770.22	763.80	762.84
Missouri	776.21	737.15	709.59	706.67	700.01
Montana	792.84	720.54	671.57	653.08	646.15
Nebraska	712.79	667.99	649.45	637.00	626.91
Nevada	1,011.20	965.96	937.54	938.94	959.84
New Hampshire	778.64	729.70	713.15	710.88	702.70
New Jersey	1,283.87	1,182.54	1,146.39	1,185.95	1,316.49
New Mexico	860.48	814.91	828.33	816.52	821.95
New York	1,240.24	1,161.27	1,093.92	1,098.15	1,126.26
North Carolina	697.57	667.93	670.35	666.23	670.17
North Dakota	683.97	633.78	601.31	595.93	572.21
Ohio	713.67	682.67	645.79	646.34	648.20
Oklahoma	809.04	756.21	736.17	712.82	712.45
Oregon	765.36	725.11	704.55	705.31	710.74
Pennsylvania	871.77	807.90	775.85	780.96	805.30
Rhode Island	1,095.57	1,027.03	972.00	977.31	989.94
South Carolina	818.03	756.20	732.53	702.50	766.23
South Dakota	694.46	648.16	618.95	617.78	613.30
Tennessee	747.67	706.80	687.09	675.51	675.68
Texas	881.74	820.24	759.45	778.01	813.03
Utah	806.18	739.19	718.03	716.30	715.51
Vermont	734.31	682.75	647.65	640.73	615.37
Virginia	712.69	688.49	650.84	634.73	635.80
Washington	879.11	836.24	803.76	784.55	787.76
West Virginia	918.41	841.08	815.10	813.75	846.58
Wisconsin	671.39	630.11	603.88	604.87	610.21
Wyoming	744.50	682.60	646.27	642.23	643.06
<b>Countrywide</b>	<b>879.99</b>	<b>818.65</b>	<b>785.07</b>	<b>782.44</b>	<b>800.63</b>

- auto laws (seat belt, speed limits, etc.)

The average expenditure and average premium are imperfect measures of the relative “price” of insurance across states because the auto insurance product is not homogenous across states. While these data reflect the average expenditures within a state, it cannot be assumed that the data represent equal exposure and coverage across states.

**Policyholder preferences:** A state’s average expenditure and average premium will be relatively higher if policyholders in that state tend to purchase higher coverage limits or insure more expensive cars. The type and amount of coverage purchased by an individual is influenced by various factors, both economic and non-economic. Policyholders make choices about coverages, limits and deductibles that depend on their economic situation, as well as their level of risk aversion, rural or urban driving areas, local weather and traffic conditions and other factors.

**Differences in auto insurance requirements, benefit levels and exposure:** Some states have tort automobile insurance laws, while others have “no-fault,” “choice” or “add-on” laws. Some states do not have a

compulsory auto insurance law. Minimum required limits for liability vary from state to state, as well as required policy benefits. Some states have a much higher uninsured motorist exposure than others. The average vehicle value differs from state to state. The variations emphasize that this data reflects how much consumers, on average, are spending for insurance, but do not provide information on how much insurance the consumers are purchasing for their dollars.

**D e m o g r a p h i c s :** Automobile premiums are

The average expenditure and average premium are imperfect measures of the relative “price” of insurance across states because the auto insurance product is not homogenous across states.

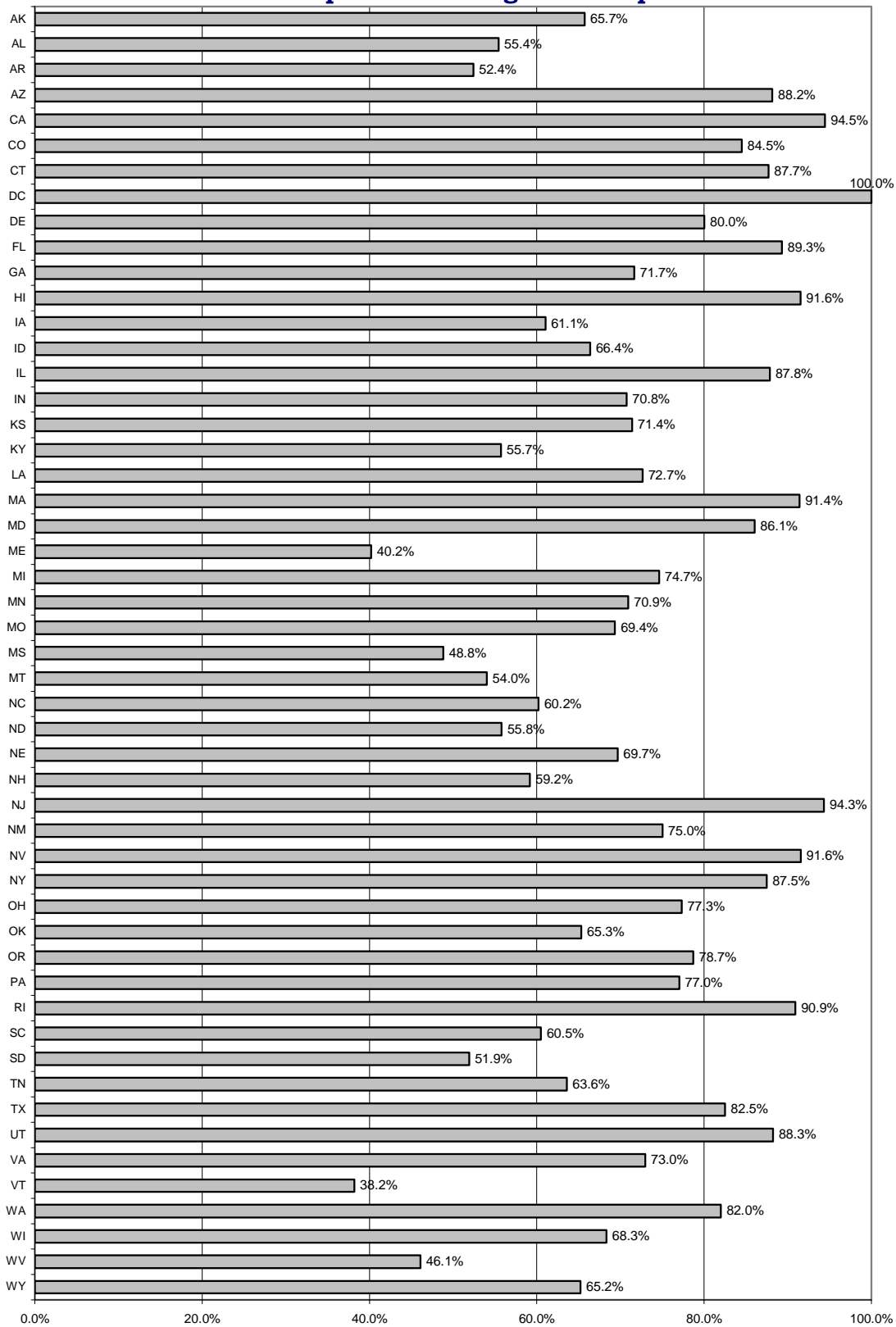
higher in urban areas. Therefore, those states with a higher percentage of population in urban areas will tend to have higher average premiums. In addition, states that gain population rapidly tend to do so in urban areas. Because the population increase is usually not evenly spread evenly over a state, the increase in average premium from year to year can fluctuate significantly.

Insurance rates are developed based, primarily, on the insurer's cost of paying claims filed by insureds. Certain broad characteristics of a state contribute to the frequency and severity of auto claims and insurer loss costs in the state. Many of these cost factors can impact insurance prices not only between states, but between communities and neighborhoods as well, making price comparison between states extremely complex.

It is reasonable to consider that the “general economic conditions” in a state may affect the price of auto insurance, but no direct measure of this characteristic exists. Measurable data, however, can be used as imperfect substitutes for these characteristics to approximate their impact on insurance price.

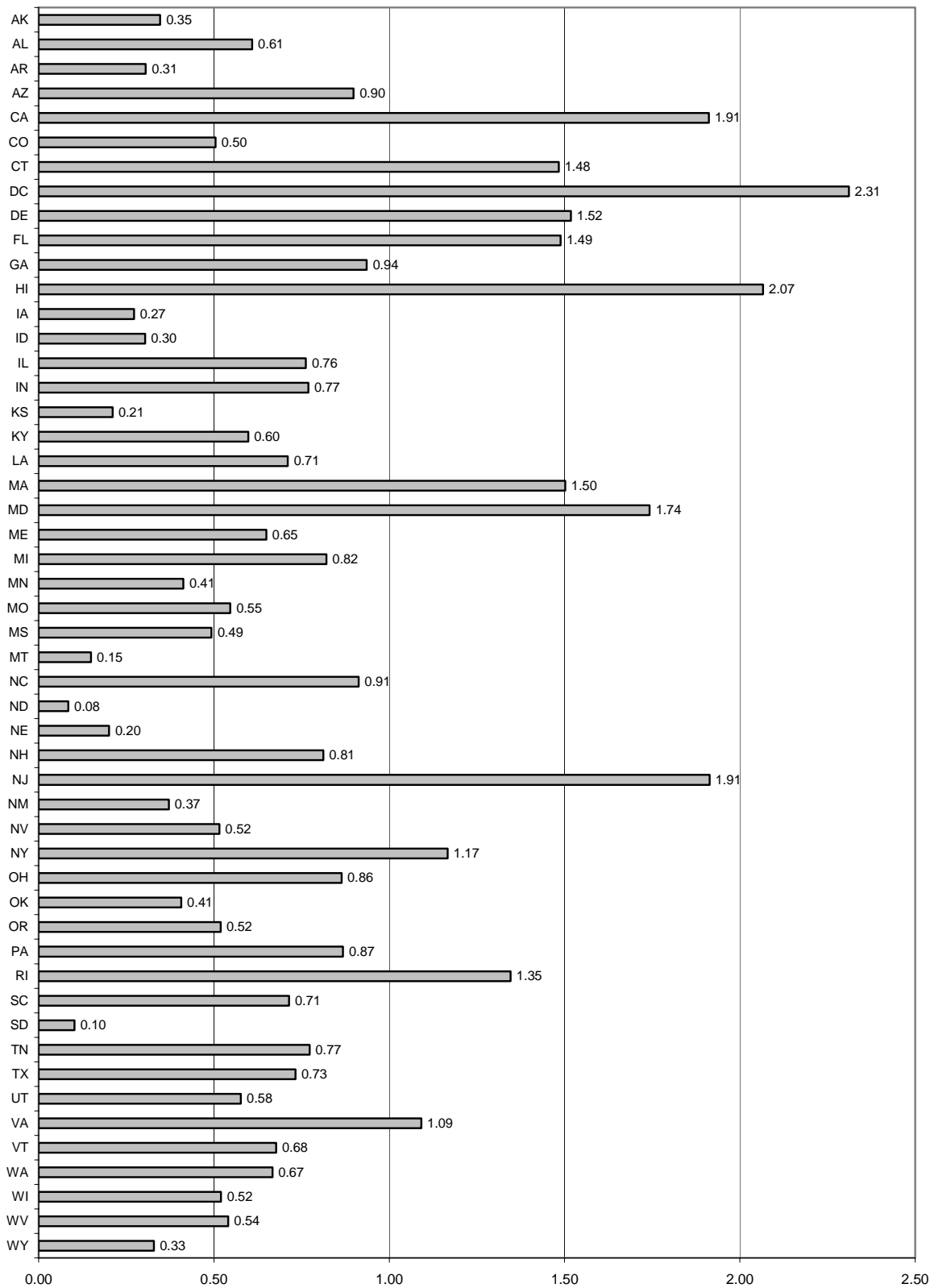
Three variables-urban population, miles driven per number of highway miles and disposable income per capita-have been identified as highly correlated with the state auto insurance premiums. Graphs on the following pages show these variables for all states. The graphs indicate that high premium states tend to also be highly urban, with higher wage and price levels and greater traffic density.

## Percent of State Population Living in Metropolitan Areas



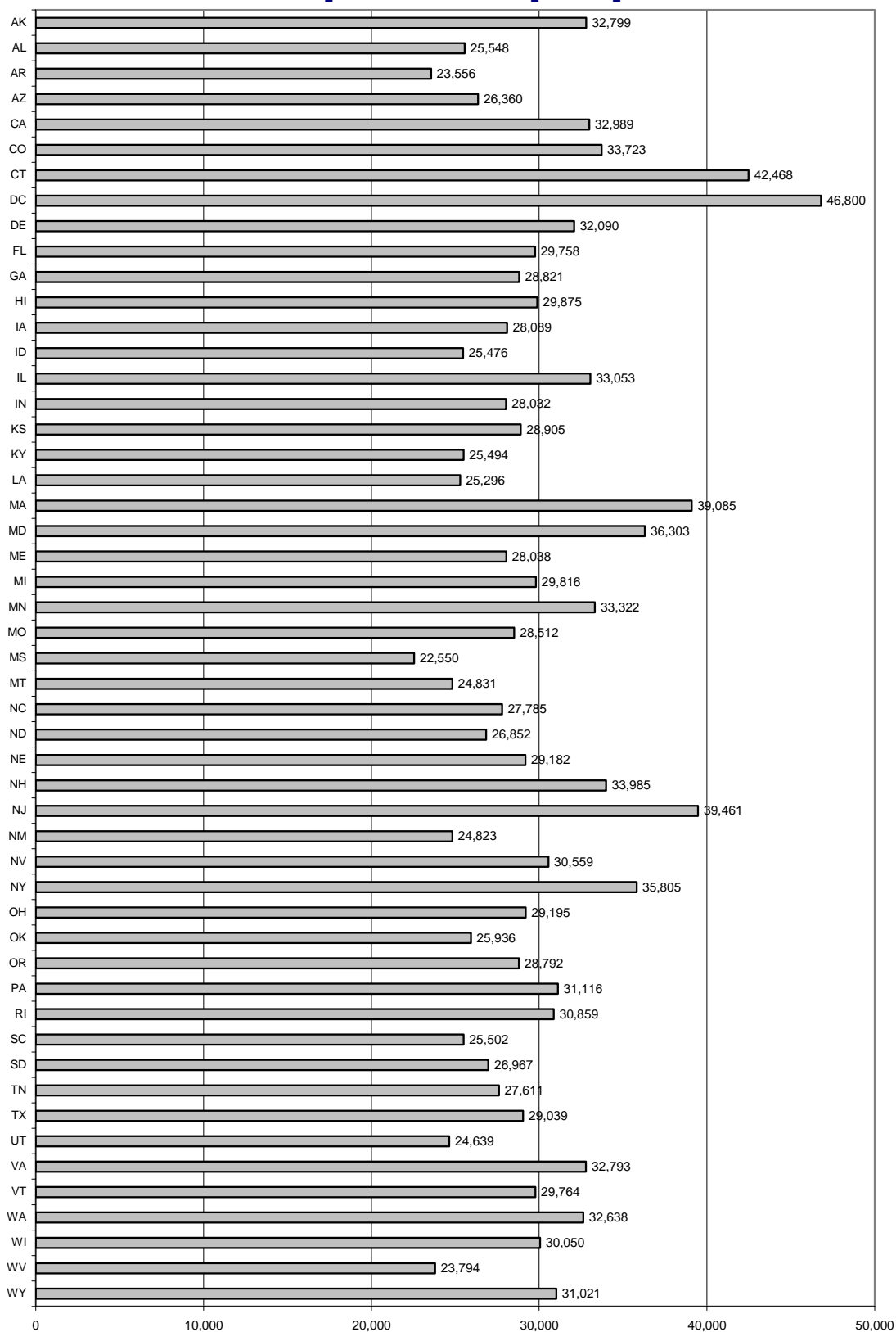
Source: U.S. Bureau of the Census Internet Site [www.census.gov]

## Millions of Miles Driven per Mile of Roadway, 2002



Source: Federal Highway Administration, 2002 Highway Statistics

## 2002 Disposable Income per Capita



Source: Bureau of Economic Analysis [www.bea.doc.gov]

# Asbestos: What's the Big Deal?

By Eric Nordman, Director of Research, NAIC

## Background Information

Asbestos has been with us for a long time. Only in recent decades has it been elevated to crisis status. Asbestos is a fibrous mineral form of impure magnesium silicate. It was widely used in industrial and consumer products in the United States until the 1980s for things such as building materials fireproofing, electrical insulation, brake linings and filters. Millions of people in this country have been exposed to potentially injurious levels of asbestos fibers, creating the potential for a serious national health problem. It has long been recognized by the medical community that significant asbestos exposure is harmful to people, and may cause such conditions as mesothelioma, other forms of cancer, and a variety of pulmonary diseases. The lengthy incubation period for development of asbestos-related diseases has resulted in a growing number of recent claims filed on behalf of claimants that have not yet manifested symptoms of asbestos-related diseases.

## The Issue

The issue that is facing Congress, state legislators, insurance regulators, U.S. businesses and the insurance industry is how to fund the obligations of the business community and the

[The issue is] how to fund the obligations of the business community and the insurance industry in ways that offer a fair settlement to those afflicted with debilitating medical conditions without bankrupting the system and impeding economic development.

insurance industry in ways that offer a fair settlement to those afflicted with debilitating medical conditions without bankrupting the system and impeding economic development. The issue of what to do about asbestos exposure has become a pressing matter for the U.S. economy. Many of the initial defendants are in or very near bankruptcy. Claimants and their attorneys realize

that the funds for a possible recovery are drying up and this has, some believe, led to an increasing number of claims from individuals that have not yet manifested symptoms of asbestos related diseases. In addition, secondary defendants have been identified and targeted as the original defendants enter bankruptcy. A recent RAND Institute for Civil Justice study found that almost 90 percent of recent claimants are unimpaired.<sup>1</sup> The study advises that 8,400 businesses have had claims made against them. Over 600,000 people have filed asbestos claims according to RAND.

This potential drain on the U.S. economy has not gone unnoticed by Congress. Last year several bills were introduced in both the House and the Senate. Included on the list are S 413, the Asbestos Claims Criteria and Compensation Act of 2003

<sup>1</sup>Asbestos Litigation Costs and Compensation: An Interim Report. Carroll, Stephen, et al. Published in 2002 by RAND Corp.

sponsored by Senator Don Nickles (D-OK); HR 1114, the Asbestos Compensation Act of 2003 sponsored by Representative Mark Kirk (R-IL); HR 1586, the Asbestos Compensation Fairness Act of 2003 sponsored by Representative Chris Cannon (R-UT); HR 1737, the Asbestos Victims Compensation Act of 2003 sponsored by Representative Cal Dooley (D-CA); and S 1125, the Fairness in Asbestos Injury Resolution Act of 2003 (also known as the FAIR Act of 2003) sponsored by Senator Orin Hatch (R-UT) and several others.

When one is able to investigate the dynamics of the asbestos crisis, it is apparent that there are two sides to the issue. Labor interests are amenable to the creation of a no-fault asbestos trust fund provided that it is funded sufficiently to compensate victims of asbestos related diseases. Insurer representatives and those representing manufacturers and suppliers support the trust fund concept provided that the solution is not prohibitively costly and the trust fund offers closure with regard to asbestos liabilities.

S 1125 seemed to be getting the most attention early in the debate and was the vehicle of choice to more discussions along. It is a bill that is intended to create a fair and efficient system to resolve claims of victims for bodily injury caused by

asbestos exposure. Among its key features are:

- **Asbestos exposure claims:** Establishes a five-member U.S. Court of Asbestos Claims, along with magistrates and claims examiners, to consider no-fault claims by people exposed to asbestos.

- **Medical criteria:** Claimants would have to meet defined medical criteria to be eligible for compensation.

When one is able to investigate the dynamics of the asbestos crisis, it is apparent that there are two sides to the issue. [labor interests and insurer representatives and those representing manufacturers and suppliers]

- **Trust fund:** Establishes a \$108 billion trust fund, consisting of contributions from defendant companies and insurers, money from existing asbestos trusts, contributions by other companies.

- **Claims payment:** Payments to eligible claimants would be made from the trust fund, according to which of several medical categories a claimant was placed into.

- **Appeals:** Asbestos court decisions could be appealed to the U.S. Court of Appeals for the District of Columbia

S. 2290 was introduced on April 7, 2004 as a substitute for S. 1125 along with support from the Bush Administration. Sponsored by Senator Hatch and eight co-sponsors, the bill contained many updates that had resulted from negotiations on S. 1125. Perhaps the most significant change was a reduction in the trust fund from \$156 billion to \$124 billion. Other changes include higher award values for certain types of diseases, elimination of private settlement for most asbestos claims and payment of administrative expenses from the trust fund rather than from the Treasury. Senate Democrats were critical of the bill as being under funded. Senate Republicans pushed for its adoption, however, on April 22, 2004 the Senate failed to reach cloture with a vote of 50-47. Cloture requires at least 60 votes. This, however, did not mean that all negotiations on asbestos reform were dead.

There have been and continue to be discussions on Capitol Hill on the asbestos reform proposals throughout 2003 and into 2004. At the time this was written Senate Majority Leader Bill Frist (R-TN) is attempting broker a deal between competing interests. Senator Frist and Senate Minority Leader Tom Daschle (D-SD) have been exchanging correspondence regarding the appropriate amount of the trust fund and

other details. In April 2004 a former federal judge was engaged to serve as a mediator for the discussions. Early mediation efforts yielded an offer from the defendant companies to increase the trust fund to \$134 billion. This led to a counter offer from Labor that included a \$15 billion contingency if funding proved insufficient.

By June 2004, the defendant's offer stood at \$128 billion with Labor interests insisting on a \$149 billion trust fund. In July 2004 Senator Frist offered an alternative plan that establishes a \$140 billion trust fund (\$90 billion from defendant businesses, \$46 billion from insurers and \$4 billion from trust) and guarantees access to \$40

billion during the first five years. Senator Daschle responded with a counter offer of \$145 billion. However, in an effort to reach a compromise, Senator Daschle, in mid September 2004, announced that he would accept Senator Frist's proposal. Compromise was also offered on an issue regarding pending cases. The senators continue to discuss the matter and exchange correspondence on the topic. In a letter of October 6, 2004, Senator Daschle acknowledged the movement on both sides of the issue and suggested that the issues dealing with pending cases and start-up of the trust fund remain.


Only time will tell if Congress is able to reach a compromise on asbestos reform legislation. In the

mean time, the uncertainties surrounding the status of outstanding asbestos claims are affecting insurer financial results. Net asbestos loss and LAE reserves have more than doubled since 1999. Information from the NAIC's financial database shows that gross asbestos reserves were reported to be \$42.6 billion and net asbestos reserves were reported to be \$22.1 billion as of 2003 year-end financial statements. The following table shows a five-year history of asbestos loss and LAE reserves.

State insurance regulators are constantly monitoring developments in this important area. Further updates will be provided as they become available.

**Asbestos Loss and LAE Reserves (in Billions)**

Reserves	2003	2002	2001	2000	1999
Gross	\$42.6	\$34.7	\$23.9	\$18.7	\$18.4
Net	\$22.1	\$17.6	\$12.0	\$10.0	\$9.8



**For Statistical Information,  
visit the NAIC Research Division  
Web site at  
[www.naic.org/research](http://www.naic.org/research)**

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## Quarterly Notes

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### NAIC Elects New Officers

Members of the NAIC elected a slate of three new officers in interim elections held during the 2004 NAIC Fall National Meeting. Pennsylvania Insurance Commissioner Diane Koken is the new NAIC president, Oregon Insurance Administrator Joel Ario the vice president, and Maine Insurance Superintendent Alessandro Iuppa will serve as secretary-treasurer. All three take office immediately.

"This is an incredibly important and exciting time for the NAIC and all state regulators, so I am honored that the members have chosen to support me in this new role," said Koken. "We need to position ourselves to adapt to an ever-changing environment while continuing to do what we do best: working together for insurance consumers across the country."

Koken has been active in NAIC initiatives since her appointment as commissioner in 1997. She currently serves on several key NAIC committees. She also is secretary of the NAIC's Northeastern Zone and is a board member of the NAIC's affiliate, the National Insurance Producer Registry (NIPR). Ms. Koken's commitment to the industry and its consumers has spanned her entire professional career. Prior to her state service, she was vice president, general counsel and secretary for a major life insurer.

Ario, who previously served as NAIC secretary-treasurer, has been the insurance administrator in Oregon since 2000. He currently serves on the Internal Administration Subcommittee and chairs the NAIC's Market

Regulation and Consumer Affairs Committee. He also serves as president and board chair for the NIPR. He has been with the Oregon Insurance Division since 1995 and previously served as a public policy analyst and executive director in the non-profit sector.

Iuppa was appointed Maine's superintendent of insurance in 1998 and was re-appointed to a second term in March 2004. He is an active participant in insurance issues at both the national and international levels, currently serving as chair of NAIC's Northeastern Zone. He also chairs or serves in other capacities on several key NAIC committees. He has been designated by the NAIC to represent the United States at the International Association of Insurance Supervisors (IAIS), where he serves as a member of the Executive, Technical, and Reinsurance committees.

### Homeowners Facing Sky-rocketing Insurance Rates in Hurricane Strike Zones

Homeowners find themselves paying increasingly higher insurance rates as more people flock to the coasts and insurers try to cut back on the billions of dollars of losses they've absorbed from previous storms. Many residents in high-risk areas have to buy separate hurricane or windstorm insurance on top of their regular homeowners' policies.

Florida's homeowners insurance rates have increased more than 150 percent since the 165-mph Andrew, which caused \$31 billion damage and stands as the costliest natural disaster in U.S. history. Texas' average premiums are up about 75 percent and Louisiana's have risen around 50 percent since

then, according to state estimates.

Insurance industry officials say the higher premiums are necessary to keep insurers from going belly up when a destructive storm hits. But Florida was only the third most expensive state in which to insure a home in 2000, after No. 1 Texas and Louisiana, according to the latest average premium data from the NAIC.

That's because homeowners insurance normally includes coverage for fires, hail, tornadoes and other catastrophes. Texas is the most expensive because it's in "Tornado Alley" and it has been hit by billions of dollars in mold claims recently, Bob Hartwig, chief economist for the Insurance Information Institute says.

In most Atlantic and Gulf Coast states, homes in coastal areas may be dropped by normal insurers and homeowners are forced to get policies from insurers of last resort that offer windstorm insurance specifically for hurricane and wind damage.

In Florida, the average annual windstorm premium has risen more than 200 percent over the past decade to reach \$1,445 this year. In Texas, windstorm rates have gone up just 30 percent over the last decade to hit an annual average of \$574.

Insurers say those rates reflect Florida's geography as a peninsula with so much coastal land, while most other states have large swaths of territory far from the water. The rapid housing development of multimillion dollars buildings along Florida's beaches also contributes to those spiraling costs.

*Excerpt of an article By John Pain, AP Business Writer, (c) 2004. The Associated Press.*

# The Value of Data Management to Your Organization

*The second in a series of three articles on how data management skills can help your organization*

*By Aimee Siliato, Insurance Data Management Association and Insurance Services Office*

## Summary

In the first article in this series, we discussed how a comprehensive data management program can align data across an organization, simplifying processes, sharing or re-using the same data and simplifying the technology architecture needed to support the business.

Data management skills bring tremendous value to a business. A knowledgeable and trained data management professional can help you save money, increase revenue, improve customer satisfaction while protecting one of the business' most valuable assets—data. These benefits can be obtained by effectively and efficiently maximizing the information contained in and conveyed by your data and ensuring that it is of the highest quality. Data are the raw material for key functions and do not realize their full value unless they are of high quality, well-understood and well-utilized.

Key values of data management skills are that

they fit in many places in an organization and they are critical skills for many professionals to have. Whether you are an actuary, claims professional, underwriting professional, statistician, compliance officer or work in almost any other function, knowledge of

Good data management allows the actuary to have more confidence in, and a better understanding of, data being used.

data management or the assistance of a data management professional can help you do your job better and help you prepare, understand and protect the raw material—the data—you are working with. In the current business environment, this is no longer a luxury. It is a necessity.

## Value To Actuaries

Wouldn't it be great to have a trained, and possibly

even certified, professional help you and your actuaries answer questions such as:

- Does the data you have represent valid, acceptable values?
- Does the data describe the true underlying situation?
- Does the data make sense? How does it compare with similar data from a prior period?
- Do you have all the data you need?
- Are the data current?

The value of data and data quality to actuaries, particularly in the era of Sarbanes-Oxley, cannot be overstated. Good data management allows the actuary to have more confidence in, and a better understanding of, data being used. This can also assist the actuary in his/her professional responsibilities to certify data quality (e.g., Actuarial Standard 23 on Data Quality).

Better decisions result from better data and better information. Better priced risks can mean improved bottom lines, greater customer satisfaction, improved customer retention, increased numbers of customers and improved ability to explain and defend decisions with better support behind them. Documented, controlled data management processes help give weight to assertions regarding the validity of data being used, improved data integrity and data utility. As data availability increases and data can be sliced ever more finely, attention to quality, privacy and confidentiality is critical. Data management skills help to ensure these concerns are addressed. The actuary's time is freed up for more focus on core professional responsibilities, decisions and analysis when effective data management is assured under the guidance of a skilled data manager. Involvement of a data management professional allows both disciplines to do what they do best and are best trained to do.

### **Value To Claims Professionals**

Expediting the claim settlement process can save an organization real dollars. Data systems that quickly handle reporting claim payments and related tasks reduce costs and improve customer satisfaction. This is not news. But with the skills of a data manager in

the process these objectives can be accomplished faster and more effectively. They can also accelerate adjuster access to financial detail and check issuance capabilities for timely payment processing.

Consider this:

- With a solid understanding of data and data patterns, how much fraud might be identified and successfully prosecuted?
- The ability to effectively and efficiently understand claim data

Documented, controlled data management processes help give weight to assertions regarding the validity of data being used, improved data integrity and data utility.

can help produce benchmarking studies and establish best practices, thereby producing better results at lower cost.

- Claim data must often be linked to data from external or separate internal sources to fully understand and gain value from a company's experience.
- When facts are required in a litigation situation, they can be more easily extracted and identified by a data manager, saving time, money and helping in

obtaining a fair result.

A trained data manager can address and respond to these situations and requirements effectively and efficiently.

### **Value To Underwriters**

How effective would customer service and product development be if there were no data and no information about individual customers or the collective customer base?

Data management processes and tools can promote speed-to-market for new products and services by defining and maintaining the data or links to the data needed by underwriters to research and develop changes to current and yet-to-be-developed coverages and policy forms.

Quality customer data enhances customer acquisition, retention, service and satisfaction. Well-maintained and understood data supports Customer Relationship Management activities. Successful and unsuccessful programs can be more easily identified.

### **Value To Compliance and Government Relations**

Regulatory initiatives (such as special data calls) can happen overnight. They can build momentum over time. Once implemented, they often persist. You need

to be able to:

- Identify solutions using available data
- Provide expertise on the availability and location of data
- Ensure the quality of data reported to regulators
- Evaluate the future enterprise impact of regulatory, as well as other industry, proposals and initiatives
- Provide professional credibility
- Ensures that systems capture all data elements and values required for regulatory and other reporting purposes

When your systems are structured and prepared to be responsive, you can be too. And by providing timely and quality data, costs associated with non-compliance are avoided.

### **Value To Data Reporting**

Data management brings a broader perspective to data reporting. This can help answer and handle reporting questions and requests more effectively. Consider these points. Good data management:

- Provides the tools and techniques to define and document data and data quality standards

- Makes data and data quality definitions and edits available to all users through the use of tools such as data repositories and data dictionaries
- Assists industry organizations in defining data and data quality standards
- Assists in the creation and population of data warehouses
- Ensures quality data reports to advisory organizations, research organizations and regulators

The IDMA is a volunteer organization made up of insurers, statistical agents, regulators and others dedicated to promoting professionalism in the data management discipline.

- Eliminates redundancies in reporting and reporting systems

The value realized goes beyond the benefits of better and more efficient data reporting. Systems are well-managed, well-defined and everyone in the organization is better informed.

### **In The Next Issue**

In the third and final installment in this series, learn how data management skills can help additional disciplines in your organization.

### **The Insurance Data Management Association**

The Insurance Data Management Association (IDMA) is a volunteer organization made up of insurers, statistical agents, regulators and others dedicated to promoting professionalism in the data management discipline. The principal means of doing this is through the IDMA curriculum. The Association provides professional certification in data management when testing is successfully completed. IDMA also provides forums for discussion and sharing of ideas on topics critical to data managers.

### **To Learn More**

To learn more about IDMA, the data management discipline and potential value to your organization visit [www.idma.org](http://www.idma.org) or contact IDMA's Executive Director Richard Penberthy at [rpenberthy@idma.com](mailto:rpenberthy@idma.com).

Aimee Siliato serves on the Executive Committee of the Insurance Data Management Association (IDMA) and is chair of IDMA's Marketing Committee. Ms. Siliato was the recipient of the 2004 IDMA President's Award in recognition of her service to the association.

Ms. Siliato is also Director in Insurance Services Office's (ISO) Government Relations & Data Management Department. ISO is a leading provider of data, analytics and decision-support solutions that help measure, manage and reduce risk.



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### What can the Insurance Data Management Association (IDMA) do for you and your organization?

- Provide non-adversarial forums involving industry and regulators
- Use traditional education and informational documents and other means to advance the interests of member insurance data managers and their employees
- Update members on vital issues through seminars and symposia
- Publish an independent monthly bulletin of key, timely information for data managers
- Publish and update twice yearly an Inventory of Carrier Reports to assist in complying with special data requests and avoiding fines
- Maintain a unique curriculum, leading to a professional certification, to ensure that IDMA's graduates understand a wide spectrum of data management and customer-related topics
- Carry on cooperative ventures with organizations such as the CAS, IASA, ACORD, RIMS, IAIABC and NAIC to share ideas and expertise

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### NAIC Members Help Consumers Protect Themselves Against Insurance Scams

Nobody likes to be scammed. But, unfortunately, fake insurance policies are on the rise in every line of insurance, and consumers are footing the bills in unpaid claims.

Just like counterfeit money, fake insurance may appear to be legitimate, but it is actually illegal and worthless. If you buy fake insurance, you'll pay premiums, but your claims won't be paid. The NAIC and state insurance departments across the country have recently launched a public awareness campaign to help consumers understand the problem and protect themselves against fake insurance scams.



With very few exceptions, insurance products cannot be sold by individual agents, brokers, or companies without the approval of that state's insurance commissioner. Fake insurance is any insurance plan intended to defraud consumers or businesses.

So, how can you protect yourself against fake insurance?

Just STOP ... CALL ... and CONFIRM before you buy insurance:

- **STOP** before signing anything or writing a check;
- **CALL** your state insurance department to
- **CONFIRM** if the company is legitimate and licensed to do business in your state.

Your state insurance department is the best resource for information about fake insurance or any other insurance-related questions you may have. Your call might help to track down and take action against the con artists who sell fake insurance.

# Medical Malpractice Insurance in the Marketplace: A Recurring Crisis

By Natalai Hughes, NAIC Stistical Information Manager

In the past several years, the number of medical professional liability or “medical malpractice” insurers in the United States has steadily diminished. At the same time, the cost of the coverage has increased to the point that in many areas, health care providers are unable find the coverage they need at a price they can afford. The problem is particularly acute for providers that specialize in high-risk practices such as emergency care and obstetrics. In fact, some states are facing a health care crisis with the exit of doctors and the closing of medical centers that offer treatment and care for patients with critical medical needs.

In September 2004, the NAIC released a study titled, *“Medical Malpractice: A Study of the Market Conditions and Potential Solutions to the Recent Crisis.”* The report was researched and developed over two years by NAIC Economist, Davin Cermak, NAIC Director of Research, Eric Nordman, and Texas Insurance Department

Insurance Specialist, Kenneth McDaniel. It was reviewed and edited by members of the Market Conditions (C) Working Group under the direction of the Property and Casualty Insurance (C) Committee. The committee chair was Texas Insurance Commissioner, Jose Montemayor. The objective was to review the available NAIC insurance data and survey the medical liability insurance environment, in an effort “to identify the primary causes of the market failures and determine certain corrective measures that could be addressed and implemented through insurance regulatory or legislative actions.”

## Recurring Crises

A “hard market,” characterized by increasing premiums and stricter underwriting, has been a cyclical occurrence in the medical liability insurance market throughout the past several decades. When these events affect policyholders’ ability to obtain coverage, major disruptions to health care systems can result.

In 2001, a number of medical liability insurers suffered financial difficulties, including insolvency, due to claims that exceeded loss and loss reserve projections. Poor operating results and declining investment income led insurers to raise rates and restrict writings. Then in 2002, a major insurer—with 20 percent of the national market and an even larger presence in some states—helped set off a domino effect on medical liability markets throughout the country, when it completely withdrew from the business. Hundreds of doctors and hospitals in many states found themselves scrambling to obtain coverage from the companies that remained.

The NAIC report indicates that in many areas of the country, the opportunity for remaining companies to compete for the sudden flood of buyers failed to bring about a reduction in prices as might be expected. Instead, the seller’s market created by the huge vacancy enabled insurers, still in business, to remain competitive at the higher rate levels. These

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higher levels were necessary for companies to meet their costs of paying claims profitably.

It is significant to note that the magnitude of medical liability market problems varies throughout the country. **Table 1** from the NAIC study [Table 13, in the study] shows that in 2002, the statewide loss ratio for medical liability insurance was above 100 percent in 28 of the 51 jurisdictions. Yet, seven jurisdictions had loss ratios below 70 percent—considered relatively favorable. The fact that some medical liability markets continue to function well, despite a nationally weak economy, supports the premise that stability is not solely contingent on the performance of the stock market.

### **Many Studies, Few New Findings**

There have been many efforts to pinpoint and curtail the events that lead to medical liability market failures. The NAIC study was one of many completed in the past year that have highlighted the primary contributing factors. These include: increasing claims experience; increasing costs for medical care and settlements in paying claims; declining investment yields; underwriting and loss reserve deficiencies; increasing reinsurance costs; and competitive pressure to consolidate or leave the market.

Through analysis of its own data and information compiled from public hearings and other studies, the NAIC shows that these factors are not very different from those that contributed to insurance market shortages in the past. What is also not very different, however, is that the data necessary to examine aspects of medical liability insurance market problems, evaluate solutions and prevent recurring trouble continue to be largely unavailable, incomplete or inconsistent.

As medical liability problems permeated throughout the country, medical associations, consumer groups and the federal government, through its General Accounting Office (GAO) also initiated studies. All found the data lacking for any type of analysis that would reveal more than is already known. The NAIC review of these findings further brought to light that a coordinated medical liability data collection system is essential for a complete assessment of the problems that can lead to improvements for greater market stability.

### **Data Limitations on Analyses**

Insurance data analyzed in the NAIC study was largely limited to the financial information in the NAIC database. The financial statements that insurers file with the NAIC each year contains data primarily used

for accounting purposes and solvency monitoring. The premiums and losses reported for financial analysis do not provide an essential match of policy experience required for actuarial analysis. Consequently, the data has limited value for evaluating rate adequacy or the full impact of claim costs on rates. Using financial data, the NAIC study necessarily focused on company underwriting results and competitive pressures to stay in business as the primary drivers of rate increases and decreased writings.

### **Medical Specialty**

Medical liability premium and loss experience is not delineated by medical specialty on financial statement forms. While the detail required for monitoring the solvency of insurers separates the experience of hospitals and physicians, data for obstetricians, for example, cannot be isolated. The NAIC reviewed medical specialty statistics compiled and published by hospital and medical associations, judicial organizations and other government entities, but the degree to which market problems impacted particular specialties could not be determined using financial data.

### **Rate Analysis**

The medical liability exposure and loss data that can be used for rate analysis is largely contained in statistical reports. Statistical

**Table 1—2002 Loss Ratios, By State  
Insurers With Market Share > 2.0 Percent**

State	Number of Insurers <sup>1</sup>	Direct Loss Incurred	Direct Defense and Cost Containment Expense Incurred	Direct Premium Earned	Loss Ratio
AK	8	9,688,367	3,559,603	13,040,393	101.59%
AL	5	22,721,191	51,606,653	107,043,834	69.44%
AR	10	34,036,781	13,945,786	46,609,986	102.94%
AZ	7	97,767,250	39,849,131	135,635,482	101.46%
CA	12	326,527,222	211,972,279	610,476,727	88.21%
CO	7	50,738,396	22,005,553	84,720,063	85.86%
CT	11	139,201,507	25,329,363	126,333,015	130.24%
DC	8	29,340,251	10,570,677	31,226,094	127.81%
DE	9	11,977,135	3,245,336	16,445,830	92.56%
FL	12	490,792,352	142,024,774	603,303,696	104.89%
GA	9	187,878,086	38,955,168	188,326,982	120.45%
HI	6	15,292,360	8,730,707	29,419,653	81.66%
IA	10	32,041,557	9,264,102	61,067,399	67.64%
ID	9	19,789,206	6,728,195	22,954,468	115.52%
IL	8	550,770,710	106,883,525	386,251,590	170.27%
IN	7	37,547,762	36,006,703	65,469,419	112.35%
KS	12	28,698,189	16,615,851	54,956,961	82.45%
KY	14	67,387,923	14,805,833	90,606,614	90.71%
LA	9	14,111,944	38,052,062	76,896,841	67.84%
MA	6	203,850,530	44,588,619	191,072,406	130.02%
MD	8	110,325,039	23,031,416	160,002,368	83.35%
ME	4	25,656,414	4,584,709	30,706,715	98.48%
MI	7	83,804,814	34,653,525	164,174,915	72.15%
MN	6	30,018,203	3,679,988	54,532,821	61.79%
MO	12	148,608,347	39,606,667	144,519,490	130.24%
MS	12	64,952,676	17,095,600	51,346,966	159.79%
MT	9	25,901,265	7,401,071	23,665,990	140.72%
NC	8	100,020,677	42,737,736	160,713,715	88.83%
ND	7	10,958,002	2,440,925	14,481,141	92.53%
NE	10	18,064,819	5,984,951	22,253,168	108.07%
NH	9	11,568,856	4,587,471	25,984,212	62.18%
NJ	6	305,928,219	69,457,174	295,520,262	127.03%
NM	7	21,661,486	7,193,142	29,117,847	99.10%
NV	13	98,897,593	24,013,871	74,182,732	165.69%
NY	6	1,014,523,451	247,858,841	875,147,752	144.25%
OH	10	306,085,894	75,568,368	293,815,222	129.90%
OK	5	69,744,661	30,248,190	78,295,765	127.71%
OR	8	49,691,883	13,186,820	53,281,382	118.01%
PA	13	315,959,973	105,484,986	347,541,753	121.26%
RI	8	25,363,865	7,021,071	25,404,335	127.48%
SC	9	19,794,163	3,855,502	27,799,717	85.07%
SD	6	7,565,842	1,091,279	12,013,090	72.06%
TN	8	223,222,841	54,023,390	231,805,158	119.60%
TX	11	294,529,837	91,944,306	391,171,921	98.80%
UT	9	34,765,810	13,821,573	44,005,214	110.41%
VA	15	95,220,055	34,229,489	135,054,057	95.85%
VT	8	7,106,841	2,486,385	15,124,870	63.43%
WA	9	136,573,681	37,172,037	146,492,048	118.60%
WI	6	29,080,061	8,292,482	60,561,634	61.71%
WV	6	79,544,101	19,609,667	89,221,443	111.13%
WY	5	9,014,109	4,947,434	13,628,143	102.45%

<sup>1</sup>This number includes all insurers that report to the NAIC that have reported earned premiums that show a greater than percent market share. It might include some insurers that no longer actively write new medical liability business.

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data is generated from policies sold and the losses associated with them (see “Statistical Data is Not the Same as Financial Data,” *Research Quarterly*, Summer 2004). This match of premium, exposure and loss data is essential for determining whether rates appropriately reflect the insurer’s cost to cover its risk. Trends in historical rate levels can be examined in conjunction with other data to assess the impact on pricing that external events such as inflation may have had.

When the NAIC initiated its study, statistical agents designated to collect medical malpractice data from insurers for statistical reporting purposes told regulators that the information they collect could be beneficial to market studies, but less than 30 percent of licensed medical liability insurers required to report statistical data actually do so. In order to effectively carry out their duty to provide comprehensive statistical reports, statistical agents emphasized to regulators that the statistical reporting requirements on medical liability insurers must be enforced.

### **Closed Claims Data**

The elements of medical liability statistical data reported to regulators are listed in the “Model Medical Professional Liability Statistical Plan” in Chapter

16 of the *Statistical Handbook of Data for Insurance Regulators*. Data collected from *closed claim* information, however is even more useful for identifying cost drivers. The NAIC does not currently collect closed claims data. Missouri and Illinois are the only states that require companies to regularly report closed claim medical malpractice data to the insurance department. Closed claim data examined in previous NAIC medical liability insurance studies was obtained through a special data call. Although the current model statistical plan does not include many data items that would be obtained from a closed claims study, it could be modified to require more information of this type.

### **State Funds and Alternative Market Mechanisms**

Some states have created medical liability insurance pools and reinsurance funds to provide coverage to healthcare workers and institutions unable to obtain coverage in the voluntary market or to help reduce insurer risk in catastrophic claims. In addition, a growing amount of medical liability business is administered by self-insurance plans or written through alternative market mechanisms, such as risk retention groups. In several of the states, these entities represent a large portion of the medical liability insurance market, but they are not subject to statistical

data reporting requirements. Therefore the data for a large segment of the market is nonexistent.

## **A Review of Regulatory/Legislative Solutions**

### **Reducing or Modifying Benefits and/or Payment Methods in Medical Liability Settlements**

During 2003, the legislatures of at least 30 states considered bills intended to stabilize or reduce the cost of medical liability insurance. The NAIC examined the experiences of states with stable markets, and a common thread in their laws appeared to be actions that brought about a reduction in awards to patients in medical liability damage settlements. Such actions have included placing caps on noneconomic damages, changing rules of evidence to provide for consideration of collateral sources for payment of benefits, allowing claimants and insurers to agree to periodic payments of future benefits and limiting contingency fees paid to attorneys. Many of these bills were patterned after the California Medical Injury Compensation Reform Act legislation.

### **Improving Patient Safety**

Measures intended to improve the safety of patients were also apparent in states attempting to legislatively mitigate medical liability

losses. Texas promulgated a model “Best Practices” patient safety and risk management program for its nursing homes. Missouri convened a patient safety commission, which consists of medical practitioners, licensing board members, and insurance regulators, to examine systemic reforms that may significantly reduce medical errors. The Missouri commission also seeks to better educate patients about possible negative outcomes prior to medical procedures, thereby reducing the likelihood that patients will seek legal redress for injuries that are not the result of negligence.

### **Controlling the Impact of Economic Trends**

The NAIC study acknowledged that the downward trend in the United States economic conditions, at the beginning of the decade, played at least some role in insurer decisions that led to underwriting restrictions and price increases during that period. A look at investment activity in 2002 shows that stock asset values comprised just 11.38 percent of total invested asset values for insurers writing at least 2 percent of the direct premium in any state market, and at least 50 percent of their written premium in medical malpractice. On the other hand, bonds, cash and short-term investments, which are less diversely affected by a declining economy,

comprised more than 86 percent of insurer assets. The report contends, therefore, that the negative impact of the declining stock market on insurer investment income was too small to be considered the primary driver of price increases over the long run.

### **Survey of Market Interventions**

The NAIC study discussed various types of market interventions that address medical liability insurance problems and identified a number of potential reforms. Depending on the specific problems in a state and on the state’s regulatory authority, emphasis on these reforms would be expected to vary. According to the GAO study, regionally owned and/or operated insurers represent over 60 percent of the medical liability insurance market. The legal and economic structures currently in place for both the medical profession and the medical liability insurance industry are also rooted at the state level. For this reason, the regulatory reform options in the survey are restricted to those actions available to insurance department regulators and/or state legislators.

### **Regulatory Reform**

- Rate Adequacy Monitoring
- Statistical Data Collection
- Market Assistance Plans or MAPs

### **Tort Reform**

- Damage Limitations, Caps
- Collateral Source Rules
- Periodic Payment of Future Damages
- Bad Faith (Over Limit) Awards
- Alternative Dispute Resolution and Mediation
- Contingency Fee Limitation
- Special Courts
- Advance Notice of Claims

### **Other Types of Reform**

- Information-feedback Model for Loss Control
- Patient Compensation Funds
- Statutory Risk Sharing Mechanisms, Joint Underwriting Associations and Other Models
- Alternative Treatment of Trauma Centers and High Risk Specialties
- Patient Safety Measures and Data Reporting Issues
- Regulation of Insurer Investments

### **Conclusion**

Notwithstanding the data limitations discussed, the NAIC study of financial data found that underwriting losses had a major influence on the rate increases

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experienced by physicians and other health care providers over the past several years. However, the range of other factors that contribute to market problems and the variety of potential solutions to address those problems requires many actions. In order to assure providers have access to medical liability insurance, communities have insured health care providers and patients receive quality medical care, these actions must be coordinated by representatives of all participants in the system.

In the meantime, the Property and Casualty (C)

Committee will work to develop and implement a data collection plan that can identify the types of data that are necessary to properly evaluate the medical liability insurance market, including the frequency, severity and causes of loss in order to evaluate regulatory and legislative proposals. In 2005, the Statistical Information (C) Task Force will be assigned to identify the sources of this data and the steps necessary to capture it, in order to build a comprehensive database for future research.. It is intended that the data be collected on an on-going basis so that regulators can

analyze loss causes, track market conditions and determine the appropriate public policy measures to address market failures as they occur.

*Medical Malpractice: A Study of the Market Conditions and Potential Solutions to the Recent Crisis* is available from the NAIC Insurance Product and Services Department. Contact IPSD at (816) 783-8300 or [www.naic.org/insprod](http://www.naic.org/insprod) to obtain a copy. The study will be updated and refined as additional data become available.



You may view and purchase any of the NAIC's publications and insurance data products, including custom and standardized products from annual and quarterly data reported at [www.naic.org/insprod](http://www.naic.org/insprod).

The NAIC 2003 catalog is available in hardcopy or CD-ROM. You may request a copy from the NAIC Insurance Products & Services Division's Customer Service Department at:

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# NAIC Action on Model Laws and White Papers at the Fall National Meeting in Anchorage

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Following is a brief description of the NAIC's action on model laws and white papers that occurred at the Fall National Meeting in Anchorage. The Executive Committee/Plenary adopted one new model in Anchorage and one by electronic vote just prior to the national meeting and voted in Anchorage to delete thirteen models from the NAIC *Model Laws, Regulations and Guidelines*. One revised model will be considered for adoption by the membership at the Winter National Meeting and four models will be considered for deletion. Nine new drafts of models, two actuarial guidelines and one white paper were released for comment during the last quarter.

## **Models Adopted by Executive Committee/Plenary**

1. Market Conduct Surveillance Model Law (Draft: 7/16/04)  
  
The National Conference of Insurance Legislators adopted a model that establishes a framework

for insurance department market conduct actions. The NCOIL model includes processes for conducting market analysis, and prioritizing market regulatory actions; coordinating market regulatory actions among states; and conducting uniform targeted examinations. At the Spring National Meeting, the Plenary asked the D Committee to review the model. The committee held several conference calls to work through revisions and adopted the model in April. In June, the Plenary decided to submit the committee's revisions as a proposal for NCOIL to consider at its next meeting in July. NCOIL made some changes and the model was adopted by the NAIC Plenary at the Fall National Meeting.

2. Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (# 651) (Draft: 8/16/04)

Because of the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Senior Issues Task Force of the Health Insurance and Managed Care (B) Committee revised the model to include two new plans and to eliminate prescription drug coverage for those who enroll in the new Medicare Part D. The task force worked intensively since the Spring National Meeting to develop a final draft and received input from the Accident and Health Working Group of the Life and Health Actuarial Task Force. The task force emphasized that other changes proposed by interested parties that exceeded the scope of those required by the federal legislation were postponed for consideration after finishing this task. Due to deadlines established by federal legislation, the Plenary adopted the model by electronic vote on September 8, 2004.

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## Models Deleted by the Executive Committee/Plenary at the Fall National Meeting

### 1. Fronting Disclosure and Regulation Act (#323)

This 1993 model was intended to ensure proper disclosure and regulation of reinsurance transactions between a domestic insurer and an unauthorized reinsurer if the ceding company delegates underwriting or claim settlement authority to the reinsurer. No state adopted the model. The Financial Condition (E) Committee recommended its deletion and the Plenary accepted that recommendation.

### 2. Model Asset Valuation Law (#330)

The Financial Condition (E) Committee referred the review of this model to the Statutory Accounting Principles Working Group, which noted that the original date of adoption for this model was before the widespread adoption of the NAIC *Accounting Practices & Procedures Manual*. The model's contents are sufficiently addressed in the statutory accounting manual. The committee recommended deleting this model and the Plenary accepted that recommendation.

### 3. Reciprocal Attorney-in-Fact Model Act (#355)

The Financial Condition (E) Committee recommended deleting this model because only two states have adopted it and it apparently does not enhance state regulation of insurance. The model was originally adopted because it was impractical to subject attorneys-in-fact for reciprocals to the managing general agents model law. The Plenary acted upon the recommendation at the Fall National Meeting.

### 4. HMO Investment Guidelines (#435)

The Financial Condition (E) Committee recommended deleting this model because only two states have adopted it. The model is referenced in Section 22 of the HMO Model Act, but the committee determined that the model does not meet the needs of state regulation of insurance. The Plenary acted upon the recommendation at the Fall National Meeting.

### 5. Guidelines for Expenditures of Health Care Contracts to be "Covered" through Special Subordinated Surplus Notes (#436)

This model was adopted in 1986 to permit certain debts to be considered covered within the meaning of the HMO Model Act if the lender agreed to certain conditions. The Financial Condition (E) Committee recommended

deleting this model because no state has adopted it and the Plenary accepted that recommendation.

### 6. Guidelines for Expenditures of Health Care Contracts to be "Covered" through Agreements with Provider (#437)

The model was submitted to the NAIC by a joint association of HMO regulators. It was intended to assist in the interpretation of the HMO Model Act. The Financial Condition (E) Committee recommended deletion of the model because it has been adopted by only one state and the Plenary accepted that recommendation.

### 7. Cash Management System Guidelines (#438)

This model was adopted to provide guidance about proper HMO cash collection and accounting arrangements. The current version of the HMO Model Act refers to the NAIC *Accounting Practices and Procedures Manual* as opposed to this model. For this reason, and because only two states have adopted the model, the Financial Condition (E) Committee recommended its deletion and the Plenary accepted that recommendation.

### 8. Prepaid Legal Expense Insurance Act (#635)

This model was adopted to

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meet an urgent regulatory need in 1974. Since then, most states have implemented legislation on this topic, but only four have adopted the NAIC model. The Financial Condition (E) Committee recommended its deletion and the Plenary accepted that recommendation.

**9. Model State Insurance Department Funding Bill (#688)**

Although state insurance departments have confronted funding issues in a variety of ways during the budget challenges of recent years, only four states have adopted this model. The Financial Condition (E) Committee recommended deleting this model because it apparently does not serve the purpose in the state regulation of insurance. The Plenary acted upon the recommendation at the Fall National Meeting.

**10. Minimum Surplus as Regards Policyholders to Assume Property or Casualty Reinsurance (#801)**

The Financial Condition (E) Committee recommended deleting this model because only two states have adopted it. In addition, the Part A Standards of the NAIC Accreditation Program require the adoption of the Risk Based Capital for Insurers Model Act, which the committee viewed as

diminishing the need for the model under consideration. The Plenary acted upon the recommendation at the Fall National Meeting.

**11. Sample Loss Cost Bulletin for Workers' Compensation (#932)**

The Workers' Compensation (C) Task Force of the Property and Casualty Insurance (C) Committee observed that this sample bulletin adopted in 1991 remains an important resource document, and it is being updated for the NAIC website. However, it is not a model law and should not have been included in the set in the first place. The committee recommended its deletion from the model laws service and the Plenary accepted that recommendation.

**12. Enabling Legislation for Workers' Compensation Data Reporting (#950)**

This 1989 model was developed to encourage the reporting of data about the factors driving workers' compensation system costs. No state adopted the model, and the Property and Casualty Insurance (C) Committee adopted the Workers' Compensation Task Force recommendation that the model be deleted. The Plenary acted upon the recommendation at the Fall National Meeting.

**13. Workers' Compensation Insurance Detailed Claim Information Reporting Model Regulation (#951)**

One state adopted this model, which was developed to encourage the reporting of data about the factors driving workers' compensation system costs. The Workers' Compensation Task Force of the Property and Casualty Insurance (C) Committee determined that the model is no longer used and has been replaced by more current methods for workers' compensation data reporting. The committee recommended its deletion and the Plenary accepted that recommendation.

**Models and White Papers to be Considered for Adoption by the Executive Committee at the Winter National Meeting in New Orleans**

**1. Prohibition On The Use Of Discretionary Clauses Model Act (#42) (Draft 7/8/04)**

At the Fall National Meeting, the Health Insurance and Managed Care (B) Committee adopted revisions to the Prohibition On The Use Of Discretionary Clauses Model Act intended to prohibit use of discretionary clauses in disability income insurance contracts. The revisions specifically bar contract language that purports to reserve

discretion to the insurer to interpret contract terms or to provide standards of interpretation or review that are inconsistent with state law.

### **Models to be Considered for Deletion at the Winter National Meeting**

#### **1. Two-Tier Annuity Model Regulation (# 247)**

The Life Insurance and Annuities (A) Committee voted to recommend this model for deletion. No states have adopted it in the more than ten years since it was adopted by the NAIC.

#### **2. Bulletin on Illustrated Interest Projections (# 572)**

This model was adopted prior to the development of the Life Insurance Illustrations Model Regulation and the revisions to the Life Insurance Disclosure Model Regulation. The A Committee believes that it is no longer needed at this time.

#### **3. Modified Guaranteed Life Insurance Regulation (#588)**

In the nearly 20 years since this model was adopted, only one state has chosen to promulgate a regulation based on the text. Therefore, the Life Insurance and Annuities (A) Committee feels it is no longer important to retain this model in the official

NAIC *Model Laws, Regulations and Guidelines*.

#### **4. Information Reporting Bill (#750)**

The Statistical Information (C) Task Force reviewed this model law, which two states have adopted. It determined that many of the model's provisions are either no longer relevant or are now included in other model laws. The model was referred to the Casualty Actuarial (C) Task Force, which concurred with the assessment that the provisions of the model have been adequately incorporated into other legislation. The Property and Casualty Insurance Committee adopted this recommendation.

### **New Drafts of Models Released for Comment**

#### **1. Long-Term Care Insurance Model Act (#640) (Draft 8/13/04)**

The Senior Issues (B) Task Force is considering amendments to the Long-Term Care Insurance Model Act that add requirements for agent training. The suggested training would consist of eight hours in a 24-month period before being authorized to sell long term care insurance, and eight hours every 24 months thereafter. The task force will refer the next draft of the education section to a producer licensing group within the NAIC for

review. Another proposed amendment clarifies that policies may be field issued if the compensation to the field issuer is not based on the number of policies issued. The task force expects to develop another draft before the Winter National Meeting.

#### **2. Long-Term Care Insurance Model Regulation (#641) (Draft 8/13/04)**

The Senior Issues (B) Task Force is considering amendments to the Long-Term Care Insurance Model Regulation to address the "cross-border" issue; that is, how insureds access benefits when they purchase the policy in one state and move to another that does not have the same provider licensing requirements. The draft provides that if a claim would be covered but for licensing issues in the second state, the claim must be approved. The draft also updates some definitions. The Task Force will be considering other amendments, such as upgrades and downgrades, and consumer disclosures, at future meetings. The task force expects to develop another draft before the Winter National Meeting.

#### **3. Long-Term Care Insurance Model Regulation (#641) (Draft 9/10/04)**

The Accident and Health Insurance Working Group

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of the Life and Health Actuarial Task Force prepared amendments to the model regulation in response to a request from the Senior Issues Task Force, which asked the group to look at issues related to the rating standards added to the model in 2000. The most significant changes in the draft prepared by the working group relate to a proposed new conditional benefit upon lapse for limited premium payment policies.

**4. Group Health Insurance Mandatory Conversion Privilege Model Act (Draft: 9/13/04)**

The Regulatory Framework (B) Task Force identified this model as in need of revision during the NAIC model law review initiative in 2003. The revisions in the draft pertain to NAIC model law drafting requirements. The task force specifically requested comments about the changes in Section 10. This section in the existing model sets out, in great detail, requirements for hospitalization or surgical expense and major medical coverages in a converted policy if the group health benefit plan being converted offered such coverage. The proposed Section 10 would require that a converted policy provide “substantially similar” benefits as compared to the group health plan being

converted. The converted policy benefits must be no less than the minimum standard benefits required by the commissioner. Comments are due no later than Nov. 19, 2004.

**5. Newborn and Adopted Children Coverage Model Act (#155) (Draft: 9/13/04)**

The Model Newborn Children Bill was endorsed by the NAIC in 1974, and it was identified for revision during the models review process. The parent committee retained the model to ensure that the requirement of covering newborns from the moment of birth is maintained in the individual market. The draft prepared by the Regulatory Framework Task Force of the Health Insurance and Managed Care (B) Committee makes the requirements for coverage of newborns and newly adopted children consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for both the individual and group markets. The draft reviewed in Anchorage incorporated some of the comments received from regulators and America’s Health Insurance Plans on the initial draft. The task force solicits comments on the second draft by Nov. 22, 2004.

**6. Public Adjuster Licensing Model Act (Draft: 9/11/04)**

The Producer Licensing Working Group of the Market Regulation and Consumer Affairs (D) Committee revised the existing draft of a Public Adjuster Licensing Model Act. The model would govern the qualifications and procedures for the licensing of public adjusters. In September, the working group discussed comments it received from interested parties about Sections 11 through 14. The working group expects to continue discussion of comments by conference call.

**7. Authorization for Criminal History Record Check Model Act (Draft: 8/5/04)**

The Producer Licensing Working Group of the Market Regulation and Consumer Affairs (D) Committee discussed the Authorization for the Criminal History Record Check Model Act that is designed to provide states with the ability to collect fingerprints on insurance entities and submit these fingerprints to the appropriate state law enforcement and the Federal Bureau of Investigation. In September, the working group studied comments from interested parties about Sections 1 through 4, including whether officers and directors of companies should be subject to the model. With regard to this issue, the working group will refer the draft to the

National Treatment (EX) Working Group to evaluate the model's treatment of company licensure processes. The working group plans to submit the final version of the model to the FBI to provide assurance to the states that the model would be sufficient to obtain criminal history background check information from the national federal database.

**8. Fiduciary Responsibility of Insurance Producers Model Act (Draft: 8/27/04)**

The Producer, Company and Unauthorized Entities Unlawful Activity Working Group of the Antifraud (D) Task Force developed this model to define a producer's fiduciary responsibility to hold funds received or collected as a producer in a separate account. It should be helpful to states that do not have a law that prohibits producers from commingling funds. The model is intended to assist law enforcement and be a criminal deterrent among the producer community. During the past year, the task force made several changes in response to industry comments. In September, the task force adopted the model after working on it for five years. The Market Regulation and Consumer Affairs (D) Committee referred the model to the Producer Licensing (D) Working Group for further review.

**9. Insurer Receivership Model Act (# 555) (Draft: 9/13/04)**

The Receivership Model Act Revision Working Group of the Receivership and Insolvency (E) Task Force discussed amendments to the model law governing receiverships. This draft compiles recommendations from various small groups that worked on updating and comparing the existing model with the Uniform Receivership Law. Since the Summer National Meeting, the working group made significant progress working through several intricate sections by weekly conference calls and an August interim meeting. The working group plans to meet twice weekly by conference call during the period prior to the Winter National Meeting.

**10. Actuarial Guideline VACARVM—CARVM for Variable Annuities Re-defined (Draft 9/9/04)**

In September, the Life and Health Actuarial Task Force incorporated additional changes into a new draft. The task force is working with the American Academy of Actuaries' Variable Annuity Reserve Work Group to examine issues surrounding the development of a reserve methodology known as "the Standard Scenario" for variable annuity products

that uses the principles of the proposed Risk-Based Capital (RBC) C-3 Phase II approach. The reserve methodology, if adopted as drafted, would be applicable to all variable annuity products. The most recent revisions implement four specific recommendations from the Academy group, changes to the Standard Scenario specifications, and a three-year phase-in of the guideline.

**11. Actuarial Guideline ABC—Projection of Guaranteed Nonforfeiture Benefits Under CARVM (Draft: 9/9/04)**

The Life and Health Actuarial Task began discussion of a new actuarial guideline related to the projection of guaranteed nonforfeiture benefits. This Guideline applies to contracts subject to CARVM and the Standard Nonforfeiture Law for Individual Deferred Annuities. Comments on the draft will be discussed at conference calls prior to the Winter National Meeting.

**New Drafts of White Papers**

**1. Communication and Coordination Among Regulators, Receivers and Guaranty Associations; An Approach to a National State Based System (Draft: 8/12/04)**

The Receivership and Intergovernmental Working Group of the

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Receivership and Insolvency (E) Task Force has been working on a white paper intended to discuss what databases would help in coordination, what manuals or other sources should be consulted, what best practices should be used and what expertise is needed at which stages of a receivership. The working group and the task force adopted the draft at an interim conference call in August. The Financial Condition (E) Committee, parent of the task force, asked for comments on the white paper.

### **No Further Versions of These Drafts Released**

#### **1. Annuity Nonforfeiture Model Regulation (Draft: 6/10/04)**

The Life and Health Actuarial Task Force is developing a new model regulation to implement the changes to the Standard Nonforfeiture Law for Individual Deferred Annuities adopted in early 2003. That model revised the 3% nonforfeiture rate to allow for a constant maturity treasury rate. The model contains extensive information on calculating the nonforfeiture rate for equity-indexed annuities. In September, the task force decided to incorporate provisions allowing “premium buckets” in an upcoming draft of the model. The task force also

heard the latest suggestions of the American Academy of Actuaries’ Annuity Nonforfeiture Implementation Work Group about the appropriate definition of “s u b s t a n t i v e participation.” The task force expects a revised draft to be reviewed by conference call prior to the Winter National Meeting.

#### **2. Unauthorized Transaction of Insurance Criminal Model Act (Draft: 6/8/04)**

A subgroup of the Antifraud (D) Task Force is preparing a model drafting to establish criminal penalties for unlawful insurance or health coverage transactions. At the Fall National Meeting, the task force reiterated that although other matters diverted its focus on this model since the Summer National Meeting, it continues to have interest in completing the model and welcomes comments on the draft. A new draft is expected before the Winter National Meeting.

#### **3. Coordination of Benefits Model Regulation (#120) (Draft: 5/7/04)**

The Regulatory Framework Task Force of the Health Insurance and Managed Care (B) Committee reviewed additional comments on this draft of the Coordination of Benefits Model Regulation. The task force focused on

provisions about high deductible health plans, the definition of “allowable expense,” and technical revisions. The task force expects to develop a new draft reflecting the discussions since the Summer National Meeting. The draft will be available for comment in anticipation that the task force will adopt the proposed revisions at the Winter National Meeting.

#### **4. Model Regulation to Implement the Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out) (#119) (Draft: 3/19/01)**

The NAIC charged the Regulatory Framework (B) Task Force with the duty to review and revise NAIC model laws and regulations affected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations adopted pursuant to HIPAA. A first draft of amendments to this model regulation to conform both to HIPAA regulatory requirements and the rating provisions of the Small Employer Health Insurance Availability Model Act has been prepared by the task force. The task force referred provisions of this model regulation concerning rating to the Accident and Health Working Group of the Life and Health Actuarial Task Force for drafting assistance.

**5. Model Regulation to Implement the Individual Health Insurance Portability Model Act (#38) (Draft: 12/4/00)**

The Regulatory Framework Task Force of the Health Insurance and Managed Care (B) Committee is considering amendments to conform this model to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Several proposed amendments concern drafting notes that speak to the differing guaranteed issue requirements for federally defined eligible individuals. A new Section 10 was added that would set out HIPAA's requirements for providing certificates of prior creditable coverage as provided in the HIPAA interim final regulations; this section likely will be revised after the final HIPAA regulations are issued.

**6. Model Regulation Requiring Annual Audited Financial Reports (#205) (Draft: 4/13/04)**

The NAIC/AICPA Working Group of the Financial Condition (E) Committee has proposed revisions to this model that would apply to all insurers. The revisions are in response to the passage of the Sarbanes-Oxley Act and to preempt those accounting problems that have occurred in recent years.

At the Fall National Meeting, the working group discussed its extensive efforts to respond to the Sarbanes-Oxley Act. Since the Summer National Meeting, it held one interim meeting and created two subgroups to intensively discuss titles II and III of the federal legislation and their relationship to the model. Each subgroup held multiple conference calls and there is progress toward consensus between regulators and industry.

**7. Standard Valuation Law (#820) (Draft: 9/12/03)**

The Life and Health Actuarial Task Force is considering a proposed revision of the model law that would remove the requirement of a Certificate of Valuation contained in Section 2 of the model. The proposed revision was prompted by a survey of the states in which a majority of the respondents favored eliminating the requirement. The task force specifically stated that this proposed revision would be adopted only if other potential changes to the model are considered and adopted in the future.

**8. Determination of Nonforfeiture Benefits and Guaranteed and Non-Guaranteed Elements for Life Insurance and Annuity Contracts (Draft: 9/8/00)**

The Life and Health

Actuarial Task Force was charged with developing a new nonforfeiture law for life insurance, health insurance, and annuities to replace the existing nonforfeiture standards. The draft under development did not have strong regulatory support. At the 2000 Winter National Meeting, a revised set of principles was discussed. Under this approach the concept of an operational plan was eliminated in favor of various policyholder protections being triggered if a company substantially changes the way it determines nonguaranteed elements. Regulators generally agree on a few concepts: retrospective design, floor for benefits, cash value and some degree of regulator control for nonguaranteed elements. At the 2003 Winter National Meeting the task force engaged in a lengthy discussion of the model's direction. There was general agreement that the project should continue, yet possibly narrow its primary focus to life insurance. The task force also questioned whether the model law should address nonguaranteed elements.

**9. Weather Financial Instruments (Temperature): Insurance or Capital Markets Products? (Draft: 9/02/03)**

The Crop Insurance (C) Working Group and its parent committee are

considering a draft of a white paper that discusses whether certain weather derivative agreements currently marketed as investments should be regulated as insurance. The proposed white paper concludes that weather derivatives should be classified as insurance products for a number of

reasons, including that the derivatives essentially perform like insurance products by transferring risk from a business to a professional risk-taker. Before the 2003 Winter National Meeting, the Property and Casualty Insurance (C) Committee received a request from the Insurance Securitization

(E) Working Group for an opportunity to comment on the white paper, specifically the definition of weather derivatives. Comments were received at the Summer National Meeting, and the Property and Casualty Insurance (C) Committee tabled discussion of the white paper.

## NAIC Education & Training Department 2004 Programs

Program	Dates	Location
ONLINE: ISQ #2 R/O – 3 Weeks 143	Oct. 12-Nov. 1	Internet
Regulating for Solvency R/O – 3.5 Days 113	Oct. 25-28	NAIC Headquarters Kansas City
ONLINE: ASIS #3 Public – 5 Days 139	Oct. 25-29	Internet
ONLINE: Market Analysis Tech.#2 R/O – 3 Weeks 158	Oct. 25 - Nov. 12	Internet
ONLINE: Schedule P #2 Public – 2 Weeks 145	Nov. 1-15	Internet
ONLINE: Health F/A R/O – 2 Weeks 161	Nov. 1-15	Internet
Electronic Age of Producer Licensing - R/O – 1.5 days 164	Nov. 8-9	NAIC Headquarters Kansas City
ONLINE: IMR/AVR Public – 1 Week 138	Nov. 8-12	Internet
ONLINE: Basic Reinsurance #2 Public – 1 Week 153	Nov. 15-19	Internet
CLE Seminar Public – 1 Day 109	Dec. 3	Nat'l Meeting-New Orleans
ONLINE: ASIS #4 Public – 5 Days 139	Dec. 6-10	Internet

