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January 1986

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

The Program Evaluation Division was established by the Legislature in 1975 as a center for management and policy research within the Office of the Legislative Auditor. The division's mission, as set forth in statute, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently. Reports published by the division describe state programs, analyze management problems, evaluate outcomes, and recommend alternative means of reaching program goals. A list of past reports appears at the end of this document.

Topics for study are approved by the Legislative Audit Commission (LAC), a 16-member bipartisan oversight committee. The division's reports, however, are solely the responsibility of the Legislative Auditor and his staff. Findings, conclusions, and recommendations do not necessarily reflect the views of the LAC or any of its members.

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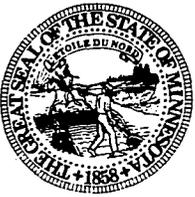
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Insurance Regulation

January 1986

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota



STATE OF MINNESOTA

OFFICE OF THE LEGISLATIVE AUDITOR

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JAMES R. NOBLES, LEGISLATIVE AUDITOR

January 19, 1986

Senator Randolph W. Peterson, Chairman
Legislative Audit Commission

Dear Senator Peterson:

In June 1985, the Legislative Audit Commission asked the Program Evaluation Division to conduct a study of insurance regulation in Minnesota. This report evaluates how well the Commerce Department monitors and regulates the insurance industry in the state and responds to consumer complaints about companies and agents. It also analyzes the problems of high cost and availability of insurance and offers recommendations for legislative action.

We received the generous cooperation of the management and staff of the Department of Commerce during this study. Others in government, at the University of Minnesota, and in the insurance industry provided information and assistance.

The study was directed by Elliot Long. David Chein and Dan Jacobson conducted the research with the assistance of Karen Sullivan.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "James R. Nobles".

James R. Nobles
Legislative Auditor

A handwritten signature in cursive script, appearing to read "Roger A. Brooks".

Roger A. Brooks
Deputy Legislative Auditor
for Program Evaluation

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Executive Summary

In June 1985, the Legislative Audit Commission directed the Program Evaluation Division to study the effectiveness of insurance regulation in Minnesota. Recent months have been a period of growing legislative interest in problems facing the insurance industry, insurance purchasers, and the Minnesota Department of Commerce, the state agency that regulates insurance and enforces laws governing industry practices.

The states have had primary responsibility for regulating insurance since insurance regulation began in the mid-nineteenth century. Insurance regulation has several purposes:

- To ensure that insurance rates are not inadequate, excessive, or unfairly discriminatory;
- to protect individuals and businesses from the consequences of insurer insolvencies;
- to ensure that insurance companies and agents treat policyholders fairly; and
- to ensure that consumers have access to essential insurance coverage.

Accordingly, the Minnesota Department of Commerce reviews insurance rates and policy forms, regulates the financial condition of insurance companies, investigates consumers complaints, and licenses insurance agents.

A. RATE AND FORMS REVIEW

Some states regulate insurance rates by requiring state approval of rate changes. However, most states, including Minnesota, rely primarily on competition among vendors to protect consumers from excessive insurance prices. In Minnesota, property/casualty insurers must file rates prior to their use, but do not need to obtain state approval of these rates. Min-

Minnesota does require prior approval of insurance forms (policies) which are reviewed to see if they meet tests of understandability and standardization.

A key premise of the "file and use" regulatory approach used in Minnesota is that the market can usually set insurance prices that are fair and appropriate. In this framework, the rate review approach that makes sense emphasizes monitoring competition rather than detailed analysis of rates, except where competition breaks down. Standardized and intelligible insurance forms and policies are also important because informed consumer choice is an essential element of a competitive market.

Our key findings relating to the rate and forms review activities of the department are as follows:

- On the whole the department is adequately reviewing insurance rates and forms.

The department is able to stay current in its rate and forms review activities. The department can show many examples of a vigorous review of policy forms and its enforcement of statutory requirements.

- Analysts we interviewed reported that most of their time was spent reviewing forms rather than rates.

Forms are often rejected because they do not conform to statutory requirements, because policy provisions are misleading, or because policies fail to provide a reasonable benefit in relation to their cost. Rate changes--even in today's environment of rapid increases--are almost never rejected.

In establishing a "file and use" competitive system for determining most insurance rates, the Legislature did not expect the department to expend the bulk of its efforts in an extensive review of every rate filing. The department has correctly interpreted its role in rate review and is not devoting an excessive amount of time and resources to it. However, since Minnesota relies on competition to protect consumers from excessive rates, it is important to determine whether there is a competitive insurance market in Minnesota, and to take timely action in the cases where the voluntary market fails to work. Our review of several indicators of competition shows that there is a competitive market for most lines of insurance.

- Most consumers have a large number of companies to choose among in purchasing insurance.
- Most lines of insurance in Minnesota are not dominated by a few large firms.
- The available data on insurance company profitability do not indicate that insurance companies have been earning excessive profits in Minnesota.

Rapid price increases in some lines of insurance, however, have presented the Department with a new challenge that requires some strengthening of rate review procedures.

The department recently reinstated a requirement that commercial insurance rates be filed. The department also needs to carry out studies of the market for the specialized lines of insurance that are difficult to obtain.

We recommend:

- The department should work with the industry to improve its information on specialized lines of insurance. If the department cannot obtain needed data through cooperative efforts and its existing authority, it should seek new authority to require that insurance companies provide information on rates, premium volume, claims and expenses for the particular categories of insurance that are of concern.

The department has recently called for legislation to allow it to base a determination that rates are excessive on an analysis of the return on net worth for a given line of insurance.

We feel there are formidable technical obstacles to making such a case, and this approach at best, could be used only selectively since each contested case would consume months of preparation.

But even if this proposed approach is successful, it is questionable whether it will yield the desired results. If the Department were to find certain rates excessive--as some almost certainly are-- insurance companies might withdraw from the market altogether.

The department has also proposed legislation that would have the effect of instituting prior approval of property/casualty insurance rates. Under this proposal, if the Commissioner of Commerce is not satisfied that proposed rates are in compliance with the law, he could suspend them until a hearing determined that the rates were reasonable. In light of our finding that a competitive market exists for most lines of insurance, we do not believe that such sweeping authority is necessary. Moreover, such a change could also exacerbate the availability problem by causing some companies to withdraw from the market.

B. AVAILABILITY AND AFFORDABILITY

Certain types of insurance are either required by law or are practical necessities for individuals and businesses. If such insurance is unavailable or prohibitively expensive, the Commerce Department and the Legislature should propose and debate possible remedies. We have examined the current availability/affordability problem, reviewed existing methods for dealing with it, and have outlined alternatives for the Legislature to consider in establishing future policy.

By far, the most pressing aspect of the problem is the rapid increase in rates for certain types of commercial liability insurance. These lines include medical malpractice, day care and foster care, municipal government, environmental impairment, dramshop and others. In some cases, businesses and professionals have been unable to obtain insurance from any source.

We examined the causes of the availability problem. We found that the evidence, although incomplete, leads to two findings:

- On the whole, the current crisis in commercial liability insurance is not the result of excessive rates and profiteering.
- To a large extent, the current availability crisis for commercial liability insurance has resulted from a period of rising claims, diminished profitability, and greater perceived risks in those lines.

The insurance industry is cyclical, going from periods of high to low profitability. The industry is currently at a low point in the cycle. The current cycle has been particularly severe and has diminished the industry's profits and its capacity to underwrite new business. The industry has been retrenching and abandoning what it considers its less profitable and more risky lines of insurance. In particular, insurance companies have stopped selling or dramatically increased prices for commercial and professional liability insurance.

Prospects for the future availability of insurance will improve as profits are restored as a result of recent price increases. While this will solve the general problem, particular types of insurance may well continue to be expensive or unavailable. Recent trends in jury awards and lawsuits have made certain lines of insurance appear very risky to insurance companies.

There is a need for the state to act to ensure that insurance is available where availability is in the public interest. The industry-wide capacity shortage has led insurance companies to withdraw from offering, at a reasonable price, insurance in areas where profit potential is limited and risks are hard to evaluate. But the insurance market finds an appropriate price by going too far in one direction and then another. Just as insurance companies can be precipitously frightened away from a market, we believe there are ways to attract them back through the promise of a constructive regulatory environment, even if the fundamental conditions of the market do not change dramatically.

There have always been problems in supplying certain types of insurance and today's problems are more severe, but not qualitatively different than problems that have existed in the past. Mechanisms already exist for dealing with the types of problems now being experienced. These include: surplus lines insurance, self insurance and pooling, market assistance plans, and assigned risk plans.

Our analysis does not lead us to conclude that major revisions to the state regulatory framework are necessary to improve the availability of

insurance, nor are we convinced that such revisions would have the intended effect.

We do recommend that the department seek legislative approval of increased authority to set up joint underwriting associations or assigned risk plans where:

- the state mandates insurance coverage, but purchasers cannot obtain it; or
- the Commerce Department can show that a clearly articulated public purpose is served.

Rates charged through these assigned risk programs should be actuarially sound. To the extent that high prices are an accurate reflection of risk levels, assigned risk programs would not necessarily lower prices although they would tend to stabilize prices in a volatile environment.

We anticipate that few assigned risk plans would be set up under this authority because the insurance industry, fearing a coercive solution, would be motivated to solve some problems voluntarily. In fact, negotiation and compromise between the Commerce Department and the industry offer greater promise than posturing on either side. It is important to remember that:

- Minnesota has about two percent of the nation's population and is limited in its ability to achieve lower insurance prices without aggravating the availability problem. The state-by-state system of insurance regulation limits what individual states can do.

Finally, there is evidence that some tort reforms enacted in other states have reduced the size and frequency of insurance claims. There are few systematic studies, but a lot of anecdotal evidence in this area. Based on a review of the best research studies and in light of the apparent fact that other states have been more active than Minnesota in enacting tort reforms, we recommend that:

- the Legislature undertake a study of tort reforms enacted in other states along with studies of their effect on the frequency and severity of insurance claims and on the cost and availability of insurance.

C. INSURANCE COMPANY SOLVENCY

Nationally, the number of insolvencies in the insurance industry has grown rapidly in recent years, particularly among property/casualty insurers during 1984 and 1985.

- The number of property/casualty insolvencies, averaging about six per year between 1971 and 1983, grew to 20 in 1984 and 20 in 1985.

The reason for this large increase is that the property/casualty industry experienced unusually large operating losses in 1984. Historically, insolvencies and profits have followed cyclical patterns. In 1984, the industry reached the bottom of an unusually deep cycle.

In order to protect policyholders from the consequences of insolvencies, Minnesota uses two strategies. First, insurance guarantee associations established by the Minnesota Legislature cover insured losses that an insolvent insurance company cannot pay. Second, the Commerce Department regulates the financial condition of insurance companies. Our report examines how effectively each of these strategies protects Minnesota residents from the consequences of insurance insolvencies.

We conclude that Minnesota's guarantee funds effectively protect Minnesota residents from large losses due to insolvencies. Because of the growing number of insolvencies, Minnesota's guarantee fund assessments exceeded \$20 million in 1985, after averaging less than \$2 million per year during the previous ten years. Nevertheless, insolvencies have not exceeded the capacity of Minnesota's guarantee funds. However, at best, guarantee funds spread the costs of insolvencies among larger groups of people. Thus, efforts to minimize the costs of insolvencies continue to be important.

The Commerce Department regulates the financial condition of insurance companies in several ways. It licenses insurance companies, monitors their financial condition, conducts field examinations, and imposes financial restrictions on financially troubled insurance companies. However, several factors beyond the control of the Commerce Department hamper the effectiveness of solvency regulation in Minnesota.

- A state by state system for monitoring the financial condition of insurance companies is not very efficient.
- It is impractical for the department to thoroughly analyze the financial condition of all insurance companies licensed in Minnesota. As of 1985, insurance companies licensed in Minnesota include 98 companies domiciled in Minnesota and over 1,000 companies domiciled in other states.
- Minnesota has limited authority to deal with financially troubled insurers domiciled in other states. The company's state of domicile has primary jurisdiction for developing remedial programs to correct the company's financial problems.

Within these constraints, we believe that the department has established a reasonable system for regulating the financial condition of insurance companies operating in Minnesota. We found that:

- When an insurance company applies for a license to operate in Minnesota, the department gives appropriate emphasis to the company's financial performance before approving its application.
- Beginning in 1985, the department gave high priority to reviewing the performance of financially troubled companies.

- The department has used its examination resources more effectively since the 1982 Legislature gave the department more flexibility in scheduling its examinations.

Nevertheless, in order to further strengthen its financial surveillance, we recommend:

- The department should revise its examination schedule by lengthening the time interval between examinations for companies it considers to be the most secure.

The department could use these additional resources to more closely monitor companies it considers to be of greater financial risk. To improve its ability to quickly identify companies in financial trouble, we recommend:

- The department should review insurance rates to identify companies that are charging unusually low rates.
- The department should increase the number of companies for which it reviews quarterly financial statements, including companies which have moderate solvency risk but which write a large amount of business in Minnesota.

D. REGULATION OF TRADE PRACTICES

Within a regulatory framework that allows insurance rates to be determined by competitive market forces, it is important that mechanisms are provided to protect consumers from unfair and deceptive trade practices and to assist consumers in making informed choices about the products they purchase. The Department of Commerce performs this function by investigating consumer complaints, conducting market conduct studies as part of its financial investigations of insurance companies, licensing insurance agents and disseminating information to the public. We reviewed the department's activities in each of these areas. We found that:

- On the whole, the Department investigates complaints in an efficient and timely manner.

The median number of days between the time a complaint is received and resolved is 34. We found no evidence of serious backlogs.

- Although the department is limited in its ability to resolve complaints, many consumers do benefit from the department's actions.

The most frequent consumer complaints involve disputes over settlements of claims and cancellation or non-renewal of policies. The department is often not able to resolve factual disputes. The department does, however, enforce trade practice laws and ensure that insurance companies are deal-

ing fairly with consumers. The department provided results sought by consumers in three out of every eight complaints we analyzed. These results usually involved company delays in paying claims and disputes over the amount of payment. The department also disciplined agents and fined companies in instances where trade practice laws were violated. Even in cases where the consumers did not receive desired results, they did receive an explanation of the applicable rule and an explanation from the company regarding its actions. However, we also found that:

- The department does not have an adequate public information program.

The department has produced few brochures and consumer guides to help the public understand insurance products and trade practices. Nor does the department have a brochure adequately explaining its own complaint investigation process. We recommend that:

- the department develop a brochure describing its consumer services;
- the department install an 800 number to provide free access for outstate citizens; and,
- the department work with the insurance industry to develop a systematic plan for disseminating information to the public about insurance and common complaint issues.

Market conduct examinations are designed to detect systematic trade practice problems. We found that the department devotes few resources to this activity and that it does not effectively target its market conduct examinations on the basis of suspected problems. The department relies primarily on consumer complaint investigations to detect systematic trade practice problems because it believes that these investigations are more effective than market conduct examinations. However, even if the department does not substantially increase the amount of resources it devotes to market conduct examinations, we believe it should improve how it targets these examinations. Specifically, we recommend that:

- the department improve its analysis of consumer complaint data to identify potential trade practice problems;
- the department schedule market conduct examinations on the basis of suspected problems;
- the department use staff who specialize in market conduct to conduct these examinations.

Overview of Insurance Regulation

Chapter 1

This report presents the results of a study of insurance regulation in Minnesota authorized by the Legislative Audit Commission in June 1985.

We feel this is a timely study. The past six months have been an eventful period for the insurance industry and the Minnesota Department of Commerce, the state agency responsible for regulating insurance and enforcing laws governing industry practices.

This report examines:

- How effectively the department responds to consumer complaints against insurance companies and agents;
- How well the department conducts its review of insurance rates and forms;
- How well the department has protected the public from the consequences of insurance company insolvencies;
- The causes of current problems with the availability and affordability of insurance and some suggested solutions.

Other important questions are discussed as well. The report is organized as follows: This chapter describes the scope of insurance regulation in Minnesota, discusses how insurance regulation is organized and financed in Minnesota, and discusses how regulation in Minnesota has changed in recent years. Chapter 2 looks at rate and forms review. Chapter 3 looks at the department's activities relating to insurance company solvency. Chapter 4 examines several trade practice issues: consumer complaints, market conduct examinations, agent licensing, and consumer information. Chapter 5 looks at the availability issue and Chapter 6 discusses problems of data processing support in the department.

A. SCOPE OF INSURANCE REGULATION IN MINNESOTA

State governments have had primary responsibility for regulating the insurance industry ever since they began regulating insurance in the mid-nineteenth century. While the federal government has the authority to supersede state insurance regulation, it has done so in only a few circumstances. The Minnesota Department of Commerce administers insurance laws and regulations in Minnesota.

Insurance regulation has several purposes:

- to ensure that insurance rates are not inadequate, excessive, or unfairly discriminatory;
- to protect individuals and businesses from the consequences of insurer insolvencies;
- to ensure that insurance companies and agents treat policyholders fairly;
- to ensure that consumers have access to essential insurance coverage.

1. RATE REGULATION AND FORMS REVIEW

Some states regulate rates by closely examining rate increase requests. However, most states, including Minnesota, rely primarily on economic competition to protect consumers from excessive insurance rates. In Minnesota, property/casualty insurers must file rates prior to their use, but do not need the department's approval. The department may order that rates be discontinued if it can demonstrate that the rates are excessive, but the department rarely disapproves property/casualty rates. By statute, property/casualty rates are presumed not to be excessive if price competition exists. Unlike property/casualty rates, health insurance rates must meet certain minimum standards before they can be used. The expected amount of claims paid must equal at least a certain percentage of the premium. This minimum percentage varies between 55 and 75 percent, depending on the type of insurance.

State laws support competition by requiring insurance companies to provide understandable policy forms and by standardizing certain insurance coverages. These requirements are designed to help the consumer evaluate different policies and compare rates among different companies.

The department reviews insurance forms to ensure that they meet these requirements. In contrast to rates, insurance forms must be approved prior to their use. The department also reviews insurance forms to ensure that they are not misleading, to ensure that new insurance products offer reasonable value to consumers, and to determine whether health policies contain certain benefits mandated by the state. For example, most health insurance policies must cover alcoholism and chemical dependency treatment.

2. SOLVENCY REGULATION

In order to protect policyholders from insolvencies, insurance regulation attempts to keep insurance companies solvent and provides an insurance guarantee mechanism. The Minnesota Department of Commerce has primary responsibility for regulating the solvency of companies domiciled in Minnesota. It conducts financial examinations, develops remedial programs to salvage troubled companies, and initiates liquidation proceedings against seriously impaired companies. However, approximately 75 percent of all insurance sold in Minnesota is sold by companies domiciled in other states. The Minnesota Department of Commerce licenses these companies, monitors their financial condition, and restricts the Minnesota operations of financially troubled companies. However, other states have primary responsibility for regulating the solvency of these companies.

State law requires licensed insurance companies to belong to one of two insurance guarantee associations--one for health and life insurance companies and one for property and casualty insurance companies. The associations assess member companies to pay claims up to \$300,000 against insolvent insurers. Currently, all states have property/casualty guarantee funds and 38 states have life/health guarantee funds.

3. AVAILABILITY

In order to ensure that certain insurance coverages are available to all consumers, the Legislature established assigned risk plans for health, automobile, property, workers' compensation, medical malpractice, and dram-shop insurance. Consumers who have been rejected by an insurer can be insured under the appropriate assigned risk plan. The auto and workers compensation plans assign eligible consumers to insurance companies in proportion to each company's premium volume in Minnesota. For health and property insurance, the plan's board issues policies and assesses insurers for any losses in proportion to their premium volume in Minnesota for the relevant type of insurance. Under the health plan, however, insurers may take a premium tax credit equal to the assessment. As a result, the state subsidizes health insurance for high risk individuals. Assigned risk plans are designed to make insurance coverage available, not cheap. Generally, assigned risk plan prices are higher than the average offered in the voluntary market.

4. TRADE PRACTICES

To protect consumers from unfair trade practices, the department handles consumer complaints, performs market conduct examinations, and licenses insurance agents. It investigates possible insurance law violations and helps law enforcement agencies enforce insurance laws. In fiscal year 1985, the department responded to over 7000 consumer complaints involving insurance.

B. ORGANIZATION AND STAFFING

The Minnesota Department of Commerce has administered insurance laws and regulations in Minnesota since 1983, at which time insurance, banking, securities, and real estate regulation were consolidated in the Commerce Department. This reorganization was designed to improve the department's ability to keep abreast of the rapidly changing financial industries. Financial institutions have become increasingly involved in more than one financial industry. Furthermore, products offered by different industries have become less distinct. For example, annuities offered by life insurers are often bought for investment purposes. For these reasons, it makes sense to coordinate the regulation of these financial industries in one department.

As shown in Figure 1.1, the Commerce Department has five divisions, of which four are involved with insurance regulation. The Policy Analysis Division regulates insurer solvency, reviews rates and policy forms, and conducts research on public policy. It is the only division within the Commerce Department that deals exclusively with insurance. This division had 42 employees in January 1986.

The other three divisions with insurance responsibilities perform their functions for other industries as well. The Enforcement Division handles consumer complaints and investigates possible legal violations involving insurance and other financial industries. In January 1986, the division had a staff of 34 employees, of which 29 were allocated to insurance.

The Registration and Licensing Division consists of three sections: Registration, Licensing, and Unclaimed Property. In this division, only the Licensing Section has insurance responsibilities. The Licensing Section reviews and processes license applications for insurance agents, cosmetologists, and brokers or agents in other financial industries. It also administers continuing education requirements for insurance agents and real estate agents. In January 1986, the Licensing Section had a staff of 13 employees, of which 6 were allocated to insurance.

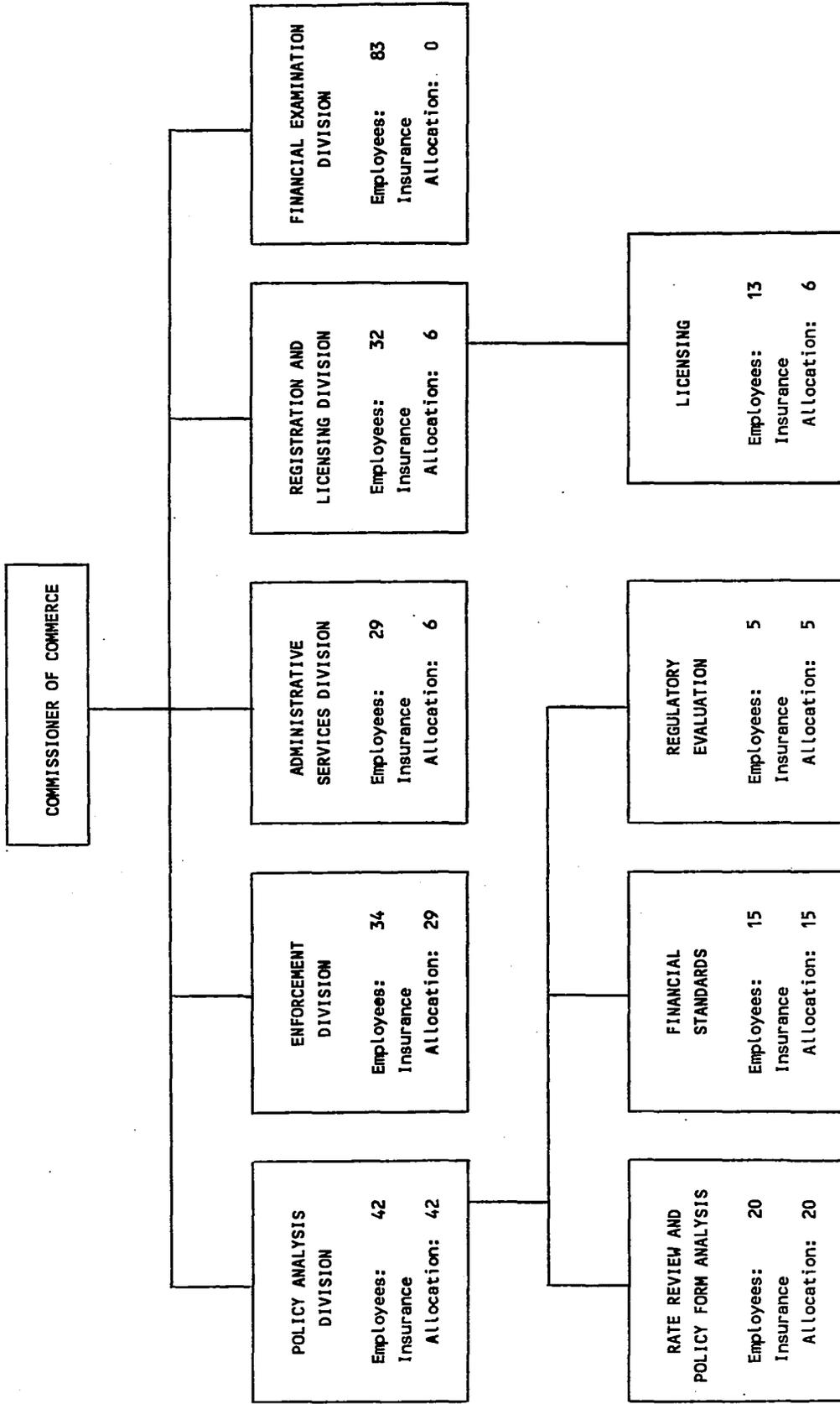
The Administrative Services Division serves the whole department. Six of its 29 employees are allocated to insurance regulation.

During fiscal year 1985, the department spent approximately \$2.76 million on insurance regulation. The department's personnel complement for fiscal year 1985 included 76 positions for insurance regulation. Between 1968 and 1985, the personnel complement for insurance has fluctuated between 68 and 78 positions. Recently, the department revised its method for allocating staff within the Enforcement Division to more accurately reflect the time spent by staff on insurance cases. As a result, the current number of employees allocated to insurance is 83.

According to a survey conducted by the National Association of Insurance Commissioners, Minnesota's insurance budget and staff size are smaller

FIGURE 1.1

MINNESOTA DEPARTMENT OF COMMERCE
ORGANIZATION CHART*



*As of January 1986.

than they are for most other states on a *per capita* basis.¹ Based on the state insurance budget per capita, Minnesota ranked 38th out of 44 states in 1982. Minnesota's insurance budget was \$.51 per capita, whereas the median state budget was \$.71 per capita and the average state budget was \$.82 per capita. Based on the number of state insurance employees per capita, Minnesota ranked 33rd out of 44 states in 1982. For every 100,000 people, Minnesota had 1.9 insurance employees, whereas the median state had 2.6 employees and the national average was 2.7 employees. Thus, the size of the Minnesota state agency responsible for insurance regulation is distinctly smaller than the national average.

C. TRENDS IN INSURANCE REGULATION

After moving towards deregulation of the insurance industry during the 1970's and early 1980's, Minnesota has strengthened insurance regulation since 1983.

Between 1969 and 1983, Minnesota scaled back insurance regulation in several ways. In 1969, the state implemented a change allowing property/casualty insurers to change their rates without prior approval by the insurance department. In 1982, the Insurance Commissioner ruled that property/casualty insurers no longer had to file rates for commercial insurance.

The 1981 Legislature also scaled back financial regulation by removing the requirement to examine every licensed insurer based in Minnesota at least once every three years. At this time, the insurance department also reduced the amount of time spent on examinations by using CPA audit results in its examinations. Because of these changes, the number of insurance financial examiners declined from 19 in 1978 to 10 in 1982.

Another area in which the Legislature cut back regulation was the licensing of insurance agents. It allowed insurance agents to obtain a perpetual license instead of an annual license.

Since the current administration came into office in 1983, Minnesota has strengthened insurance regulation in several ways. The department established rules governing agent conduct, marketing standards, and nonrenewal of automobile, homeowners, and commercial insurance. It also re-established the rate filing requirement for commercial policies, effective January 1986. The 1984 Legislature established minimum standards for settling insurance claims. It also improved the department's ability to investigate consumer complaints and enforce insurance laws and regulations by funding an additional 12 positions in the

¹State budget data and employee data are based on the National Association of Insurance Commissioners (NAIC) survey presented in the NAIC Proceedings-1983, Vol. I, Kansas City, MO, pp. 169-172. Population data are based on the 1980 census.

enforcement division. Finally, it established continuing education requirements for insurance agents and resumed licensing insurance agents annually instead of offering perpetual licenses.

During the 1986 legislative session, the department plans to seek broad authority to establish joint underwriting associations to ensure that individuals and businesses can obtain insurance that is not competitively available in the marketplace. The department has also proposed some changes in the regulatory framework. These changes would have the effect of reinstating prior approval of property/casualty rates and would allow the department to determine the reasonableness of rates on the basis of their projected return on net worth.

Review of Rates and Forms

Chapter 2

During the past year, there has been increasing concern among the public and lawmakers over rapidly increasing insurance costs. Our discussions with Department of Commerce staff and our review of recent insurance literature confirms the accuracy of this general perception, although the extent of recent rate increases varies among different lines of insurance. It is, therefore, important to understand why insurance rates are increasing and to assess the existing regulatory framework to determine whether it is adequately protecting consumers from excessive rates in the light of current trends.

A fuller discussion of current rate increases and the availability problem for some lines of insurance appears in Chapter 5. In this chapter, we review Minnesota laws that regulate insurance rates and we examine the manner in which the Department of Commerce enforces the legal requirement that insurance rates not be excessive, inadequate, or unfairly discriminatory. Our review includes a brief overview of the history of regulation, a description of current laws and procedures for reviewing insurance rates and forms and an analysis of the current state of competition in the Minnesota insurance industry. We focus on the following two issues:

- Do Minnesota laws relying on a competitive market for insurance adequately protect individual citizens and businesses from excessive rates?
- Are the rate and forms review functions of the department necessary and beneficial to the public and are they being conducted in an efficient and effective manner?

Concern over insurance rates is heightened by the fact that many types of insurance, such as automobile, homeowners, health and liability are necessities for most individuals and businesses. In this context, the state has an interest in monitoring the rates charged by insurance companies to ensure that necessary insurance is generally available and affordable.

As is true for many regulated industries, the state must be concerned that the rates not be so low as to threaten the viability of particular companies or the industry as a whole. In a competitive market, companies will

not offer a product that is expected to be unprofitable. Thus, if rates are maintained at too low a level, insurance will not be available. Furthermore, if companies are forced to compete in adverse markets, some may not be able to honor their commitments to insured customers when claims are filed. Insolvencies can impose severe hardships on policyholders and require special safeguards and contingency plans to protect the public.

The issues of availability and solvency will be discussed separately in subsequent chapters. We mention them here to emphasize the conflict inherent in insurance regulation. The state must exercise its regulatory authority to protect citizens against excessive rates, and at the same time protect them from the possible consequences of rates that are too low.

Insurance policies are often complex and difficult to comprehend. The average citizen may not be able to determine whether or not a particular policy provides the necessary and desired coverage. The state has a role, made more important when rates are not regulated, to require standardization of products to help ensure that insurance companies do not mislead the public or offer worthless or unnecessary coverages. Therefore, we will evaluate the department's review of insurance products as well as insurance rates.

A. HISTORY OF INSURANCE REGULATION

In this section, we briefly review the events and historical forces leading to the enactment of state regulatory laws. This review is helpful in understanding the current issues which shape public policy toward insurance regulation.

State laws regulating many facets of the insurance industry originated in the nineteenth century.¹ In 1872, in an attempt to ensure the stability of insurance companies and protect the interests of the insured, Minnesota created the position of an Insurance Commissioner. The Commissioner was responsible for licensing insurance companies, holding securities deposited by insurance companies in case of insolvency, and reviewing company finances and operations. Insurance companies were required to maintain specified levels of capital and were restricted in their investments.²

In Minnesota and the other states, early regulation was directed primarily at ensuring solvency. Aside from some state laws prohibiting discrimi-

¹Jon S. Hanson, Robert E. Dineen and Michael B. Johnson, *Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business* (Madison, Wisconsin: National Association of Insurance Commissioner, 1974), p. 16.

²"State Regulation of Insurance", Minnesota House Research, September 1984, p. 6.

nation, there was no effort to regulate rates until the late nineteenth century. Rate regulation originated when it became apparent that additional measures were needed to ensure insurance companies' solvency. Insurance companies promoted rate regulation in order to control highly competitive prices which were reducing profits and sending many companies into bankruptcy. While it is expected that some companies will go bankrupt in a competitive market, insolvencies are particularly distressing to the insurance industry because they diminish consumer confidence in companies' ability to fulfill their promise to pay future claims. Consumer confidence and trust is an essential ingredient to the success of the insurance industry, since an insurance policy is essentially a carefully worded promise.

Early attempts at insurance rate regulation involved groups of companies joining together in "compacts" to set minimum rates. These compacts were determined by the courts to be lawful on the basis of an 1869 U.S. Supreme Court ruling. This ruling, in *Paul v. Virginia*, held that, "issuing a policy of insurance is not a transaction of commerce," and, therefore, not subject to federal regulation of interstate commerce and to subsequent anti-trust laws.³ Nevertheless, these insurance compacts were, for the most part, unsuccessful as member companies frequently violated the agreements.

The first state law regulating insurance rates was enacted in Kansas in 1909. Its constitutionality was upheld by the Supreme Court on the basis that insurance is "affected by the public interest" and thus a reasonable object of state regulation.⁴ As a result, many states passed laws in the ensuing years regulating insurance rates.

In 1944, the Supreme Court reversed its 1869 decision and ruled that insurance did constitute interstate commerce and that insurance companies were not exempt from federal anti-trust law.⁵ Fearing federal regulation, the insurance industry and many states lobbied Congress for an exemption from federal anti-trust legislation. Congress responded by passing the McCarran-Ferguson Act in early 1945⁶ which affirmed that state regulation of insurance was in the public interest. The act exempted insurance from most aspects of federal anti-trust law to the extent that the industry was regulated by the states.

As a result of the McCarran-Ferguson Act, most states passed laws regulating insurance. Based on a model law supported by the National Association of Insurance Commissioners (NAIC), these laws typically included provisions that rates not be excessive, inadequate or unfairly discrimi-

³Paul v. Virginia, 8 Wall 168 (1869).

⁴German Alliance Insurance Co. v. Lewis, 233 U.S. 389 (1914).

⁵United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944).

⁶59 Stat. 33-34 (1945), 15 U.S.C.A. Secs. 1011-1015.

natory, that they be based on past or prospective experience, that they be supported by data and that they be filed with state insurance commissioners.⁷

Today, states differ considerably in the extent to which they monitor and regulate rates.⁸ The trend in recent years has been away from formal regulatory control of rates toward greater reliance on competition as the appropriate means to set economically sound rates. Earlier concerns that competitive rates will lead to insolvency have been mitigated by several factors, including:

- 1) the emergence of national networks of financial data to monitor solvency;
- 2) the emergence of sophisticated actuarial methodologies and rating organizations which pool data to reduce the likelihood that insurance companies will charge insufficient premiums;
- 3) The advent of insurance guaranty funds to protect consumers in the event of insolvencies; and,
- 4) the absence of any valid data linking insolvencies to the type of regulation practiced in a state.⁹

Indeed, some have suggested that in states where prior approval of rate increases is required before they go into effect, political considerations and regulatory lag may work to artificially suppress prices and increase the risk of insolvency.¹⁰

Whereas the concerns of early regulators were aimed at protecting the insurance industry from cutthroat competition and ensuing insolvencies, current regulatory concern has shifted toward protecting the public from excessive rates. This concern, in some states, has taken the form of close scrutiny of rate increases and careful monitoring of company profitability. In many states, however, the assumption has been that an openly competitive system coupled with some regulatory oversight will result in reasonable rates. The theory of competitive markets suggests that if insurance becomes excessively profitable, new competitors will enter the market and drive prices down. This is especially true in a non-capital intensive industry such as insurance, where there are relatively few barriers to entry for new firms.

⁷For a discussion of the historical evolution of contemporary insurance laws and the role of the NAIC in their development, see Hanson, et. al., *Monitoring Competition*, pp. 9-53.

⁸See Hanson, et. al., *Monitoring Competition*, pp. 53-57, for a discussion of these differences.

⁹See Hanson, et. al., *Monitoring Competition*, pp. 383-389.

¹⁰See Hanson, et. al., *Monitoring Competition*, pp. 62-65.

Under these circumstances, the focus of regulation shifts from rate monitoring toward monitoring the extent of competition. If the insurance market is determined to be non-competitive, intervention may be necessary to protect the public from excessive rates. Attention is also focused on the trade practices of insurance companies. Efforts are made to ensure that companies are competing fairly and that the public is sufficiently informed about insurance to make intelligent purchases.

B. STATUTORY REQUIREMENTS

1. FILING OF RATES

Minnesota's regulatory framework is known as a "file and use" system.¹¹ This is a competitive system which does not require that rates receive prior approval before they become effective. For most types of insurance, companies merely have to file rate changes with the department. They become effective immediately, but they are subject to a 30-day review period during which time the Commissioner of Commerce may, after an administrative hearing which finds that the rates are not in compliance with statutory requirements (discussed below), order that use of the rates be discontinued.¹²

There are generally three statutory requirements governing the reasonableness of rates. Rates must be adequate, they must not be excessive, and they must not be unfairly discriminatory.¹³ Property and casualty insurance rates are inadequate if they endanger the solvency of an insurer or if they are insufficient to sustain projected losses and expenses within the state. Rates are discriminatory if they fail to equitably reflect categorical differences in expected losses, expenses and risk.¹⁴

Property and casualty insurance rates are presumed not to be excessive if price competition exists at the consumer level. In determining whether or not competition exists, the department may consider, among other things, the number of insurers actively engaged in a class of business, the nature of rate differentials in that class of business, and whether long run profitability is unreasonably high in relation to that class of business.¹⁵ If competition is determined to be insufficient, the Commis-

¹¹A minor exception to the file and use rates in Minnesota applies to workers' compensation insurance., where rates may be filed up to 15 days after their effective date (Minn. Stat. §79.56).

¹²Minn. Stat. §70A.06, 61A.02, 62A.02, 62B.07.

¹³Minn. Stat. §70A.04, subd. 2.

¹⁴Minn. Stat. §70A.04, subds. 3 and 4.

¹⁵Minn. Stat. §70A.04, subd. 2.

sioner of Commerce may promulgate rules to require prior approval of rate changes.¹⁶

In the case of life and health insurance, the benefits provided must be reasonable in relation to the premium charged. For health insurance, the statute requires that the anticipated future claims paid to consumers be at least 50% of the expected future premiums.¹⁷ Accident and health insurers are also required to exercise reasonable cost controls.¹⁸

2. FILING OF FORMS

In contrast to rates, most policy forms are subject to a 30 to 60 day prior approval period, depending on the type of insurance.¹⁹ Forms are to be reviewed for compliance with statutory requirements and for form and content. This includes checking to see if policies include mandated coverages and required provisions and determining if they meet acceptable standards of readability.

C. COMMERCE DEPARTMENT PROCEDURES

The rate regulatory functions of the department are performed by the Policy Analysis and Insurance Division of the Department of Commerce. This division is divided into three sections. The Financial Standards section monitors insurance company solvency. The Regulatory Evaluation section conducts research and public policy analysis. The Rate Review and Policy Form Analysis section reviews rates and forms. The Rate Review and Policy Form Analysis section currently employs 14 full-time professional analysts including one assistant commissioner, five policy analysts assigned to life and health insurance, five policy analysts assigned to property and

¹⁶Minn. Stat. §70A.10.

¹⁷Minn. Stat. §61A.02, subd. 3; Minn. Stat. §62A.02, subd. 3; Minn. Stat. §62B.07, subd. 2. The department has implemented guidelines requiring that future claims be from 55 to 65 percent of benefits. In the case of medicare supplement insurance, expected benefits must be 75 percent of premiums for group policies and 65 percent of premiums for individual policies. Minn. Stat. §62A.36.

¹⁸Minn. Stat. §62A.02, subd. 3(3).

¹⁹For property and casualty insurance, the Commissioner has 30 days to disapprove the form or it is automatically approved. The Commissioner may extend this period by up to 30 additional days (Minn. Stat. §70A.06, subd. 2.). For life insurance, the Commissioner has 60 days (Minn. Stat. §61A.02, subd. 3). For credit life insurance and for accident and health insurance, he has 30 days (Minn. Stat. §§62A.02, subd. 2, 62B.07, subd. 3).

casualty insurance, one policy analyst assigned to workers' compensation insurance and two actuaries. The Regulatory Evaluation section employs three analysts.

In order to understand the rate and forms review functions of the department, we conducted in-depth interviews with the Deputy Commissioner for Policy Analysis and Insurance, the Assistant Commissioner for Policy Analysis, the supervisors of the life/health and property/casualty sections, and eight of the policy analysts. We also reviewed department correspondence with insurance companies regarding rates and forms. Because of problems with its data processing system, the department was unable to provide us with a reliable statistical summary of its activities in reviewing rates and forms. Accordingly, our analysis is based on less formal estimates of the department staff.

Our analysis focused on the extent and nature of rate and forms review, the criteria used to evaluate the reasonableness of rates and the adequacy of forms, and the efforts undertaken by the department to monitor competition and determine whether it is sufficient to ensure that rates are reasonable and industry profits are not excessive.

1. RATE REVIEW

In general, the department does not perform extensive analyses of proposed rate changes. The property/casualty analysts who were interviewed estimated that 30-40 percent of their time is spent on rate review.

- For the most part, requests for rate changes are accepted routinely.

Analysts could only recall two or three instances since the file and use system was adopted in 1969 where a request for a general rate increase or decrease for property/casualty insurance was disapproved. Requests are filed with statistical data supporting the change. The department's property/casualty actuary reviews some of the requests and may question some of the underlying assumptions behind company projections. For the most part, however, companies ask for lower rates than the amounts which their projections would justify. Policy analysts believe this is due to the competitive nature of most lines of property/casualty insurance.

We note here that commercial policies have been exempt from rate and form filing requirements as a result of a rule promulgated under a previous administration. The department now holds that the commercial filing exemption hampered its efforts to monitor commercial rates. Accordingly, it has reinstated the filing requirement as of January 1, 1986. Policy analysts report that commercial and professional liability insurance is generating the greatest number of consumer complaints about availability and affordability. The department is now attempting to address these concerns by surveying businesses and insurance companies on their rates and practices in particular lines of insurance, such as dramshop, day care, and product liability.

Although general rate increases are rarely disapproved, property/casualty analysts report that amendments or riders to policies are sometimes disapproved. For example, a provision in an auto insurance policy providing for a 40 percent increase in rates if the driver has a single traffic violation might be disapproved as unreasonable. In most instances, the department reports that it is not necessary to formally disapprove a rate. Rather, the department communicates its objections to the company and the company agrees to modify the objectionable rate.

Property/casualty analysts accept the legislative presumption that rates are not excessive if there is sufficient competition. Accordingly, they disapprove few rate increase requests and devote most of their efforts to reviewing policy forms. We believe that this strategy is effective so long as efforts are undertaken to monitor competition and prompt additional action is taken where problems of availability or affordability indicate a failure of the voluntary market. We address this topic in Chapter 5.

In contrast to property/casualty insurance, the life/health policy analysts apply a more explicit standard in evaluating rates. As discussed earlier in this chapter, health insurance rates must be designed so that at least 55-75 percent of the premiums collected are returned to policyholders in the form of benefits. The life/health policy analysts review rate filings to determine whether the insurance company has presented sufficient historical data to justify its projections. Some requests are referred to the department's life actuary to review the company's data and projections. The life/health analysts estimate that between 10 and 20 percent of the rate increase requests for accident and health insurance are not approved. Life insurance rates, on the other hand, are generally determined at the time the policy is issued. Thus, any questions about the reasonableness of life insurance rates are handled in the context of forms review.

2. FORMS REVIEW

Property/casualty analysts estimate that between 60 and 80 percent of their time is spent reviewing forms. Estimates of life/health analysts suggest that they spend a slightly higher proportion of their time reviewing forms. For all types of insurance, forms must be approved before they can be used. Analysts report that they review between 15 and 100 forms per week. In contrast to rate increase requests, property/casualty analysts estimate that between 15 and 50 percent of the forms that are filed are not approved. For life and health insurance, the estimates range from 40 to 95 percent disapproval for initial filings. (Estimates vary due to the different specializations of the analysts.) While some forms are rejected outright, in most cases the analyst sends a letter to the insurance company specifying the objectionable parts of the form and requesting changes. The company usually resubmits the form with the requested changes. Companies rarely request a hearing on an issue pertaining to policy forms.

A form is disapproved if it does not conform to statutory requirements as to form and content. Each form must include an affidavit and test results

which indicate that it meets readability standards. There are also certain statements which must be included in some types of policies. Finally, there are state mandated coverages for some types of insurance.

In addition to monitoring compliance with specific statutory requirements, the policy analysts review forms to ensure that the provisions of insurance policies are not misleading and that the policies provide useful benefits to consumers in relation to costs. An example of a misleading policy which was not approved was an accident/life insurance policy which provided an additional death/dismemberment coverage for rape. The policy analysts believed that the policy was misleading because it gave the impression that insureds would receive benefits if they were raped, whereas in actuality, the benefits would only be provided if the rape resulted in death or dismemberment. An example of an unreasonable provision which was disapproved was an option to purchase an additional \$10,000 of life insurance if the insured was killed in an auto accident and was wearing a seat belt at the time. Analysts felt that, in many instances, it would be extremely difficult to prove whether or not an insured was wearing a seat belt at the time of the accident. Furthermore, this benefit cost \$6.87 and a \$10,000 accidental death rider which covered all kinds of accidents could be purchased for \$9.00.

3. EVALUATION OF RATE AND FORMS REVIEW ACTIVITIES

Because the department was unable to provide us with a detailed list of its rate and forms review decisions, we are unable to provide a quantitative summary of the department's rate and forms review activities. Elsewhere, we discuss needed improvements in the department's data processing support. Here, we offer the following conclusions as to the value of the rate and forms review functions of the department and the effectiveness of its efforts:

- We find the rate and forms review functions of the department to be necessary and beneficial to the public.

Every policy has numerous provisions and exclusions and it is difficult for consumers to fully understand what they are purchasing. We believe, therefore, that it is proper for the state to provide a mechanism to review insurance policies to help ensure that they do not confuse or mislead. The Legislature has itself addressed this issue by passing an insurance readability statute, by requiring that specific language informing consumers of certain policy provisions and certain rights of consumers be printed on the face of policies, and by providing that certain coverages and provisions deemed to be in the public interest are mandatory. The forms review functions of the department, in addition to monitoring compliance with legislative requirements, provide additional public safeguards against misleading and deceptive insurance policies and policies that provide little or no public benefit.²⁰

²⁰There are, nevertheless, insurance products sold which have limited value. We believe that the MDOC could take a more active role reviewing such products and informing consumers about them.

We also believe that rate monitoring is necessary to identify situations where pricing abuses may occur in an imperfectly competitive market.

- We find that the department's review of insurance rates and forms is adequate and consistent with statutory requirements.

We found no evidence that the department was falling behind in its forms review activities or that it approaches its job in a haphazard manner. To the contrary, the department was able to provide us with many examples of its vigorous review of policy forms and its enforcement of statutory provisions.

- We find that the department has correctly interpreted legislative intent and has appropriately placed its primary emphasis on forms review as opposed to rate review.

It is clear to us that in establishing a "file and use" competitive system for determining most insurance rates, the Legislature did not expect the department to exert the bulk of its efforts in an extensive review of every rate filing. The department has correctly interpreted its role in rate review and is not devoting an excessive amount of time and resources to it.

As we discuss in Chapter 5, insurance rates have increased most rapidly over the past two years in specialty lines of commercial liability insurance. The rapid rate increases for these lines of insurance has presented the department with a new challenge that requires a strategy that goes beyond routine rate review procedures.

In response to this challenge, the department has reinstated a requirement that vendors of commercial insurance file their rates with the department. The department has also initiated surveys of the market for those specialty lines that are currently difficult to obtain.

Although the department has authority under Chapter 70A to find that insurance rates are excessive, the department takes the view that it is prohibitively difficult to invoke this power. Minnesota law requires the department to make the case that competition has failed in order to show that rates are excessive and the department believes that it is virtually impossible to meet this test. Accordingly, the department has called for legislation to allow it to base such a determination on an analysis of the return on net worth for a given line of insurance. Under this proposal, rates would be considered excessive if they result in a rate of return which is unreasonably high for that line of business.²¹

Although the department's proposal to determine the reasonableness of rates on the basis of return on net worth is theoretically sound, there is no simple way to allocate insurance company profits among states and lines of insurance. Criteria need to be developed if this approach is to work.

²¹Other aspects of the department's proposed changes in property/casualty rate regulation are discussed in Chapter 5.

In addition, the department will need to develop standards to determine when rates of return are excessive and a methodology to evaluate company projections of future premiums, claims and investment income. The department will have to be very selective in its rate monitoring activities. There are over 1,000 companies selling insurance in Minnesota, most offering several lines. Each contested case will consume months of detailed preparation. The department will need to concentrate its efforts on those lines where it believes rates are excessive or where it believes competition is insufficient to ensure that rates are reasonable.

Even if the department's proposed approach is successful, it is questionable whether it will yield the desired results. Specialty lines are not central to the profitability of the insurance industry. If the department were to find rates excessive - as some almost certainly are - insurance companies might withdraw from the market altogether. This is quite possibly the result that insurance companies were looking for when they raised their rates in the first place. Thus, the rate review process does not necessarily culminate in a good solution in the face of rapid rate increases and withdrawal of vendors from the market. In our view, a different strategy is called for to deal with the availability and affordability problems now experienced by many businesses and professionals seeking to purchase liability insurance. We discuss this strategy in Chapter 5.

D. MONITORING COMPETITION

In a "file and use" state such as Minnesota, rate review consists largely of monitoring competition. Our analysis in the following section indicates that, on the whole, competition is effective for most lines of insurance, even in the face of the current financial problems facing the insurance industry. Nevertheless, there are situations where competition is not sufficient to ensure that rates are reasonable. Identification of such problem areas enables the department to concentrate its efforts in those areas and develop a strategy for ensuring that rates do not become excessive.

There are no absolute criteria for judging the competitiveness of a market. There are general indicators, however, such as the number of firms issuing insurance policies for a given line of insurance, the market concentration for each line, pricing patterns, and long-term profitability trends. The department is aided in its monitoring efforts by regular statistical reports produced by several organizations. The National Association of Insurance Commissioners (NAIC) produces annual reports on market share by line of insurance for each state. A. M. Best, Inc., rates the financial health of insurance companies and performs analyses of company profitability. The Insurance Services Office, Inc. (ISO) is a major rating bureau which compiles information on industry rates by state and by line. The data compiled by these organizations do have shortcomings. They rely on insurance companies to report information to them and do not generally receive total industry compliance. No method has yet been

devised to accurately determine profitability on a state-by-state basis, although reasonable approximations are possible. Perhaps the biggest shortcoming is the failure of the NAIC to require reporting by specialized lines of insurance. These lines are generally combined in the category "other liability". Most states, including Minnesota, require that insurance companies use the NAIC reporting format to file their annual statements. Thus, the department often has to conduct costly and time consuming industry surveys to determine which companies are issuing specialized lines of insurance.

The recently reinstated rate filing requirements for commercial lines of insurance will strengthen the department's knowledge base in this area. In addition, we recommend that:

- The department should work with insurance industry organizations such as the ISO to improve its ability to monitor competition of specialized lines. If the department cannot obtain accurate and complete data through cooperative efforts, it should seek legislation to require that insurance companies provide information on rates, premium volume, claims and expenses for specialized lines of insurance.

E. THE CURRENT STATUS OF COMPETITION

In this section, we review four indicators of competition to ascertain the level of competition which currently exists in the insurance industry in Minnesota. These indicators are 1) the number of companies issuing insurance, 2) market concentration, 3) price variations among companies, and 4) long-run profitability.

1. NUMBER OF COMPANIES ISSUING INSURANCE

One measure of the competitiveness of a market is the number of firms actively engaged in providing products or services in that market. If one company charges excessive rates or provides inferior products or services, consumers are free to take their business to a competitor. Thus, a large number of firms ensures a healthy competitive climate and encourages companies to provide quality service at affordable rates. In Minnesota, there are over one thousand companies licensed to write insurance. This indicates a considerable amount of choice available to consumers.

Viewing competition in the aggregate, however, may mask non-competitive markets in some lines of insurance. Therefore, we examined the number of companies which received premiums for writing insurance in Minnesota for selective lines of insurance. These data are summarized from reports prepared by the NAIC from annual statements filed by insurance companies with state insurance departments. Reports were available for the years 1982 through 1984. This information is presented in Table 2.1.

TABLE 2.1

NUMBER OF COMPANIES ISSUING INSURANCE IN MINNESOTA FOR SELECTED LINES

<u>Line of Insurance</u>	<u>Number of Companies Issuing Insurance</u>			<u>Number of Companies Writing Premiums of at Least \$1 Million</u>		
	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
Life	401	417	426	115	127	142
Private Passenger Auto Liability	231	234	232	63	65	68
Homeowners Multi-Peril	205	210	215	45	46	50
Farmowners Multi-Peril	46	48	51	9	10	9
Commercial Multi-Peril	255	265	266	40	41	48
Commercial Auto Liability	279	277	282	27	26	27
Medical Malpractice	61	61	69	2	3	5
Other Liability	346	368	362	39	35	39
Workers Compensation	237	246	253	78	66	71

Source: Data provided by the National Association of Insurance Commissioners.

Table 2.1 presents both the number of companies earning premiums (lefthand columns) and the number earning annual premiums in excess of \$1 million (righthand columns). The latter figures are provided as an estimate of those companies seriously marketing their product. We recognize that \$1 million is an arbitrary figure and its significance depends on the total premium for a given line of insurance. Nevertheless, we feel it provides a reasonable estimate of the actual number of choices available to most consumers.

Table 2.1 indicates that for most lines of insurance, consumers had many companies to choose from in purchasing insurance. For example, in 1984, there were over 200 companies issuing insurance in seven of the ten lines of insurance included in the analysis. In only two lines (farmowners and medical malpractice insurance), were there fewer than ten companies with premiums over \$1 million. These two lines, however, deal with more specialized kinds of insurance, suggesting that fewer choices are available to consumers who wish to purchase specialized lines. Unfortunately, as we noted earlier, the NAIC data do not permit more detailed breakdowns of the other lines of insurance, such as "other liability". These broad categories may indeed mask non-competitive markets for specialized lines of insurance or for customers with specialized needs.

Apart from these qualifications, the data indicate that most consumers have a large number of companies to choose among. This suggests that for

most lines of insurance, the insurance market in Minnesota can be characterized as competitive.

2. MARKET SHARE

The mere presence of several companies providing insurance in a given line does not preclude the existence of a non-competitive market. A few companies may, for example, issue most of the insurance in a given line. The other companies may not have the resources to provide the insurance to many customers or they may choose to concentrate their business in other lines of insurance or in other states. Therefore, using the same NAIC data base, we examined the market share of the largest companies in different lines of insurance to detect patterns of market dominance. Domination of the market by a few companies may permit them to provide inferior products or services, charge excessive prices and earn excessive profits.

Table 2.2 presents market share data for the years 1982 through 1984. The lefthand set of columns present the percentage of the total premium earned by the top five companies which issued each line of insurance. The righthand set of columns present the percentage of total premium earned by the top ten companies.

TABLE 2.2

MINNESOTA MARKET CONCENTRATION FOR SELECTED LINES OF INSURANCE

<u>Line of Insurance</u>	<u>Market Share of Top Five Companies</u>			<u>Market Share of Top Ten Companies</u>		
	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
Life	27%	26%	24%	41%	40%	36%
Private Passenger Auto Liability	52	51	52	61	61	61
Homeowners Multi-Peril	41	44	46	53	55	57
Farmowners Multi-Peril	47	43	45	74	72	68
Commercial Multi-Peril	29	31	31	40	41	42
Commercial Auto Liability	23	27	24	36	38	36
Medical Malpractice	90	88	94	95	94	97
Other Liability	21	18	20	33	31	32
Workers Compensation	22	23	23	35	36	37

Source: Data provided by the National Association of Insurance Commissioners.

There is no definitive standard to determine when a market is non-competitive. To a large extent, market domination is determined by the ability of one or a few companies, with significant market power, to compel other companies to follow their pricing policies. Our data do not allow us to analyze market power or market domination. Nevertheless, we believe that a level of market concentration for the top five companies above 90 percent suggests that the market may be non-competitive and that it bears watching.

On the whole, the data presented in Table 2.2 indicate that the major lines of insurance in Minnesota are not dominated by a few large firms. For example, the top five companies accounted for less than half the total premium in seven of the ten lines included in the analysis. Only for medical malpractice insurance does the market share of the top ten companies exceed 90 percent. In fact, the market concentration for medical malpractice is even more concentrated than Table 2.2 reveals. In 1984, two companies accounted for 85 percent of the total premium. Evidence of a non-competitive market for medical malpractice insurance receives corroboration from the fact that it is a line of insurance with serious availability and affordability problems, a topic we explore in Chapter 5.

On the whole, with the exception of medical malpractice insurance and the qualification that the broad categories of insurance used by the NAIC may hide non-competitive markets for more specialized lines of insurance, the data presented in Table 2.2 suggest that the Minnesota insurance industry is competitive.

3. PRICE VARIATION

Another measure of the competitiveness of a market is the degree to which there is price variation among similar products. A situation in which all companies charge the same price indicates the possibility of price-fixing or collusion. This is particularly germane in the insurance industry because many companies rely on the services of rating bureaus to provide them with actuarial data and, in many instances, suggested rates. In Minnesota, rating bureaus are required to file their rate schedules and provide supporting data. Insurance companies are permitted to adopt rating bureau rates.

In the absence of price collusion, we would expect some deviation from rating bureau rates. Deviation may be based upon underwriting policy. Some companies might be very restrictive on whom they insure. By being restrictive, they reduce their risk of future loss and can, therefore, charge lower rates. Companies which agree to insure more risky customers would be expected to charge higher rates. In addition to underwriting strategy, companies may be able to charge lower rates by being more efficient at controlling expenses. Some companies may decide to earn lower profits or even lose money for a while in order to gain market share. Others may, through advertising, emphasize their superior service or dependability and thus be able to charge higher prices for equivalent services.

One measure of competition in the insurance industry, then, is the presence of price variation for equivalent policies. Unfortunately, price comparisons are difficult to make because of the lack of standardization of products. Our analysis of price variation, therefore, is limited to auto and homeowners insurance where the department provided us with a price comparison undertaken by the Insurance Services Office (ISO), a major rating bureau. Tables 2.3 through 2.6 present this information.

We caution the reader that Tables 2.3 through 2.6 have not been prepared as a shopping guide and should not be used as one. To begin with, the rates have changed since these data were compiled in March and April, 1985. The rates are for specific types of coverage. Price comparisons may differ for other coverages. Since it is unlikely that the reader precisely matches the examples cited here in terms of coverage requirements and characteristics, the reader is likely to find quotes different from those cited here. Finally, these data do not report on quality of service, experience in settling claims or company policy towards increasing rates if customers have accidents or traffic violations. Many customers would consider these factors to be more important than rates. Nevertheless, these price comparisons do suggest that it pays to shop around in purchasing insurance.

Table 2.3 presents price comparisons for auto insurance for selected territories in Minnesota. The rates are for a single car family with a safe driving record and no children under age 25. Table 2.4 presents a similar comparison for a two car family. The coverages and particulars relating to each policy are explained in footnote (a) corresponding to each table. The 16 companies were selected on the basis of statewide and national market share and accounted for 64 per cent of the premium volume in Minnesota in 1984.

The comparison reveals that there are price differences for auto insurance within rating territories. For example, Table 2.3 shows that for Duluth (the lefthand column), prices for the same amount of coverage range from a low annual premium of \$329 to a high of \$560, a difference of \$231. Similar price differentials exist for the other rating territories and for the example used in Table 2.4. Some of this variation is undoubtedly due to underwriting differences. Companies with higher premiums are most likely willing to accept greater risks. Indeed, some insurance corporations offer insurance through two or three companies at different rates. Presumably, each company specializes in different levels of risk. Nevertheless, there is sufficient price variation to suggest that companies are not blindly adhering to rating bureau rates and that price competition plays an important role in the Minnesota auto insurance market.

Similar price comparisons for homeowners and home renters insurance are presented in Tables 2.5 and 2.6, respectively. Again, the particular features of each policy are explained in footnote (a) of each table. The data reveal significant price differences for both homeowners and home renters insurance. For example, rates for insuring a \$75,000 home in Minneapolis or St. Paul (second column from the left in Table 2.5) range from a low of \$266 to a high of \$462, a difference of \$196. Similar price variations exist in the other regions and for the home renters example presented in Table 2.6.

TABLE 2.3
 AUTO INSURANCE RATE COMPARISON
 Example 1^a

Company	Duluth	Iron Range	Mankato	Minneapolis ^b Area	Moorhead	Rochester
Aetna Group						
Aetna Casualty and Surety	\$438	\$340	\$314	\$386 ^d	\$314	\$314
Auto Insurance of Hartford	546	424	392	484 ^d	392	392
Allstate	436	406 ^d	380	380 ^d	358	318
American Family	438	438 ^d	348	484 ^d	362	364
American Financial Group						
American Alliance	446	438	330	438	372	332
American National Fire	560	568	418	568	468	418
Auto-Owners Group						
Auto Owners	476	470	384	470	384	384
Owners	406	402	330	402	330	330
CIGNA Group ^c						
Bankers Standard	376	352	290	368	290	290
Cigna	422	398	326	412	326	326
INA	518	486	396	504	396	396
Illinois Farmers	476	422	380	454 ^d	360	350
Milbank	504	482	410	514	416	396
Mutual Service	480	416	350	436 ^d	324	346
State Farm	442	418	368	366 ^d	324	302
Western National	329	322	269	331	269	269

Source: Data prepared for the Minnesota Department of Commerce by the Insurance Services Office, Inc.

^aRates based on a single car, 1982 model, original cost \$9,000, used for pleasure, annual mileage above 7,500.

No drivers under 25, principal driver 30 years old with safe driving record. Coverage is for 25/50/10 liability, 25/50 uninsured motorist, full personal injury protection, \$100 deductible comprehensive, \$200 deductible collision. Annual rates as of April 1985, exclusive of new membership fees and reductions for continuous accident free coverage.

^bIncludes Minneapolis and surrounding suburbs.

^c\$60,000 liability. No split liability.

^dIncludes significant premium additions (\$312-\$464) for certain portions of rating territory.

TABLE 2.4

AUTO INSURANCE RATE COMPARISON

Example 2^a

Company	Duluth	Iron Range	Mankato	Minneapolis ^b		Rochester
				Moorhead	Area	
Aetna Group						
Aetna Casualty and Surety	\$702	\$520	\$486	\$602 ^d	\$486	\$486
Auto Insurance of Hartford	878	648	610	752 ^d	610	610
Allstate	766	710 ^d	662	668 ^d	618	554
American Family	786	786 ^d	616	886 ^d	648	658
American Financial Group						
American Alliance	632	640	484	640	528	480
American National Fire	790	828	606	828	660	602
Auto-Owners Group						
Auto-Owners Owners	760	776	618	776	618	618
	648	672	526	672	526	526
CIGNA Group ^c						
Bankers Standard	642	604	502	638	502	502
Cigna	720	674	560	718	560	560
INA	880	824	688	880	688	688
Illinois Farmers	848	740	672	816 ^d	632	626
Milbank	726	688	576	748	572	574
Mutual Service	836	742	626	772 ^d	574	618
State Farm	802	740	656	676 ^d	584	546
Western National	595	591	493	617	493	493

Source: Data prepared for the Minnesota Department of Commerce by the Insurance Services Office, Inc.

^aRates are for two cars, a 1980 car originally costing \$6,000 driven less than 15 miles each way to work, annual mileage above 7,500, and a pleasure car, original cost \$9,000, annual mileage above 7,500. No drivers under 25, principal driver 60 years old with safe driving record. Coverage is 100/300/25 split liability, full personal injury protection, 25/50 uninsured motorist, \$100 deductible comprehensive and \$200 deductible collision. Annual rates as of April 1985, exclusive of new membership fees and reductions for continuous accident free coverage.

^bIncludes Minneapolis and surrounding suburbs.

^c\$300,000 liability. No split liability.

^dIncludes significant premium additions (\$542-\$834) for certain portions of rating territory.

TABLE 2.5

COMPARISON OF RATES FOR HOMEOWNERS INSURANCE^a

<u>Company</u>	<u>Duluth</u>	<u>Mpls./ St. Paul</u>	<u>Anoka, Dakota, Washington Counties</u>	<u>Most Outstate Counties</u>
Allstate	\$278	\$328	\$285 ^b	\$285 ^c
American Family	324	324	278 ^b	273
American National Fire	302	354	287	304
Auto Owners Group				
Auto Owners	297	347	297	297
Owners	266	328	266	266
Farmers Group				
Farmers Insurance Exchange	386	473	411	399 ^c
Illinois Farmers	288	352	307	298 ^c
Insurance Company of North America	319	352	319	319
Milbank Preferred	276	323	285	276
St. Paul Group				
St. Paul Fire & Marine	462	530	459	459
St. Paul Guardian	335	369	306 ^b	310 ^c
St. Paul Mercury	337	387	335	335
State Farm	304	360	305	296 ^c

Source: Data prepared for the Minnesota Department of Commerce by the Insurance Services Office, Inc.

^aComparison is for \$75,000 frame construction home, policy form HO-3, \$100 deductible, \$100,000 personal liability and \$1,000 medical payments coverage. Rates outside Duluth and Minneapolis/St. Paul for communities with a fire protection classification of 6. Policies may vary slightly as to coverage exclusions.

^bAverage rate. Rates vary by community.

^cAverage rate. Rates generally higher for counties closer to Twin Cities metro area.

TABLE 2.6

COMPARISON OF RATES FOR RENTERS INSURANCE^a

<u>Company</u>	<u>Duluth</u>	<u>Mpls/St Paul</u>	<u>Anoka, Dakota Washington Co.</u>
Allstate	\$ 90	\$ 97	\$ 90
American Family	87	94	87
American National Life	144	144	144
Auto-Owners	89	89	89
Farmers Group:			
Farmers Ins. Exch.	129	143	129
Illinois Farmers	95	107	95
Insurance Company of North America	84 ^b	102 ^b	84 ^b
Milbank Standard	70	94	81
St. Paul Group:			
St. Paul Fire & Marine	118	126	118
St. Paul Guardian	106	114	105
St. Paul Mercury	114	118	114
State Farm	87	99	91

Source: Data prepared for the Minnesota Department of Commerce by the Insurance Services Office, Inc.

^aComparison is for \$15,000 coverage, masonry construction dwelling with more than four family units, policy form HO-4, \$100 deductible, \$100,000 liability and \$1,000 medical payments. Rates outside of Duluth and Minneapolis/St. Paul are for communities with a fire protection classification of 6. Policies may vary slightly as to coverage exclusions.

^bAverage rate. Rates vary according to number of units per dwelling.

Because these price comparisons are limited to auto and homeowners insurance, we cannot conclude that insurance prices for all lines of insurance show a competitive pattern. It is possible that in those lines of insurance identified earlier in this section as less competitive, there is also

less price variation. We can conclude, however, that there is no evidence of non-competitive pricing in the auto or homeowners insurance market.

4. PROFITABILITY

In theory, rates cannot be excessive in a competitive market because if one company charges too high a rate, customers will take their business to a competitor. If the market is not competitive, however, companies will be able to charge unreasonable rates to customers and earn excessive profits. The existence of excess profits is one indicator of a non-competitive market.

Profitability, in the insurance industry, is difficult to measure on a line by line basis. Expenses for highly competitive personal lines of insurance such as auto and homeowners may be proportionately greater, because of the need to advertise, than expenses for specialized lines of insurance with less competition. Investment income, on the other hand, may be greater for lines of insurance, such as medical malpractice and other liability, which have long periods over which claims are paid. Since claims are not paid for some time, the premiums earn more investment income.

We also emphasize that profitability for one year does not tell us anything about the adequacy or excessiveness of that year's rates. This will only be known in the future when all of the claims resulting from insurance written in that year are paid. The nature of insurance rating is an attempt to base premiums on the best estimate of future losses. To the extent that such estimates prove to be wrong, the company may earn inadequate or excessive profits in the future.

There is a natural tendency for insurance companies to overestimate future claims in order to ensure future profits. This is balanced, however, by the need to charge competitive rates to attract customers. If competition does not exist, there are no incentives for insurance companies to hold down their premiums. Thus, rates would usually be higher than necessary and, over the long run, profits would be excessive. The existence of excessive profits over the long run, therefore, is both an indicator of and a consequence of a non-competitive market. A competitive market, on the other hand, would indicate some years of high profitability and some years of low profitability or even losses. This is normally expected for most companies as a consequence of the business cycle. It is especially true in the insurance industry and has come to be known as the "underwriting cycle", a topic we discuss in Chapter 5.

In Chapters 3 and 5, we present information on profitability for the United States insurance industry as a whole and data on trends in claims paid by insurance companies in Minnesota and nationwide. These data do not indicate that insurance companies have been earning excessive profits in Minnesota. Figure 3.2 in Chapter 3 indicates a cyclical pattern of insurance industry profits since 1970, with recent years characterized by low after-tax profits. Figure 5.2 in Chapter 5 indicates that loss ratios (claims incurred divided by premiums earned) for Minnesota have, in recent

years, exceeded national loss ratios. This suggests that the Minnesota insurance industry has been less profitable than the nation as a whole. Although it is possible, if not likely, that some lines of insurance have generated excess profits, the evidence we have gathered does not indicate a pattern of excess profitability. Based on this finding and the other findings in this section, we conclude that:

- for most lines of insurance, there is a competitive market in Minnesota.

F. DISCRIMINATORY RATES

Although insurance statutes prohibit unfairly discriminatory rates, they allow insurance companies to categorize customers in terms of differences in expected losses, expenses or risks. Different premiums for individuals in different risk or expense categories are permitted as long as rates reflect the differences with reasonable accuracy.²² Risk may be classified by any reasonable method, but due consideration must be given to past and prospective loss and expense experience. Classification may not be on the basis of race, color, creed or national origin.²³

Risk classification has been criticized in the past because it penalizes customers on the basis of characteristics of the group to which they belong. For example, auto insurers typically charge higher premiums to drivers in urban areas because, on the average, they are involved in more accidents. This, in effect, penalizes the safe driver who happens to live in an area with an above average accident rate. Critics also charge that insurance company rating procedures are based on arbitrary categorizations which are not very accurate in terms of predicting future losses. Municipal boundaries are often used to establish rating territories. Variations within municipal boundaries are often not considered. Furthermore, a study of auto risk classification conducted by the Stanford Research Institute found that rating classifications were only successful in predicting 22 percent of subsequent claims.²⁴

Proponents of class rating point out that some predictability is better than none at all. The alternative is to have everybody pay the same rate, in which case, low risk customers would still be penalized by having to pay the average rate. To the extent that insurance companies are able to identify and charge higher premiums to riskier customers, they can reduce premiums to their remaining customers. Finally, it is argued that if

²²Minn. Stat. §70A.04, subd. 4.

²³Minn. Stat. §70A.05, subd. 2.

²⁴Stanford Research Institute, *The Role of Risk Classification in Property and Casualty Insurance: A Study of the Risk Assessment Process*, May 1976.

insurance companies were not permitted to charge different rates on the basis of risk classification, they would simply refuse to insure high risk customers, thereby creating an availability problem.

Ultimately, the question of risk classification is one of public policy. Although we recognize that there are some injustices in the current system, we believe that classification does benefit the average consumer and we see no compelling reason to abolish it. The current rating system should be closely monitored, however, to ensure that it is based upon objective data and accurate projections.

We have not conducted an extensive study of the rating practices of insurance companies in Minnesota, nor have we analyzed the validity of existing rating criteria. Our discussions with department staff indicate that they are concerned about rating practices and do review the rates filed by the rating bureaus. One property/casualty analyst commented that, "You always look for discrimination in classifications. ISO (the major rating bureau in Minnesota) presents a well documented product. We have, in the past, asked them to make changes."

In the case of life and health insurance, premiums are usually based upon the age and sex of the insured. Life/health analysts are more concerned with discrimination in insurance benefits than in premiums. For example, the department rejected a disability insurance provision which excluded coverage for consumers who receive treatment at a Veterans Administration hospital. The department has also rejected forms that exclude non-Minnesota residents from receiving legally mandated benefits.

Other than reviewing the data supporting insurance company projections, there is little the department can do to protect consumers from unfair discrimination. With the exception of race, the statute allows insurance companies to classify risks "by any reasonable method" and determine rates accordingly. Thus, the rate classifications employed by insurance companies are legal. We also believe that there is no logical reason for insurance companies to employ actuarially unsound rating systems. Rating is one of the cornerstones of the insurance industry. Those companies which do the job well have an edge on the competition. ISO, the largest rating bureau, is also concerned with providing a quality product to insurance companies, or it will lose their business.

Although we appreciate the egalitarian concerns that are raised by opponents of rate classification, we conclude that rating systems help to lower rates for the majority of citizens. We find current practices to be consistent with statutory requirements. Finally, we have not uncovered any evidence that consumers are overwhelmingly concerned about discriminatory rates. For these reasons, we conclude that:

- The current system of classifying customers according to risk is not unfairly discriminatory and should be maintained.

G. CONCLUSIONS

Our analysis indicates that for most lines of insurance, competition is serving as an effective regulator of rates in Minnesota. For personal lines of insurance such as life, auto and homeowners, there are no dominant companies in a position to control the market and the consumer has ample opportunity to select a suitable company. We did not find evidence of excess profitability in the insurance industry as a whole. In light of this finding, we believe that the department is correctly placing primary emphasis on forms review and that it is adequately performing that task.

Although we do not have market data on sub-lines of insurance, our findings on availability discussed in Chapter 5 indicate that some specialized lines of insurance may be characterized by non-competitive market conditions. Our analysis suggests that for these lines, traditional rate review activities may not be sufficient to ensure reasonable rates and that an alternative strategy is needed. We discuss this strategy in Chapter 5.

Insurance Company Solvency

Chapter 3

Protecting consumers from the consequences of insurer insolvencies has historically been an important objective of insurance regulation. Recently, the growing number of insolvencies in the insurance industry has heightened concern about the adequacy of regulatory protection.

An insurance company is insolvent if it does not have enough assets, if made immediately available, to pay all of its liabilities. When an insurance company becomes insolvent, it can no longer fulfill its promise to pay policyholders for insured losses. Government regulation seeks to protect insurance consumers from insolvencies because consumers are not able to adequately protect themselves. To protect themselves from insolvencies, insurance consumers would need to evaluate the risk of insolvency prior to purchasing insurance. However, consumers lack the information and expertise to evaluate the financial condition of an insurance company.

The state uses two strategies to protect Minnesota consumers from insolvencies. First, it maintains guarantee funds to cover insured losses that insolvent companies are not able to pay. Second, the Minnesota Department of Commerce regulates insurers' solvency. It licenses insurance companies, monitors their financial condition, and enforces financial requirements such as investment restrictions and capital and surplus requirements. It also restricts the operations of financially troubled companies and initiates rehabilitation or liquidation proceedings against seriously impaired companies.

In this chapter, we focus on the following issues:

- How serious is the threat of insolvencies in the insurance industry?
- How well do the state's guarantee funds protect Minnesota consumers from insolvencies?
- How well does the Minnesota Department of Commerce regulate the financial condition of insurance companies operating in Minnesota?

A. INSOLVENCY TRENDS

Nationally, the number of insolvencies has rapidly increased during the 1980's. Figure 3.1 shows that the annual number of insolvencies exceeded 10 only once between 1971 and 1981, but reached 25 in 1984 and 23 in 1985.

The growing number of insolvencies is largely due to declining profits in the property/casualty insurance industry. As shown in Figure 3.2, profits in the property/casualty insurance industry tend to be cyclical. Return on net-worth reached lows in 1975 and 1984/1985, corresponding to the years with unusually large numbers of property/casualty insolvencies. Return on net-worth reached the high point in the cycle in the late 1970's, when there were few property/casualty insolvencies.

Currently, the property/casualty industry is at the bottom of an unusually deep cycle. According to Insurance Services Office data, return on net worth declined from 22.7 percent in 1977 to a low of 2.3 percent in 1984. Similarly, pre-tax operating income declined to a loss of \$3.8 billion in 1984, the largest operating loss in the industry's history.¹ This \$3.8 billion loss is about 3.3 percent of earned premiums and about six percent of net worth. Operating losses for the first nine months of 1985 were \$3.5 billion and return on net-worth was less than five percent. While insurance prices are rising in 1985, their effect will not be fully felt until 1986.

In contrast, the nation's life/health insurance industry became more profitable during 1984. Operating profits after dividends and federal taxes remained near \$5 billion from 1979 through 1983 and rose to \$6.9 billion in 1984.²

B. GUARANTEE FUNDS

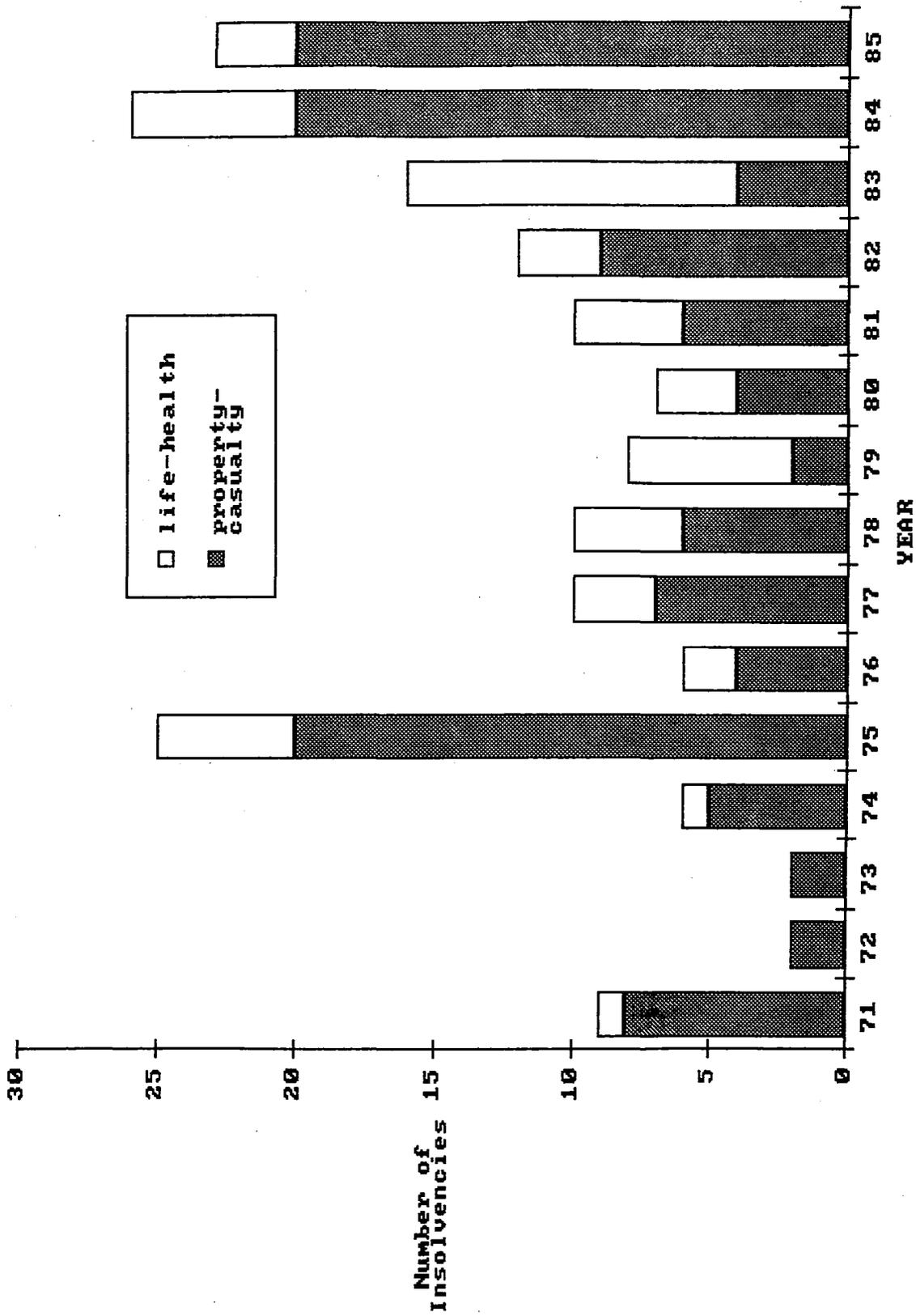
In this section, we describe how Minnesota's guarantee funds operate and examine the capacity of these funds to protect Minnesota consumers from insolvencies. We also examine guarantee fund assessments because they are the best available measure of the impact of insolvencies in Minnesota.

The Minnesota Legislature established guarantee funds for property and casualty insurance in 1973 and for life and health insurance in 1977. These funds protect Minnesota individuals and businesses for claims up to \$300,000 (except workers compensation claims, which have no limit). The guarantee funds are also liable for premiums lost because policies were

¹A. M. Best Company, *Best's Insurance Management Reports: Property/Casualty*, Release No. 9, April 8, 1985, Oldwick, NJ.

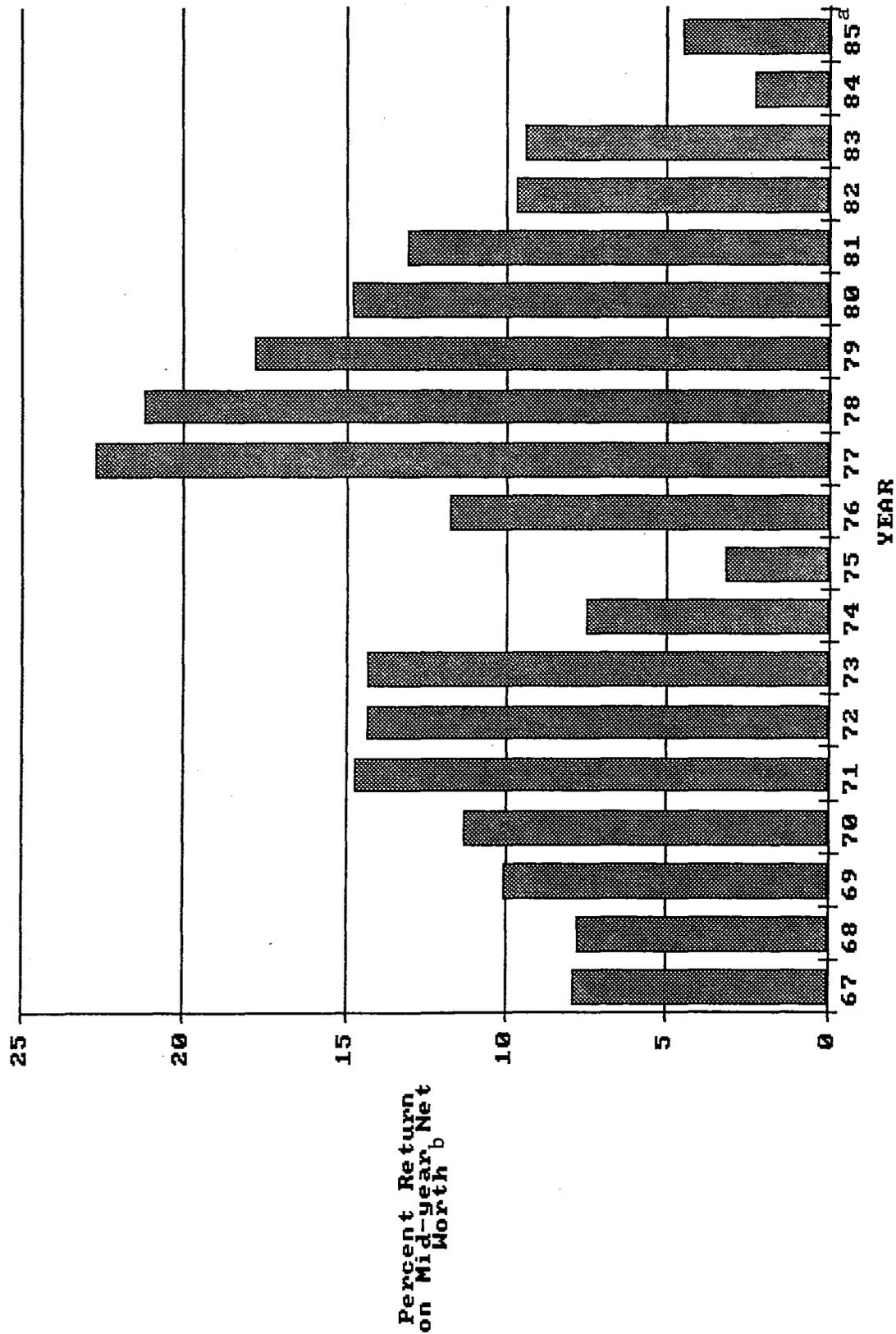
²A. M. Best Company, *Best's Insurance Management Reports: Life/Health*, Release No. 23, October 7, 1985, Oldwick, NJ.

FIGURE 3.1 - NATIONAL INSOLVENCY TRENDS



Source: Property/casualty data--National Committee on Insurance Guaranty Funds; Life/health data--National Organization of Life/Health Guaranty Associations and National Association of Insurance Commissioners.

**FIGURE 3.2
RATE OF RETURN: PROPERTY/CASUALTY
INDUSTRY**



Source: Insurance Services Office.

^aThrough September 1985.

^bUnrealized capital gains are based on a 20 year average.

cancelled after the liquidation. All claims against the guarantee funds are subject to a \$100 deduction.

The property/casualty guarantee fund covers Minnesota residents for claims against all insolvent companies licensed in Minnesota. It does not generally cover claims made by residents of other states against insolvent companies based in Minnesota. In contrast, the life/health guarantee fund covers claims made by all U.S. residents against insolvent life/health companies based in Minnesota. It also covers claims made by Minnesota residents against licensed companies based in other states if the home state does not have a guarantee fund.

The board of a guarantee fund finances claim payments by assessing other insurance companies after an insolvency. Guarantee fund officials determine the total assessment by estimating the amount of claim payments that will be made. The boards assess only those companies which wrote the same types of insurance written by the insolvent insurance company. The property/casualty guarantee fund law establishes separate accounts for five types of insurance: automobile, workers compensation, fidelity and surety, township mutuals, and other property/casualty. The life/health guarantee fund law establishes three accounts: life, annuities, and health.

For example, if an automobile insurance company becomes insolvent, the guarantee fund would assess other insurance companies in proportion to their automobile premium volume during the year prior to the insolvency. State law limits the total annual liability for each insurance company to two percent of its annual premium volume for the affected type of insurance. If the fund can not pay all claims because of this limit, it can make assessments in succeeding years.

Overall, insolvencies have not been a great burden to Minnesota consumers since the guarantee funds were established in the mid 1970's. To date, consumers insured by insolvent companies have lost only the \$100 deductible or any insured loss over the \$300,000 maximum because of insolvencies. Guarantee fund assessment data in Tables 3.1 and 3.2 show that assessments through 1984 never came close to the capacity of any of the guarantee fund accounts. The closest any account came to its maximum was in 1983 when a \$4 million assessment was about 20 percent of the annual assessment maximum for the automobile account. For each of the eight accounts, the average annual assessment during this period was less than five percent of the limit .

In 1985, however, assessments increased greatly. Property/casualty assessments never exceeded \$4 million in any year until 1985, when the guarantee fund board made assessments totaling \$21.4 million for the Ideal Mutual, Excalibur, Commercial Standard, and Iowa National Mutual insolvencies. Similarly, life/health assessments never exceeded \$1.2 million in any single year until 1985, when the guarantee fund board made a \$6 million assessment for the Baldwin United insolvency.

As a result, workers compensation assessments for the Ideal Mutual and Excalibur insolvencies reached the two percent limit in August 1985. In

TABLE 3.1

PROPERTY-CASUALTY GUARANTEE FUND ASSESSMENTS
(all figures in 000's)

	<u>Automobile</u>	<u>Workers Compensation</u>	<u>Fidelity Insurity</u>	<u>Township Mutuals</u>	<u>Other Property-Casualty</u>	<u>Total</u>
Premium Volume-1984	\$909,403	\$346,701	\$47,996	\$30,227	\$1,018,571	\$2,352,898
Assessment Limit-1985	18,188	6,934	960	605	20,371	47,058
Assessments						
1973	90	--	--	--	235	325
1974	285	100	--	--	215	600
1975	550	--	--	--	50	600
1976	1,105	--	--	--	460	1,565
1977	--	--	--	--	--	--
1978	1,550	--	--	--	950	2,500
1979	--	--	--	--	--	--
1980	250	25	--	--	750	1,025
1981	26	60	17	--	2,904	3,007
1982	--	315	--	--	--	315
1983	4,000	175	--	--	--	4,175
1984	1,000	1,400	--	--	--	2,400
1985 (through October)	<u>8,750</u>	<u>6,934</u>	<u>100</u>	<u>--</u>	<u>5,150</u>	<u>20,934</u>
Total Assessments	\$17,606	\$9,009	\$117	\$ 0	\$10,714	\$37,446
Refunds	<u>4,074</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>1,946</u>	<u>6,020</u>
Net Liability	\$13,532	\$9,009	\$117	\$ 0	\$8,768	\$31,426

Sources: Minnesota Insurance Guarantee Association and Workers Compensation Rates Bureau (this bureau made workers compensation assessments prior to 1984).

TABLE 3.2

LIFE-HEALTH GUARANTEE FUND ASSESSMENTS
(all figures in 000's)

	<u>Life</u>	<u>Annuity</u>	<u>Health</u>	<u>Total</u>
Premium Volume (1983)	\$766,964	\$400,515	\$717,803	\$1,885,282
Assessment Limit (1984)	15,339	8,010	14,356	37,705
Assessments				
1977	--	--	--	--
1978	100	--	400	500
1979	70	--	280	350
1980	--	--	--	--
1981	--	--	--	--
1982	--	--	--	--
1983	--	--	--	--
1984	--	--	1,200	1,200
1985 (through October)	--	6,000	--	6,000
Total Assessments	\$ 170	\$ 6,000	\$ 1,880	\$ 8,050
Refunds	216	--	864	1,080
Net Assessments	\$ (46)	\$ 6,000	\$ 1,016	\$ 6,970

Source: Minnesota Life and Health Insurance Guarantee Association.

October 1985, the Iowa National Mutual Insurance Company became insolvent. Thus, the fund could not make any more assessments in 1985 to pay workers compensation claims for this company. Instead, the fund will borrow from other accounts to pay these claims until it can make an assessment in 1986. The guarantee fund board plans to make additional assessments early in 1986 for Iowa National, Ideal Mutual, and Excalibur, including a two percent assessment against the worker's compensation account.

It is difficult to predict whether future insolvencies will exceed the capacity of the guarantee funds. This depends largely on whether there are several insolvencies for medium sized companies or a major insolvency. To date, the insolvent company with the most property/casualty insurance premiums written in Minnesota was the Iowa National Mutual Insurance Company. In 1984, 25 property/casualty companies had Minnesota premium volumes exceeding the \$19 million written by Iowa National Mutual. Three companies wrote more than \$100 million in premiums. The department did not place any of these companies on its list of 60 companies with the most serious financial problems. However, the fact that Iowa National became

insolvent even though it was not on the department's problem list illustrates the difficulty in predicting insolvencies.

There is another policy issue involving guarantee funds which we believe the Legislature should consider. Under Minnesota's statutes, if a Minnesota based life or health insurance company becomes insolvent, Minnesota's life/health guarantee fund would be liable for losses by all U.S. residents. In addition, if a life or health insurance company based in a state which does not have a guarantee fund becomes insolvent, Minnesota's guarantee fund would be liable for losses by Minnesota residents. These provisions of the guarantee fund law are based on the model law proposed by the National Association of Insurance Commissioners. If all states enacted these provisions of the model law, each state would be responsible for the claims against insolvent companies based within its own borders (domestic companies). This would make sense because each state has primary responsibility for monitoring the financial condition of domestic companies. However, as of 1985, thirteen states had not established guarantee funds for life or health insurance. Included are populous states such as California, Ohio, New Jersey, and Massachusetts as well as the nearby states of Iowa and South Dakota. In addition, four states, including Illinois and New York recently changed their life/health guarantee fund law to cover only residents of their own states. Thus, Minnesota's life/health guarantee fund could make large payments to protect consumers in other states without receiving reciprocal protection from many states. Since this would increase the cost of selling insurance in Minnesota, some of these costs would probably be passed on to Minnesota consumers. To date, this has not been a problem because no Minnesota-based life or health insurance company has become insolvent since the life/health guarantee fund was established in 1977. An argument for keeping the current law is that it simplifies the treatment of insurance policies after an insolvency occurs. If the guarantee association in each state protected its own residents, guarantee associations from many states would collect premiums, pay claims, and service policies for a single insolvency instead of a single guarantee association assuming these responsibilities. This may cause inconvenience to consumers.

We recommend:

- The Legislature should consider changing the life/health guarantee fund law to cover only Minnesota residents and residents of states which provide reciprocal protection.

C. SOLVENCY REGULATION

Even though the guarantee funds help protect Minnesota residents from insolvencies, it is also important to regulate the solvency of insurance companies. Preventing insolvencies or reducing the severity of insolvencies reduces the cost of doing business in Minnesota, thereby reducing insurance premiums. It also reduces the chances that insolvencies will exceed the capacity of the guarantee funds.

In this section, we describe the framework for regulating insurer solvency and present our analysis of the Minnesota Department of Commerce's solvency regulation.

1. REGULATORY FRAMEWORK.

The regulatory department of each state has primary responsibility for regulating the solvency of insurance companies domiciled in its own state (domestic companies). Each state has primary responsibility for conducting financial examinations of domestic companies and for developing remedial programs to salvage troubled domestic companies. Approximately 75 percent of all insurance sold in Minnesota is sold by companies domiciled in other states (foreign companies). Thus, other states serve an important role in protecting Minnesota consumers from insolvencies.

While there is no federal control over this process, the National Association of Insurance Commissioners (NAIC) helps coordinate state financial regulation. The association developed the annual financial statement forms used by all insurance companies. It also established a zone system whereby examiners from other states may participate in examinations called by a company's home state.

During the mid 1970's, the NAIC developed an early warning system (now called the Insurance Regulatory Information System) that helps identify companies that deserve extra regulatory attention. This system uses companies' annual financial statements to calculate financial indicators designed to predict the probability of insolvency. A team of examiners then reviews companies with poor indicator results to identify companies which need immediate attention. These results are distributed to all state insurance departments to help each department target regulation of all companies operating in its state.

In Minnesota, the Financial Standards section of the Minnesota Department of Commerce has primary responsibility for regulating the financial condition of insurance companies. It employs an assistant commissioner, a chief examiner, ten examiners, and it has access to two actuaries.

The Financial Standards section devotes most of its resources to field examinations of insurance companies. It focuses on domestic companies and relies heavily on other states to examine foreign companies. It conducts financial examinations of all domestic insurance companies approximately once every four years. While it can examine foreign insurance companies whenever it wants to, it is impractical to examine over 1000 companies located across the nation. During the past five years, it participated in zone examinations of 27 out of 1061 foreign insurance companies licensed in Minnesota.

The department focuses on the financial condition of foreign insurers in two ways. First, the department controls the entry of insurance companies into the Minnesota market. An insurance company, wherever domiciled, must be licensed by the department in order to sell most types of insurance in Minnesota. The department reviews the financial condition of companies

applying for a license to sell insurance in Minnesota. As of July 1985, insurance companies licensed in Minnesota include 98 companies domiciled in Minnesota and 1061 companies domiciled in other states.

Minnesota does not license surplus line carriers. These are companies that sell certain specialized types of insurance not provided by the regular market. For example, if a baseball team wanted to insure a pitcher's arm, it would probably obtain such insurance from a surplus lines carrier. In this case, the baseball team rather than the state would be responsible for evaluating the solvency of the carrier.

A second way that the department attempts to protect Minnesotans from insolvencies is to monitor the financial condition of all companies licensed in the state and to restrict the operations of financially troubled companies. Each year the department performs desk audits of both domestic and foreign companies licensed in Minnesota to identify financially troubled companies. Since the department's practical authority is limited to the Minnesota operations of foreign insurance companies, its options include increasing the financial reporting requirements, revoking the company's license or imposing restrictions on its Minnesota business. Possible restrictions include limits on the amount or type of insurance written in Minnesota and requiring the company to increase its capital or surplus.

2. EFFECTIVENESS OF SOLVENCY REGULATION

To assess how effectively the department regulates the solvency of insurance companies, we compared insolvency rates in Minnesota with rates in the rest of the nation. We also reviewed the procedures used by the department to license insurance companies, to schedule field examinations, to monitor the financial condition of all insurance companies, and to regulate financially troubled insurance companies.

a. *Insolvency Rates*

We compare Minnesota's insolvency rates to the rates in other states in two ways. First, since each insurance department has primary responsibility for regulating insurance companies domiciled in its own state, we compared insolvency rates by state of domicile. Second, because each state has some responsibility for regulating foreign companies operating in its jurisdiction, we also compare the number of insolvencies affecting each state and guarantee fund assessments per capita in each state. These comparisons can be indicators of problems but are not by themselves conclusive evidence of a department's effectiveness because factors beyond the control of state regulation can cause insolvencies.

Based on insolvencies since 1971, Minnesota's insolvency rate for insurance companies domiciled in Minnesota compares favorably with that of the nation. Based on insolvencies requiring a guarantee fund assessment, Minnesota's insolvency rate is about one percent over a 15 year period whereas the national rate is at least 3 percent. Among 96 companies

domiciled in Minnesota, one (Excalibur Insurance Company) has been placed in liquidation since 1971, one has been successfully rehabilitated, and one (National Family Insurance Company) is currently in rehabilitation. In 1985, National Family was sold to All Nation Insurance Company. The department expects All Nation to bring National Family out of rehabilitation by about 1987. The guarantee fund has not needed to make any assessment to pay claims for either company in rehabilitation.

Among the nation's 4700 insurance companies, composite data from the national guarantee fund associations and NAIC show 171 insolvencies since 1971.³ These data may underestimate the actual number of insolvencies in the nation because NAIC data include only multi-state insolvencies and not all insolvencies were reported to the life/health guarantee fund association.

Guarantee fund assessment data reflect the severity as well as the frequency of insolvencies. However, the ultimate liability for the only insolvency among Minnesota-based companies has not yet been determined.

Nevertheless, guarantee fund assessment data help indicate how insolvencies (both domestic and foreign) have affected Minnesota compared to other states. Survey data collected by the National Committee on Insurance Guaranty Funds indicates that between 1969 and 1984, Minnesota's property/casualty guarantee association assessed \$1.80 per capita, whereas the corresponding associations in other states assessed \$1.88 per capita. Unfortunately, these data do not include assessments made in 1985, a year in which Minnesota's assessments exceeded all of its previous assessments combined. Thus while insolvencies have not hurt Minnesota more than other states through 1984, it is not clear whether this is true in 1985.

b. *Financial Monitoring*

Two key elements of a financial surveillance system are early detection of financially troubled companies and effective follow-up action. Prompt detection and follow-up are important to minimize costs of insolvencies or to avoid insolvencies. While financial examinations are the best way to detect financial problems, the state by state system for conducting financial examinations has important limitations. First, financial examinations usually do not provide timely information on companies' financial condition. Examination intervals for most companies in the nation are three years or longer and Minnesota usually receives examination reports from other states more than a year after the period covered by the examination.

³National Committee on Insurance Guaranty Funds, *State Insurance Guaranty Funds and Insurance Company Insolvency Assessment Information*, Schaumburg, IL, June 1985; and National Association of Insurance Commissioners, *Status of Multi-State Insurance Company Departmental Supervisions, Conservatorships, Rehabilitations and Liquidations*, Kansas City, MO, December 2, 1985.

Second, according to department staff, the quality of examinations varies from state to state. Some states lack adequate resources to effectively examine insurance companies' financial condition.

Because of these limitations, it is important for the department to monitor the financial condition of insurance companies operating in Minnesota. The McKinsey study and recent work by a NAIC task force indicates that financial indicators developed by the NAIC (the Insurance Regulatory Information System or IRIS ratios) are a useful device to identify companies most likely to become insolvent.⁴ They will not detect concealed financial problems as well as a financial examination would, but the evidence indicates that they can help target a department's regulation efforts. As recommended by the NAIC, states need to further analyze potential problems indicated by the financial ratios to determine how serious they are.

We believe that the department has established a reasonable system for monitoring insurers' financial conditions and identifying financially troubled insurers. The system has several strengths. First, for nearly 1200 companies licensed in Minnesota, the department reviews appropriate financial information in a timely manner, including annual financial statements, IRIS financial ratios, CPA annual audits, and state examination reports. Second, the department assigns its chief examiner and two of its top examiners to review this information. Finally, our review of insolvencies affecting Minnesota since 1976 indicates that the department detected financial problems that were apparent from the above information prior to the insolvency. In three out of the six largest property/casualty insolvencies since 1977, the department identified the company for closer financial monitoring prior to the insolvency. Two of the other three insolvencies developed rapidly so that there was little opportunity to detect the problem before the company was declared insolvent. In the third case, the Illinois Insurance Commissioner filed suit against the company's officers, charging that the company fraudulently concealed its financial problems for several years.

Nevertheless, the department's financial monitoring approach has some weaknesses. If a financial problem develops quickly, annual financial statements may not provide timely information. For example, if a company suddenly begins expanding its business during the first quarter by charging rates which are clearly inadequate, annual statements would not reveal the problem until a year after the fact.

One way to obtain more timely information is to review companies' quarterly financial statements. These quarterly statements do not provide nearly as much information as the annual statement, but can be useful for quickly detecting changes in a company's operations. As of December 1985, the department required 190 companies to submit quarterly financial state-

⁴McKinsey and Company, Inc., *Strengthening the Surveillance System*, Report prepared for the National Association of Insurance Commissioners, 1974; and Proceedings of National Association of Insurance Commissioners (1984, Vol. II) pp. 255-276.

ments. The department selected these companies because they appeared to have financial problems. An additional 70 companies voluntarily submit quarterly financial statements. It makes sense for the department to target its resources on the most risky companies. But it also makes sense to closely watch companies which have moderate risk but which write large amounts of business in Minnesota. These companies are generally not closely watched by the department.

Another way in which the department could obtain more timely information is by monitoring insurance rates. If insurance rates are unusually low, the company may be jeopardizing its solvency. For example, a company experiencing cash flow problems may attempt to dramatically increase its business by offering insurance at very low rates. Monitoring prices may alert the department to possible financial problems before they are revealed in financial statements. We believe that it is impractical to determine the adequacy of all rates used by insurance companies. Instead, the department should focus on detecting rates which are much lower than the market rate. The department could then further analyze the insurance companies' financial condition to determine if action is appropriate. Towards that end, the department should coordinate its rate review activity with its financial surveillance activities.

The Iowa National Mutual Insurance Company insolvency illustrates the importance of obtaining timely financial information. Through 1983, this company consistently received A+ ratings from Best's Review and had no unusual IRIS ratios. Based on its 1984 performance, Best's rating, IRIS ratios, and the NAIC review team all indicated that its financial condition was declining but the company was not placed in the highest risk category. The department concluded that it was not a high risk company and thus did not place it on its problem company list. However, Florida's insurance department, which monitors quarterly statements for all companies it licenses, noticed that Iowa National's financial condition was rapidly deteriorating in 1985. At the time Iowa's insurance department initiated insolvency proceedings against Iowa National in September 1985, Florida was preparing to take action against Iowa National. In this case, it is unlikely that Minnesota would have affected the outcome even if it had more closely monitored this company. But, if Iowa and Florida had not been monitoring its financial condition, the company's financial condition could have kept deteriorating.

After financially troubled companies are identified, it is important to determine how serious the problem is and take appropriate action to minimize losses to consumers. In 1985, the department gave high priority to dealing with troubled companies. As before, the department monitored troubled companies by requesting that they submit quarterly financial statements, explanations of their financial performance, and future plans to address their financial problems. The department monitored more companies in 1985 largely because the number of troubled companies increased. Unlike prior years, the department held meetings with companies with more serious financial problems and frequently placed formal restrictions on companies' Minnesota insurance operations. The department issued orders or made stipulation agreements with approximately 60 companies in a timely manner. These restrictions ranged from prohibiting the company from

writing new business in Minnesota to limiting the amount of business written to what the company planned to write. Based on three meetings we attended and interviews with department staff, we believe that the department acted reasonably. Companies that were ordered not to write any new business in Minnesota included companies which the department doubted would remain solvent and financially troubled companies with very small Minnesota operations. Most restrictions involved limits on the amount of business that could be written in Minnesota. In the insolvencies we reviewed, companies often significantly increased their business volume prior to their insolvency. While increased business volume may temporarily solve cash flow problems, it often increases the risk of insolvency, particularly if a company's surplus has been declining because of financial losses. Thus, these limits may help avoid insolvencies or reduce losses if an insolvency does occur.

While we believe that these actions are beneficial, it is important to recognize that Minnesota has limited authority to deal with financially troubled companies domiciled in other states. The company's state of domicile has primary jurisdiction for developing remedial programs to correct the company's financial problems. Thus, effective financial regulation often requires the cooperation of many states, particularly the state of domicile.

c. *Licensing*

An effective licensing program can reduce insolvencies by keeping financially risky companies out of the state. Key components of an effective licensing program include 1) a review of an applicant's financial performance and management; and 2) adequate capitalization and surplus requirements. Based on interviews with department staff and a review of files, we believe that the department reviews appropriate financial and management information, including the companies' financial statements, CPA audit reports, state examination reports, and IRIS ratios. The department screens out companies that have not demonstrated adequate financial performance. For example, one company has been seeking a Minnesota license for several years. The department has not approved its application because the company is still not profitable. If a new company domiciled in another state applies for a license in Minnesota, the department would require that it operate for at least two years before considering its application.

The McKinsey study found that states with low capital and surplus requirements for investor-owned life insurance companies had much higher than average insolvency rates between 1963 and 1972.⁵ Ten year insolvency rates for life insurance companies ranged from 8 percent for states with capital and surplus requirements less than \$300,000 to 1 percent for states with capital and surplus requirements exceeding \$900,000. In current dollars, the upper range would be equivalent to about \$3,000,000. Minnesota's capital and surplus requirements are currently \$3,000,000 for

⁵McKinsey and Company, Inc., *Strengthening the Surveillance System*.

stock life insurance companies and \$2,000,000 for most property/casualty companies. The actual requirement varies depending on the type of insurance lines written. Thus, Minnesota's minimum capital and surplus requirements seem reasonable, though they should probably be adjusted occasionally because of inflation.

d. *Financial Exam Schedules*

The McKinsey study concluded that to use their resources effectively, insurance departments should schedule examinations on the basis of insolvency risk rather than the traditional triennial method⁶. The study found that a company was more likely to become insolvent if 1) it was a very small life insurance company; 2) it failed several early warning tests (now called IRIS ratios); or 3) it recently changed management. The study recommended that insurance departments should also give high examination priority to companies it believes may be financially troubled based on such factors as 1) the company writes business in high risk lines, or 2) it significantly changes its mix of business. The study also criticized state examinations for duplicating much of the work done by CPA audits.

The 1981 Minnesota Legislature removed the requirement that the department conduct comprehensive examinations of all domestic insurance companies every three years. However, this amendment did not affect fraternal beneficiary associations nor non-profit health service plans. Fourteen insurers in these two categories still must be examined at least once every three years.

We believe that the department has taken advantage of this flexibility to monitor the financial condition of insurance companies more efficiently. One improvement is that by utilizing CPA audits, the department does not usually need to conduct comprehensive examinations. Examiner staff estimate that when CPA audits are used, the examination time is nearly cut in half. The department regularly uses CPA audit reports except when its tests of a CPA audit indicate that the audit is deficient.

The department also takes advantage of this flexibility by scheduling examinations more often for financially troubled companies. Usually, the department tries to examine domestic companies once every four years. However, it shortens this interval for financially troubled companies. For example, the department examined one financially troubled company in 1985 and plans to examine it again in 1987. It also conducts special examinations targeted at specific concerns such as unusual financial results or past non-compliance with statutory standards. During the past six years, it has conducted 21 targeted examinations of domestic companies. It also conducted two targeted examinations of foreign companies, including one instance in which the department's staff felt that the company was not being properly monitored by its home state.

⁶McKinsey and Company, Inc., *Strengthening the Surveillance System*.

The department monitors management changes among domestic companies. Department staff say that they would consider targeting an examination for this reason, but Minnesota companies have not recently made any major management changes.

A shortcoming of examination scheduling is that some very secure companies have been examined on the same four year rotation that is used for average companies. The department staff and other experts agree that chances of insolvency vary significantly among insurance companies.⁷ Just as some companies are financially risky and should be examined more frequently, some companies are very secure and should be examined less frequently than the average company. In recent years, the department has occasionally extended the examination interval by a year in order to give more attention to problem companies. For example, the department delayed examinations of two companies from 1984 to 1985 for this reason. However, two other very secure companies were examined in 1984 on the regular four year rotation. By extending the examination interval for companies the department considers to be very secure, we believe it could strengthen its surveillance of companies with greater financial risk, including companies domiciled in other states.

The department cites two other benefits of financial examinations that could affect their scheduling interval. First, examinations may help the company obtain licenses in other states. One company requested that the department conduct their examination sooner than scheduled because it wanted to expand its business. Second, financial examinations can help enforce statutory financial requirements. We believe that even if the first benefit is important enough to conduct an examination, it should only be considered on a case by case basis. Furthermore, since financial requirements are primarily designed to protect the public from insolvencies, we would argue that enforcing these requirements is more important for less stable companies. If the department believes that certain companies are not complying with statutory requirements, it could also consider this on a case by case basis.

In summary, we believe that flexible scheduling has substantially improved how the department uses its resources. Further improvements could be made by further adjusting the examination interval according to the financial security of the company. Since the early 1980's, the department reduced its financial standards section staff from 19 examiners to 10 examiners and two actuaries. We believe that this has not significantly impaired the department's financial surveillance because of the above changes.

Accordingly, we recommend:

- The department should revise its examination schedule by lengthening the time interval between examinations for companies the department considers to be the most secure.

⁷McKinsey and Company, Inc., *Strengthening the Surveillance System*.

Implementing this recommendation would allow the department to devote more resources towards companies the department considers to be a greater solvency risk. To improve its ability to quickly identify companies in financial trouble, we recommend:

- The department should review insurance rates to identify companies that are charging unusually low rates.
- The department should increase the number of companies for which it reviews quarterly financial statements, including companies which have moderate solvency risk but which write a large amount of business in Minnesota.

Regulation of Insurance Trade Practices

Chapter 4

Within a regulatory framework that allows insurance rates to be set by competitive market forces, it is important that mechanisms are provided to protect consumers from unfair and deceptive trade practices, and to assist consumers in making informed choices about the products they purchase. The Department of Commerce performs this function by investigating consumer complaints, conducting market conduct studies as part of its financial investigations of insurance companies, licensing insurance agents, and disseminating information to the public. In this chapter, we review the department's activities in each of these areas.

Our examination focuses upon the following issues:

- What types of complaints do consumers file with the Department of Commerce?
- What does this complaint record tell us about problems in the insurance industry?
- Does the department investigate and resolve complaints in a timely and effective fashion?
- How well does the department target its complaint investigations and market conduct examinations to minimize unfair trade practices?
- Is the department allocating appropriate resources to individual complaint investigations, or could department resources be put to better use by concentrating on patterns of abuse and unfair trade practices?
- How well does the department provide consumers with information about insurance?
- Is the department conducting its licensing function in a timely and effective manner?

A. CONSUMER COMPLAINT INVESTIGATIONS

In this section, we examine the department's complaint investigation procedures. The purpose of this examination is both to acquire a better understanding of the problems faced by citizens in their dealings with insurance companies and agents as well as to examine the adequacy of the department's procedures for responding to complaints.

1. CHARACTERISTICS OF CONSUMER COMPLAINTS

The department was able to provide us with some summary data on the nature of complaints filed by consumers. There were 7,087 consumer complaint files opened in FY 1983, 6,555 in FY 1984, and 7,088 between July 1984 and May 1985. The department indicated that it also responded to 36,447 telephone inquiries or complaints between July 1984 and May 1985. This number includes inquiries and complaints related to real estate, securities, collection agencies and the other functions of the department, as well as insurance.

The department provided us with data on 6,744 cases closed between September 1, 1983 and January 14, 1985 showing the distribution of cases by insurance type. We were unable to secure from the department information on the length of time it took to resolve complaints or the outcomes of different types of complaints. This deficiency is the result of an inadequate data processing system, a topic we discuss in Chapter 6. Therefore, in order to perform further analysis, we drew a random sample of 150 cases from the files of the Enforcement Division of the department. These cases were filed between January 1, 1984 and May 10, 1985. All but five of the cases were closed by the time the data were collected in July 1985. Data were gathered on the nature of the complaint, the outcome of the investigation, and the amount of time it took to resolve the complaint. We also examined the many documents contained in each file, in order to obtain a complete understanding of the issues and circumstances surrounding each complaint. Such an examination provided us with a more in-depth understanding of consumer issues than could be ascertained by examining summary data alone.

In addition to the case file analysis, we interviewed 22 complaint investigators regarding their assessment of the investigation process, insurance trade practices, the nature of complaints and the major problems they faced in investigating and satisfactorily resolving consumer complaints. We also asked for their suggestions for improving insurance regulation in Minnesota.

For both data sets, the two lines of insurance receiving the most complaints are automobile and accident and health insurance. Together, they account for over 70 per cent of the cases in the department data set (Table 4.1) and 60 per cent of the cases in our sample (Table 4.2). Homeowners, fire and casualty, and life insurance account for most of the remaining cases.

TABLE 4.1

INSURANCE COMPLAINTS CLOSED BY COMMERCE DEPARTMENT IN 1984
BY TYPE OF COVERAGE^a

<u>Type of Coverage</u>	<u>Number of Complaints</u>	<u>Percent of Total</u>
Life	754	11.2%
Auto	2570	38.1
Homeowners and Commercial Casualty	949	14.1
Accident/Health	2173	32.2
Other	<u>298</u>	<u>4.4</u>
Total	6744	100.0%

Source: Minnesota Department of Commerce.

^aMay include some cases closed between September 1 and December 31, 1983 and between January 1-14, 1985. Does not include cases closed in 1984 that were opened prior to September, 1983.

TABLE 4.2

SAMPLE OF INSURANCE COMPLAINTS RECEIVED ACCORDING TO TYPE OF COVERAGE

	<u>Number of Complaints</u>	<u>Percent of Total</u>
Life	13	8.8%
Automobile	47	31.8
Homeowners	17	11.5
Accident/Health	45	30.4
Fire/Casualty	16	10.8
Other ^a	<u>10</u>	<u>6.8</u>
Total	148 ^b	100.0%

Source: Sample of 150 complaints drawn from Enforcement Division files.

^aIncludes disability (5 cases), credit life (2 cases), workers compensation (2 cases) and crop insurance (1 case).

^bTwo complaints concerned agent behavior and did not specify the type of coverage.

Both sets of data also indicate that the most frequent type of complaint involves a claim dispute, including claim processing delays, claim denials, unsatisfactory settlement offers, and disputes over the cash value of life insurance. Over one half of the complaints in the department data set (Table 4.3) and 48 per cent of the complaints in our sample (Table 4.4) were of this type. Typically, these are cases where the insurance company and the insured differ over the value of the loss or whether or not the insured was covered for the specific loss. This category also includes cases (usually accident/health) where the consumer is complaining about delays in receiving insurance benefits.

Table 4.4 indicates that claim disputes account for all but one of our sample homeowner's insurance complaints. These complaints typically center around the value of the lost items and occasionally involve disputes over policy terms and exclusions. Claim disputes are at stake in the majority of our sample of complaints relating to accident and health insurance. Several of these complaints concern delays experienced by a consumer or a doctor in receiving claim payments. The remainder involve disputes over the legitimacy of claims, such as whether or not the services provided were reasonable and proper, whether or not the treatment was related to a pre-existing condition excluded by the policy, and whether the fees charged by the physician were reasonable. Claim disputes account for over one-third of the auto insurance complaints and one-fourth of the fire and casualty complaints in our sample. These typically involve valuation of damages to property.

Complaints about cancellation or non-renewal of coverage was the second most frequent type of complaint, accounting for about one-fifth of the complaints in both data sets. This type of complaint was most prevalent in auto insurance. Auto insurance cancellation and non-renewal notices are required to notify insureds of their right to appeal the action to the Commissioner of Commerce. This requirement may encourage some individuals to file formal letters of complaint.

Complaints about agent behavior are the third most prevalent, accounting for about one-tenth of the complaints in the department data set and one-twelfth of the complaints in our sample. Complaints about agent behavior either relate to agent rudeness and unresponsiveness, or they allege actual agent misconduct. Most of the latter complaints in our sample are made by or on behalf of elderly consumers of medicare supplement health insurance packages who were sold duplicative policies. A few complaints allege agent mishandling or misappropriation of funds.

Lesser percentages of complaints involve marketing, policy service (such as the failure of insurance companies to promptly refund premiums when the consumer cancels a policy), refusal to insure and premium increases. Some complaints are more accurately categorized as requests for information or clarification regarding coverage and policy provisions. These requests for information often concern life insurance.

The results of the case file analysis are corroborated by the responses of the insurance investigators. Investigators were asked to give their assessments of the three most frequently received complaints. Table 4.5

TABLE 4.3

INSURANCE COMPLAINTS CLOSED BY COMMERCE DEPARTMENT IN 1984
BY NATURE OF COMPLAINT^a

Nature of Complaint	Type of Insurance						Total
	Life	Auto	Homeowners/ Fire/Casualty	Accident/ Health	Other		
Claim Disputes							
Number of Complaints	152	1226	520	1368	159	3425	
Percent of Category	20.1%	47.7%	54.8%	63.0%	53.4%	50.8%	
Cancellation/Non-renewal							
Number of Complaints	29	931	195	84	24	1263	
Percent of Category	3.8	36.2	20.5	3.9	8.1	18.7	
Agent Behavior							
Number of Complaints	180	152	117	221	52	722	
Percent of Category	23.9	5.9	12.3	10.2	17.4	10.7	
Marketing							
Number of Complaints	270	7	19	159	20	475	
Percent of Category	35.8	0.3	2.0	7.3	6.7	7.0	
Policy Service							
Number of Complaints	79	101	48	120	16	364	
Percent of Category	10.5	3.9	5.1	5.5	5.4	5.4	
Refusal to Insure							
Number of Complaints	23	77	17	175	5	297	
Percent of Category	3.1	3.0	1.8	8.1	1.7	4.4	
Premium Increase							
Number of Complaints	21	76	33	46	22	198	
Percent of Category	2.8	3.0	3.5	2.1	7.4	2.9	

Source: Minnesota Department of Commerce.

^aMay include some cases closed between September 1 and December 31, 1983 and between January 1-14, 1985. Does not include cases closed in 1984 that were opened prior to September 1983.

TABLE 4-4

NATURE OF INSURANCE COMPLAINTS RECEIVED IN SAMPLE
BY TYPE OF COVERAGE

Nature of Complaint	Type of Insurance						Total
	Life	Auto	Homeowners	Accident/ Health	Fire/ Casualty	Other/ Unknown	
Claim Disputes							
Number of Complaints	2	17	16	27	4	6	72
Percent of Category	15.4%	36.2%	94.1%	60.0%	25.0%	50.0%	48.0%
Cancellation/Non-Renewal							
Number of Complaints	0	22	1	3	4	0	30
Percent of Category	0.0	46.8	5.9	6.7	25.0	0.0	20.0
Agent Behavior							
Number of Complaints	2	2	0	6	2	1	13
Percent of Category	15.4	4.3	0.0	13.3	12.5	8.3	8.7
Premium Refund							
Number of Complaints	2	3	0	5	2	1	13
Percent of Category	15.4	6.4	0.0	11.1	12.5	8.3	8.7
Other							
Number of Complaints	7	3	0	4	4	4	22
Percent of Category	53.8	6.4	0.0	8.9	25.0	33.3	14.7

Source: Sample of 150 complaints drawn from Enforcement Division files.

includes the types of complaints mentioned by at least two investigators. Auto cancellation and non-renewal and accident/health claim disputes are mentioned by most investigators. Claim handling and settlement disputes in general, agent misconduct and questions regarding life insurance policy provisions are also mentioned by some investigators.

TABLE 4.5

INVESTIGATOR'S ASSESSMENT OF MOST FREQUENT COMPLAINTS

<u>Type of Complaint</u>	<u>Number of Investigators Including it Among Three Most Frequent Complaints</u>
Auto cancellation/non-renewal	18
Accident/health claims (including medicare supplement)	13
Claim handling; settlements (in general)	9
Agent misrepresentation, missappropriation of funds	5
Life insurance - questions about policy provisions	3

Source: Interviews with Enforcement Division investigators.

The case analysis indicates that consumers are not lodging many complaints about rate increases or discriminatory rates. To verify this finding, we asked investigators whether they received many complaints about rate increases or discriminatory rates. Sixteen of the 22 investigators said that they did receive complaints about rate increases and thirteen said they received complaints about discriminatory rates. Most of these were not formal written complaints but were received over the phone. No files were opened on the basis of telephone conversations and no records of these complaints were kept. Half of the investigators were unable to estimate the percentage of calls related to rate increases or discrimination, but of those who would make an estimate, most said the percentage was 10 percent or less. This may underestimate public concern about high rates since many phone calls about insurance rates are referred to the department's policy analysts.

The department receives several types of complaints encompassing all types of insurance. Although some types are more common than others, it is

clear that a variety of skills and strategies are required by department investigators to perform their task.

Data on complaints such as the data presented here could be useful both in focusing enforcement efforts and developing public policies which protect consumers from systematic patterns of abuse. Unfortunately, the department is limited in its ability to systematically analyze complaint data because of its inadequate data support system, a topic we address in Chapter 6. Complaint data could also be used to pinpoint areas of consumer confusion and misinformation, in order to improve consumer education efforts. We discuss the department's consumer education efforts in Section C of this chapter. In the next section of this chapter, we examine the complaint investigation process and evaluate the department's enforcement activities.

2. THE COMPLAINT INVESTIGATION PROCESS

In this section, we review the department's complaint investigation process in order to determine whether or not consumer complaints are being addressed in an efficient and effective manner. We again rely on the sample of 150 case files and our interviews with insurance investigators.

Written complaints are required by the department before formal investigations are undertaken. These usually take the form of a letter. Sometimes, a consumer will write out the complaint in person at the department. Many inquiries and complaints are initially received over the phone. Three investigators are assigned to phone duty each day to answer questions from consumers, agents and company representatives. Investigators will advise callers with complaints to write them out and mail them to the department.

- Our review of case files indicates that cases are, on the whole, handled in an efficient and timely manner.

Upon receipt of a consumer complaint, a file is created and the case is assigned to an investigator. Within a week, letters are mailed to the complainant acknowledging the complaint and to the insurance company and/or agent involved requesting a response within ten days. Follow-up letters are sent if responses are not received. If the response resolves the issue in the investigator's mind, it is forwarded to the complainant and the case is closed. On the other hand, if the response is incomplete or raises new questions, further inquiries are made. The investigation also determines if agent or company misconduct is involved. Investigations in the sample of 150 cases ranged from two to 336 days. The median length of investigation, from the date the department received the complaint until a letter was mailed to the complainant informing him or her of the disposition of the complaint, was 34 calendar days.

Table 4.6 contains department data on the number of cases opened and closed in fiscal years 1983-1985. Table 4.6 indicates that the number of cases closed in FY 1984 and FY 1985 (through May) is approximately equal to the number opened in the previous year. Thus, there has been no buildup of a case backlog.

TABLE 4.6

INSURANCE INVESTIGATION FILES OPENED AND CLOSED
Fiscal Years 1983 - 1985

<u>Fiscal Year</u>	<u>Cases Opened</u>	<u>Cases Closed</u>
1983	7,087	unavailable
1984	6,555	7,133
1985 ^a	7,088	6,525

Source: Minnesota Department of Commerce.

^aThrough May 1985.

Investigators reported that they are typically working on 50 to 75 cases at any one point in time. Most investigators were assigned between 30 and 40 new cases each month. Thirteen of the 22 investigators believed the Enforcement Division was understaffed; six believed that the number of investigators was about right; three felt that there were too many investigators. When asked which aspect of complaint handling takes the most time, eight investigators said waiting for companies to respond to inquiries and six said developing memos summarizing the case. (Memos are prepared when formal action against a company or agent is contemplated.)

In response to a question asking for investigators' opinions on improving the efficiency of complaint investigations, the most frequent responses were: acquiring a new computer (seven responses), developing a system of cross-checking responses to complaints to ensure greater uniformity (four responses) and hiring more investigators (three responses).

3. INVESTIGATION OUTCOMES

a. *Benefits to Consumers*

Our case file analysis enabled us to examine the results of department investigations and review the effectiveness of department intervention. While we recognize that the results of any investigation depend upon the facts of the case, we also expect that the results should provide some tangible benefits to citizens if the effort is to be worthy of continued support.

Tables 4.7 through 4.9 present the outcomes of 147 of the 150 case files which we analyzed. (Three cases were still pending.) Table 4.7 presents the outcome of complaints from the consumer's perspective. In over half

TABLE 4.7
OUTCOMES OF CONSUMER COMPLAINT INVESTIGATIONS

Outcome of Complaint	Type of Insurance						Total
	Life	Auto	Homeowners	Accident/ Health	Fire/ Casualty	Other	
No Relief: Beyond MDOC Authority							
Number of Cases	0	8	4	9	4	3	28
Percent of Category	0.0%	17.0%	25.0%	20.9%	25.0%	25.0%	19.0%
No Relief: Company Correct							
Number of Cases	10	21	4	10	3	1	49
Percent of Category	76.9	44.7	25.0	23.3	18.8	8.3	33.3
Claim Awarded or Increased							
Number of Cases	0	8	8	11	0	2	29
Percent of Category	0.0	17.0	50.0	25.6	0.0	16.7	19.7
Nonrenewal or Cancellation Rescinded							
Number of Cases	0	4	0	1	1	0	6
Percent of Category	0.0	8.5	0.0	2.3	6.3	0.0	4.1
Premium Refunded							
Number of Cases	2	3	0	8	6	1	20
Percent of Category	15.4	6.4	0.0	18.6	37.5	8.3	13.6
Other ^a							
Number of Cases	1	3	0	4	2	5	15
Percent of Category	7.7	6.4	0.0	9.3	12.5	41.7	10.2

Source: Sample of 150 complaints drawn from Enforcement Division files.

^aIncludes cases where no relief was sought or where the investigation was dropped at the consumer's request.

of the cases, the department was unable to secure the specific relief requested by the consumer. In one-third of the cases, the department concluded that the company acted correctly and/or legally. This was the most frequent resolution in auto cases and typically involved complaints about non-renewal of insurance policies. Here, the department has established a point system which allows a specific determination of the combination of accidents and traffic violations which make non-renewal justified. The department also supported companies when its review of the case indicated that the provisions of policies were applied correctly.

Table 4.7 also shows that in about one-fifth of the cases, the department informed the consumer that it lacked the authority to resolve the issues. In most of these cases, the department suggested that the complainant pursue the matter in small claims court or secure legal assistance. These cases typically involved disputes over questions of fact, such as who was at fault in an auto accident, what was the extent of damages or losses, or whether or not medical expenses were necessary and/or reasonable.

The resolution of complaints in favor of companies does not mean that consumers receive no benefit from filing complaints. At a minimum, such consumers receive an explanation of the applicable standards. This may increase their understanding of the insurance business, better prepare them for future interaction with insurance companies, and, in some instances, leave them with the feeling that the system has not cheated them.

The department did provide results sought by complainants in 37.4 percent of the cases. Table 4.7 shows that investigators were most successful in resolving company delays and disputes involving the amount of claims. These results occurred in one-half of the homeowners cases, one-fourth of the accident/health cases, and one-sixth of the auto cases. The department also secured premium refunds for customers who cancelled policies or had their policies cancelled by insurance companies. In a few cases, the department was able to get companies to reverse cancellation or non-renewal decisions.

The department reports that over \$2.5 million was recovered for consumers as a result of claim settlements between July 1984 and May 1985. In our sample of cases, the amount of money recovered for consumers ranged from \$3 to \$93,495. (The latter case involved an agent who had allegedly forged the insured's signature to withdraw money from her annuity. The company agreed to reinstate the cash value with interest.) Table 4.8 presents a breakdown of the monetary recoveries for consumers. As Table 4.8 shows, most of the recoveries were under \$1,000. Of those cases involving a recovery, the median amount recovered was \$604. Money was recovered for consumers in 26.5% of the cases.

There is no way to measure whether some or all of the complaints could have been satisfactorily resolved by consumers themselves through greater persistence or effort. In some cases, the consumer may have initiated a complaint without first trying to resolve the matter with the agent or company. Our analysis leads us to conclude, however, that in many cases the consumer did make a considerable effort to resolve the matter before

TABLE 4.8

MONEY RECOVERED FOR CONSUMERS

<u>Dollars</u>	<u>Number of Consumers</u>	<u>Percent of Total</u>
None	108	73.5%
Under \$100	11	7.5
\$100-\$499	7	4.8
\$500-\$999	12	8.2
\$1,000-\$3,300	8	5.4
Over \$3,300	1	0.7
Median Recovery Amount for Cases With Monetary Recovery: \$604		

Source: Sample of 150 complaints drawn from Enforcement Division files.

contacting the department. In several cases, the insurance company reported that it had reached a settlement with the insured or mailed a check at about the same time it received the inquiry from the department. We can only wonder whether these matters would have been resolved without department intervention. In other cases, the effect of department intervention is clearer. In these cases, companies changed their position when confronted by the department's arguments. In our opinion, it should not be entirely the consumer's burden to keep insurance companies on their toes. We believe that the department is providing a useful and necessary service in investigating individual complaints and securing tangible results for many consumers.

b. *Disciplinary Actions*

The department reports that between July 1984 and May 1985, there were a total of 141 administrative actions taken against insurance companies or agents. This represents approximately two percent of the cases closed during this time period. Actions included 46 license revocations, 49 suspensions, six censures of insurance companies, and 40 cease and desist orders. A total of \$112,600 in civil penalties were collected during this period.

Table 4.9 reports the disciplinary actions taken by the department in the sample cases. As Table 4.9 shows, actions were taken against agents in nine (6.2 percent) of the sample cases. This included four warnings or reprimands, two license suspensions, and three license revocations. These cases sometimes included fines or assessments of investigation costs up to \$150. There were four cases where insurance companies were fined or assessed civil penalties. In these cases, the company also signed a

consent decree agreeing to cease and desist from engaging in an unfair trade practice. Interestingly, none of the disciplinary actions in our sample resulted from formal hearings. All were the results of consent decrees.

TABLE 4.9

ADMINISTRATIVE ACTIONS AGAINST
COMPANIES OR AGENTS

<u>Type of Action</u>	<u>Number of Cases</u>	<u>Percent of Total</u>
No Formal Action	130	89.7%
Reprimand or Warning	4	2.8
License Suspension	2	1.4
License Revocation	4	2.8
Fine or Civil Penalty ^a	<u>5</u>	<u>3.4</u>
Total ^b	145	100.0%

Source: Sample of 150 complaints drawn from Enforcement Division files.

^aIncluded Cease and Desist order.

^bFive cases were still pending.

4. THE EFFECTIVENESS OF COMPLAINT INVESTIGATIONS

Our case analysis and our interviews with investigators lead us to several conclusions regarding the effectiveness of the department's enforcement efforts. The department is able to secure favorable results largely through the cooperation of the insurance companies that follows from the implicit threat of instigating formal enforcement proceedings and investigations. The department is unable to resolve factual disputes and, in most cases, lacks the means to probe beyond the companies' and/or agents' responses as to what representations were made to the consumer and whether or not there are alternatives to the companies' interpretations of policy provisions. Given its limited resources and the volume of complaints that are handled, the department is necessarily selective in pursuing cases only where the investigators feel they can produce tangible results or which raise suspicions about agent wrongdoing or company unfairness.

Complaints are handled efficiently and in many cases, result in tangible benefits to consumers. However, the department has not developed a strategy to detect and enforce trade practice violations beyond those uncovered through the complaint investigation process. Investigators expressed concern that because each case is handled on an individual basis, there is not always a consistent approach to dealing with similar

consumer complaints. Eighteen of the 22 investigators we interviewed felt that the department has no systematic strategy for dealing with unfair trade practices.

To some extent, this deficiency results from an inadequate data processing system which has not assisted the department in uncovering patterns of abuse or trends in consumer complaints. Such patterns and trends are sometimes uncovered in the course of discussions among staff. Uncovering these patterns would enable the department to conduct systematic investigations of companies which consistently violate trade practice regulations and to target market conduct examinations toward those companies. We address this topic in greater detail in the next section.

We note that despite the inadequacy of its data support system, the department has uncovered some patterns of unfair trade practices. Furthermore, the department is not reluctant to challenge such practices and has, on several occasions, levied penalties and issued cease and desist orders to companies that violate trade practice regulations. The department has also promoted legislation which resulted in the passage of the Minnesota Insurance Claims Settlement Act. This law defines and proscribes unfair claim settlement practices. The department has also promulgated rules governing the cancellation and non-renewal of auto, homeowners and commercial insurance and defining agent conduct standards. Despite its lack of adequate data processing or a systematic approach for dealing with trade practice violations, the department has been able to keep abreast of trade practices and actively promote policies aimed at protecting consumers from trade practice abuses.

B. MARKET CONDUCT EXAMINATIONS

During a market conduct examination, state examiners review company records to identify problems such as misleading advertising, improper rates or policy forms, improper cancellation or non-renewal practices, and unfair claim practices. While department staff investigate individual consumer complaints to detect similar problems, both approaches can perform an important function. Investigating individual consumer complaints is the easiest and quickest way to detect unfair trade practices. However, consumers do not always realize when they are treated unfairly and consumers do not always complain even when they do realize they were treated unfairly. It is therefore important to determine the existence of systematic problems. The department has two ways of identifying systematic trade practice problems: investigations conducted by Enforcement Division staff and market conduct examinations performed by the Financial Standards Section staff. If market conduct surveillance is effective, it may also reduce the number of consumer complaints. In this section, we focus on market conduct examinations. First, we describe the department's examination process and then we examine its effectiveness.

1. THE EXAMINATION PROCESS

The department's financial standards section is responsible for both market conduct examinations and financial examinations. Usually an examination includes both components. Any of the section's ten examiners may work on either component. Since the department gives priority to examining the financial condition of insurance companies, only two full time equivalent staff positions are allocated to market conduct examinations.

The department examines the market conduct of insurance companies domiciled in Minnesota (domestic companies) approximately once every four years. Minnesota rarely conducts market conduct examinations of insurers based in other states (foreign insurers). During the five and a half year period ending June 30, 1985, the department participated in only 26 market conduct examinations of the 1061 foreign insurers licensed in Minnesota.

During a typical market conduct examination, staff review the company's advertisements and its internal consumer complaint files. They take a sample of policy holders to review whether the company charges the correct rates, uses the proper forms, follows proper cancellation and non-renewal procedures, and settles claims promptly and equitably. Examiners do not attempt to determine whether rates are excessive, inadequate, or unfairly discriminatory, but just whether they comply with rate filings.

2. EFFECTIVENESS OF MARKET CONDUCT SURVEILLANCE

The 1974 McKinsey study sponsored by the National Association of Insurance Commissioners identified several key elements of Market Conduct Surveillance.¹ These include:

- a complaint analysis system that identifies companies and lines of business which have a large number of complaints in relation to the amount of business,
- an examination schedule and examination scope based on the incidence of problems,
- use of staff who specialize in market conduct examinations.

Targeting market conduct exams is important because it is not practical to thoroughly examine all companies which sell insurance in Minnesota. In addition to consumer complaint data, targeting can be based on previous examination results, information from staff who review rates and policy forms, and results of examinations by other states. In this section we examine Minnesota's market conduct surveillance approach using the standards outlined above.

¹McKinsey and Company, Inc., *Strengthening the Surveillance System*. Report prepared for the National Association of Insurance Commissioners, 1974.

a. *Consumer Complaint Analysis*

Consumer complaints to the Commerce Department are the most comprehensive information available on insurance trade practice problems in Minnesota. Thus, it makes sense to use complaint information to help schedule market conduct examinations and to help define the scope of these examinations. However,

- The department does not adequately analyze consumer complaints to effectively target market conduct examinations.

The enforcement section records complaint data and gives complaint summaries to the financial standards section. These summaries present the number of complaints by company and line of business. However, the examiners do not use this information because the complaint summaries do not present meaningful comparisons, such as the ratio of complaints to business volume. The complaint summaries should also present the nature of the complaints by company and line of business in order to help identify which trade practices to examine closely. Obviously, knowledge of the complaint volume by itself does not help identify problem companies. As we discuss in Chapter 6, the department needs to strengthen its computer support capability to adequately analyze its consumer complaint data.

b. *Scheduling Examinations*

The department's scheduling of market conduct examinations has two important shortcomings. First, the department rarely targets its market conduct examinations on the basis of suspected market conduct problems. Out of 154 market conduct examinations performed between January 1980 and June 1985, the department targeted only two because of market conduct problems. Second, the department does not pay enough attention to foreign (non-Minnesota) insurance companies. Although foreign insurance companies sell approximately 75 percent of all insurance sold in Minnesota, the Minnesota Department of Commerce devotes only a small share of its market conduct resources to foreign companies. The department examines the market conduct of each domestic insurance company about once every four years. However, during the five and a half year period ending June 1985, it participated in only 26 market conduct examinations of the 1061 foreign insurance companies licensed in Minnesota.

The department rarely targets its market conduct examinations because it performs market conduct examinations jointly with financial examinations. Since the department gives priority to the financial portion of these examinations, market conduct considerations rarely affect the schedule of these examinations.

One might argue that the department should depend on other states to examine the market conduct of foreign insurance companies, as is the case with financial examinations. This practice makes sense for financial examinations because financial problems affect all states in which the company sells insurance. However, this argument does not apply equally to market conduct. Insurance trade practice laws vary among states and actual trade practices may vary among a company's regional offices. Thus, an insurance

department can correct market conduct problems in its own state without necessarily correcting problems in other states. According to examiners we interviewed, examiners tend to focus on market conduct practices in their own state and are usually not familiar with laws of other states. Furthermore, the quality of examinations varies from state to state. Thus, we believe that other states probably do not effectively regulate the trade practices of foreign companies in Minnesota. Because of these problems, the 1974 McKinsey study recommended that each state insurance department oversee the market conduct of all companies operating in its state.²

Market conduct examinations may also deter unfair trade practices by companies which are not examined as long as they know they might be examined. However, Minnesota's examinations have little deterrence value for foreign companies because these companies are so rarely examined.

c. Defining the Scope of an Examination

To help identify the trade practices that should be closely examined, the examiners consider the results of previous examinations and the type of problems usually found in companies with the same line of business. Again, the main shortcoming with this process is that it does not use the department's own consumer complaint data.

d. Staff Specialization

Studies by McKinsey and the U.S. General Accounting Office concluded that because of the wide range and complexity of market conduct problems, effective trade practice regulation requires full-time market conduct specialists.³ However, the Financial Standards Section of the Minnesota Department of Commerce does not have any full-time market conduct specialists. The ten examiners who are responsible for market conduct examinations spend most of their time on the financial component of the examinations. Furthermore, most examiners have educational backgrounds in financial fields and are primarily interested in the financial component of the examination. Their only market conduct training is on the job training.

e. Discussion

We conclude that the department's market conduct examinations are not very effective. The department devotes few resources to this activity and does not effectively target these examinations on the basis of suspected trade practice problems. The department relies primarily on consumer complaint investigations to detect systematic trade practice problems because it

²McKinsey and Company, Inc., *Strengthening the Surveillance System*.

³McKinsey and Company, Inc., *Strengthening the Surveillance System*; United States General Accounting Office, *Issues and Needed Improvements in State Regulation of the Insurance Business*, Washington, D.C., 1979.

believes that these investigations are more effective than market conduct examinations. However, even if the department does not substantially increase the amount of resources devoted to market conduct examinations, it should improve how it targets these examinations. As the department improves its consumer complaint analyses, the department probably would identify more potential problems. We believe that the department could more effectively use its market conduct examination resources if they were directed at these suspected problems. Specifically, we recommend:

- The department should analyze consumer complaint data to identify companies with unusually large complaint ratios. For each company, it should identify the nature of the complaints and the potential problem areas.
- The department should schedule market conduct examinations on the basis of suspected problems.
- The department should use staff who specialize in market conduct to conduct these examinations.

To make all of these changes, the department needs to begin conducting market conduct examinations separately from financial examinations. The department schedules market conduct examinations jointly with financial examinations in order to be more efficient. While there is some overlap between market conduct and financial examinations, department staff said that these two components are largely independent of each other. Even if there is some loss in efficiency, we believe that targeting market conduct exams would improve their overall effectiveness.

We believe that the department could make these improvements by adding one supervisor specializing in market conduct or by assigning responsibility for market conduct to the enforcement section. The advantage of placing market conduct surveillance in the enforcement division is that market conduct examinations and consumer complaint investigations have similar objectives and require knowledge of trade practice problems.

We also believe that the department needs to review how it should best allocate its resources among consumer complaint investigations and market conduct examinations. Currently, the department allocates about two full-time-equivalent positions for market conduct examinations and about 27 full-time-equivalent positions for consumer complaint investigations. The department estimates that in order to examine foreign companies in addition to domestic companies, it would need about six additional staff, making a total of eight market conduct examiners. In 1974, the McKinsey study estimated that the nation would need a total of about 250 market conduct examiners. Based on Minnesota's share of the population, this implies that Minnesota would need a total of five market conduct examiners. To determine whether more staff are needed, the department should review the experience of other states which have recently strengthened their market conduct programs and monitor the impact of its own market conduct surveillance once it makes the above improvements. For example, the insurance department in Virginia reports that the the number of trade practice complaints declined since it strengthened its market conduct

program about five years ago. The Minnesota Department of Commerce should take advantage of what Virginia and other states learn about different approaches to regulate trade practices.

C. CONSUMER INFORMATION

In this section, we evaluate the department's program for disseminating information about insurance to consumers. A competitive system of regulation requires that consumers be adequately informed about the products they purchase. The Enforcement Division is capable of protecting the public against unfair trade practices that come to its attention. However, in order for the public to bring problems to the attention of the department's complaint investigators, the public must have some understanding of insurance products, legal requirements of companies and agents, and the procedures to follow in order to register complaints. Moreover, an informed public can make wise purchasing choices and is better protected against unfair trade practices. An effective program of consumer information prevents abuses and misunderstandings from occurring and, therefore, is more efficient than complaint investigations in protecting the public.

Our review of the department's consumer information activities leads us to the following conclusion:

- The department does not have an adequate public information program for insurance.

The department has produced few brochures and consumer guides to help the public understand insurance products and trade practices. With the exception of a brochure explaining the Minnesota Insurance Claims Settlement Act, the department has not published any informative brochures regarding insurance. The department does distribute a weekly "consumer alert" or "investor alert" column to weekly newspapers. However, this column is not specific to insurance, dealing with such topics as con artist investment schemes, tips on purchasing a home, tax shelters, and so on. Although these articles may be of value to some consumers, they are not available to most consumers and, more important, are not likely to be available at the time the information is needed.

In addition to its brochure on the Insurance Claims Settlement Act, the department does keep brochures published by the insurance industry and the Federal government. However, the department does not have a systematic procedure for disseminating these brochures. Thus, unless consumers happen to be at the department's office or request information, they are unlikely to receive these brochures.

It is noteworthy that the need for better public information has been recognized by the department. In a report on auto insurance published in 1983, the department made the following recommendation:

An option to consider is a modest program of consumer education. Informational brochures or pamphlets...could be de-

veloped. These could then be distributed by insurers along with renewal notices or other periodic correspondence. Agents and insurance companies could also be required to provide such brochures when new policies are written.⁴

To date, such a procedure has not been implemented by the department.

We suspect that many consumers are unaware of the department's complaint investigation service and are unsure of their rights as consumers. The department could develop a brochure describing its complaint investigation procedures and explaining the types of issues over which it does and does not have jurisdiction. The department could also explore the possibility of securing public service advertisements to inform customers of its services. Finally, the department could install an 800 telephone number so that outstate consumers can call toll free.

The net result of a greater community outreach effort could be an improvement in the department's effectiveness by focusing its caseload on complaints over which it has jurisdiction, facilitating its ability to uncover patterns of trade practice violations, and providing services to those citizens who are currently unaware of the department's functions. Accordingly, we recommend that:

- the department install an 800 number to provide free access for outstate citizens;
- the department develop a brochure describing its services.
- the department work with the insurance industry to develop a systematic plan for disseminating information to the public about insurance and common complaint issues.

D. AGENT LICENSING

Another way in which the Department of Commerce seeks to protect consumers from unfair trade practices is through the licensing of insurance agents. By establishing licensing requirements, the department can screen applicants and reject those with criminal backgrounds. By establishing minimum educational requirements and an examination procedure, the department can ensure that agents have a reasonable knowledge of the statutes and administrative rules and are informed about the products they sell. Continuing education requirements are intended to ensure that agents keep abreast of changes in laws and rules and the characteristics of insurance policies that are sold.

⁴Minnesota Department of Commerce, "Automobile Insurance in Minnesota: Affordability and Other Issues", February 1983, p. 87.

The department is responsible for licensing approximately 34,000 insurance agents working in Minnesota. This includes maintaining a computerized information base on all existing agents and monitoring their compliance with continuing education requirements. The department is also responsible for administering exams, reviewing applications and issuing licenses to approximately 8,000 new applicants for licenses per year. In addition to insurance agents, the Licensing Division of the department is responsible for licensing insurance agencies, insurance adjusters, real estate agents and cosmetologists and for approving continuing education courses and instructors.

The department has embarked on a course of strengthening licensing and continuing education requirements, including reinstating an annual renewal of license requirement. Between 1981 and 1983, perpetual licenses were issued. It was thought then that annual license renewal was needlessly bothersome and contributed little to the competence and professionalism of insurance agents. The department now claims that it was difficult to keep track of agents under the perpetual licensing system and that an annual renewal system is necessary.

Licenses are renewed each June 1. There are several lines of authority, with property/casualty and life/health being the two main lines. Each line of authority costs the agent \$20 per year, with the exception of surplus lines insurance, which is \$150 per year. Agencies (partnerships or corporations) must also be licensed at an annual cost of \$50. The department estimates that the annual revenue collected by the state for insurance licenses was \$1.2 million in FY 1985.

In addition to requiring annual licensing of agents, the department has moved to update examinations and educational prerequisites as well as to stiffen continuing education requirements. The department claims that the previous administration did not exert its authority to approve continuing education courses. The department maintains that most training programs had been administered by the insurance companies and were of little educational value.

The department maintains that licensing is necessary to identify and discipline agents who engage in unfair trade practices or otherwise violate the law. Licensing also assists consumers and insurance companies in locating agents and allows the department to inform agents of changes in insurance laws and rules.

We are not convinced that licensing is the most effective means of protecting consumers from agent abuse even though the threat of suspension or revocation of one's license may deter some agents from unfair trade practices. Our analysis of consumer complaints indicates that suspensions and revocations are infrequent. Furthermore, disciplining an agent does not always result in undoing the wrong suffered by the consumer. We noted in our discussion of consumer complaints that there were several cases in which elderly consumers were sold several medicare supplement insurance policies. In some of these cases, the consumer did not receive a refund of premium despite the fact that the agent was disciplined. Furthermore, the consequences of agent indiscretions or errors are often not exper-

enced by the consumer until a claim is filed. In some cases, the agent who sold the policy may no longer be in the insurance business. In those instances, disciplining the agent may not offer an effective remedy to the consumer.

- We believe that the most effective way to protect the public is to hold insurance companies responsible for the actions of agents who represent them.

According to the department, this is the case in practice, although there appears to be no explicit statutory language setting out this policy. If there is any question about the legal status of this important responsibility, the department should propose changes to the law to specifically hold insurance companies responsible for any actions of their agents which unlawfully harm consumers. This would provide an incentive to companies to hire trustworthy agents and provide them with adequate training.

The department reports that agents, insurance companies and other states are all in favor of annual licensing. It also is a net revenue producer for the state. We also note the the department only recently (1983) returned to an annual licensing system. To switch to a different system now might be disruptive to agents. Accordingly, although we are unconvinced that annual licensing of agents is necessary, we do not believe that a change is warranted at this time.

- The department is administering insurance licensing in a timely and adequate manner.

We did not uncover any major failings with the department's licensing operation. We did find that although the department's computer system performed better in its licensing functions than in its other applications, it still had some shortcomings. These shortcomings are discussed in Chapter 6. On the whole, the department is able to process applications, administer exams, issue licenses and handle inquiries about agents in a timely manner.

Insurance Availability and Affordability

Chapter 5

Many types of insurance are practical necessities for individuals and businesses and some are required by law. Where insurance is a practical or legal requirement, the Legislature and the Department of Commerce should take steps to ensure the availability of insurance for those individuals and businesses who cannot obtain it through regular channels. In this section, we examine the extent of the availability/affordability problem, discuss the sources of the problem, review department efforts to deal with the problem, and outline some alternatives for the Legislature to consider in establishing future policy. Our research focuses on the following questions:

- How extensive is the current availability crisis? What types of insurance are most affected?
- What factors underlie the current availability crisis? What are the prospects for the future?
- What mechanisms have been set up by the Legislature and the department to deal with the problem? How effective are these programs?
- What policy options are available to the Legislature to deal with the problem?

A. THE CURRENT AVAILABILITY CRISIS

There are three dimensions to the availability problem. The first is the general increase in insurance premiums for all lines of insurance. The second is the difficulty encountered by some consumers in obtaining personal lines of insurance because they present above average risks to insurance companies. The individual with a poor driving record or the homeowner who has experienced several burglaries are examples. The third are those lines of insurance (primarily commercial and professional liability) which have become unavailable or experienced a rapid increase in

price. As a result, some businesses and professional groups have been unable to obtain insurance from any source. Others find the price prohibitive. In this section, we review the evidence pertaining to these three dimensions of the availability issue.

1. RECENT INSURANCE RATE INCREASES

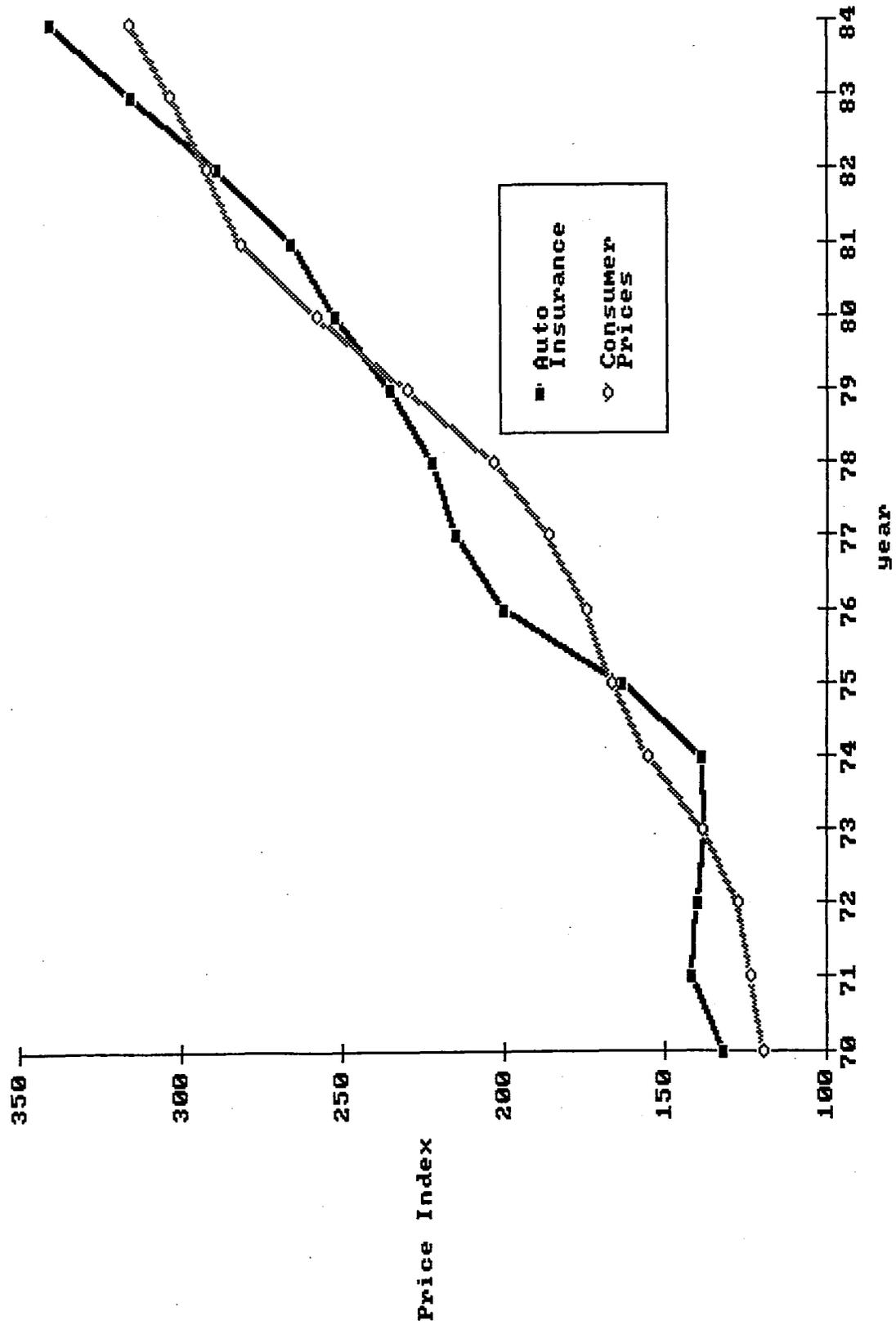
Although the Department of Commerce maintains files on insurance rates for most lines of insurance, it has not analyzed trends in insurance premiums for different lines of insurance. Such an analysis is difficult to accomplish because coverages change over time and differ among companies. We were able to obtain national data on insurance pricing trends from the Bureau of Labor Statistics of the United States Department of Labor which publishes a monthly consumer price index (CPI). Two components of this index are automobile insurance and household (homeowners) insurance prices. These indices are computed on a national basis. The household insurance price index was established in 1983, so data are limited to the last two years. Between August 1983 and August 1985, the cost of household insurance in urban areas has increased at a compound annual rate of 4.5 percent. This is slightly above the overall CPI rate of increase of 3.8 percent per year for the same time period. Auto insurance rates have increased at a more rapid rate of 9.3 percent for the same time period.

Between December 1970 and December 1984, auto insurance rates increased at a compound annual rate of 7.0 percent. This compares with an increase in the overall CPI of 7.2 percent per year for the same time period. This comparison, depicted graphically in Figure 5.1, indicates that, for United States urban areas as a whole, there are periods (including the period since 1981) in which auto insurance premiums have risen at a faster rate than inflation and periods when the rate of increase has been slower than inflation. Over the long run, however, the two are increasing at about the same pace.

The Bureau of Labor Statistics does not compute price indices for commercial lines of insurance. We were able, however, to obtain some data on commercial price increases from insurance industry sources. Table 5.1 presents the annual percentage price increase for commercial lines of insurance in Minnesota between 1980 and 1985. The left-hand columns present the rate changes recommended by the Insurance Services Office (ISO), the major rating bureau in the United States. Although not binding, many companies, especially smaller ones with limited actuarial expertise, adhere to ISO rates. The right-hand columns present actual rate increases for those companies which report their rates to ISO. ISO estimates that these data include rates for about one-third of the commercial policies issued in Minnesota. Table 5.1 indicates that both recommended and actual rates increased slowly, and in some cases decreased, between 1980 and 1983. Rates have increased dramatically in 1984 and the first half of 1985. Table 5.1 also shows that increases for commercial liability lines have greatly exceeded increases for commercial fire and auto insurance.

It is noteworthy that for the years 1980 to 1983, actual rate increases were less than ISO recommended. Many analysts feel that this was short-

**FIGURE 5.1
COMPARISON OF AUTO INSURANCE AND
CONSUMER PRICE INCREASES, 1970-1984**



Source: U.S. Department of Labor, Bureau of Labor Statistics.

TABLE 5.1

MINNESOTA COMMERCIAL INSURANCE: COMPOUND ANNUAL RATES OF CHANGE

	<u>ISO Recommended Rates</u>		<u>Actual Rates Reported to ISO</u>	
	<u>1980-1983</u>	<u>1984-1985^a</u>	<u>1980-1983</u>	<u>1984-1985^a</u>
Fire and Extended Coverage	4.8%	-1.2%	0.9%	3.3%
Manufacturers and Contractors Liability	-4.1	19.3	-5.7	30.8
Product Liability	-0.1	18.7	-4.0	29.1
Owners, Landlords and Tenants Liability	15.1	25.2	7.3	42.1
Commercial Auto	11.1	5.2	-0.2	14.0
Commercial Multi-Peril	7.3	18.1	-2.2	29.5

Source: Computed from Insurance Services Office, Inc., CSP Rating Modification and Rate Departure Summary Reports for Minnesota and other data provided by the ISO.

^aThrough second quarter, 1985.

sighted and contributed to the magnitude of the rate increases that have recently occurred. Indeed, Table 5.1 shows that 1984 and 1985 increases have exceeded ISO recommendations.

The ISO has also published a summary of its proposed insurance rate increases in the United States for the first nine months of 1985. This summary, presented in Table 5.2, indicates that rates for other types of liability insurance have also been increasing dramatically in 1985. By contrast, the consumer price index increased at an annual rate of 3.8 percent for the first nine months of 1985.

Recent rate increases for commercial liability insurance have caused considerable consternation on the part of consumers and have provoked much attention from the news media. Over the long run, however, the data presented here do not indicate a pattern of excessive rate increases for commercial property or personal lines of insurance.

TABLE 5.2

PROPOSED RATE INCREASES FOR 1985^a

<u>Line of Insurance</u>	<u>Increase Recommended by Insurance Services Office^a</u>
Personal Lines:	
Auto	1.2%
Homeowners	-1.7
Personal Liability	0.6
Commercial Lines:	
Auto	8.0%
Fire	-0.7
General Liability	18.7
Professional Liability	40.6
Farmowners/Ranchowners	4.1
Commercial Multi-Peril	14.3

Source: Insurance Services Offices, Inc., *Chief Executive Circular*, October 4, 1985.

^aFigures reflect national averages of ISO advisory rates approved by state insurance departments. Percentages reflect changes over year-end 1984 rates through September 30, 1985.

2. INSURANCE FOR HIGH-RISK CONSUMERS

The decision whether or not to insure an individual or business is fundamental to the insurance industry. The companies which are successful at underwriting decisions can limit the claims they have to pay. This, in turn, enables them to charge lower premiums to customers and compete effectively. While the practice of risk evaluation and underwriting may reduce rates for the majority of consumers, it leaves a pool of customers who are unable to obtain insurance through conventional means. These consumers must acquire insurance (for a higher premium) from companies specializing in high risks or from a government mandated assigned risk plan. These plans are discussed in a subsequent section. The extent of this dimension of the availability problem are the numbers of consumers enrolled in the assigned risk plans. This data, presented in Table 5.3, indicates that the number of policies issued by assigned risk plans has declined for auto and property (FAIR Plan) insurance and increased for health insurance. Workers compensation plan figures were unavailable prior to 1983, but partial figures for 1985 (23,447 policies issued through October) indicate that enrollment is increasing.

TABLE 5.3
NUMBER OF POLICIES ISSUED BY ASSIGNED RISK PLANS

<u>Year</u>	<u>Auto Plan</u>	<u>FAIR Plan</u>	<u>MCHA</u>	<u>Workers' Compensation</u>
1979	15,368	2,660	726	N/A ^a
1980	16,948	2,096	903	N/A ^a
1981	9,047	1,773	1,449	N/A ^a
1982	3,842	1,414	2,195	N/A ^a
1983	2,599	1,250	3,274	16,330
1984	1,756	968	4,423	17,438

Source: Data supplied by the administrators of each of the assigned risk plans.

^aData not available.

3. COMMERCIAL LIABILITY INSURANCE

The aspect of the availability issue that merits the term "crisis" is the rapid increase in commercial liability rates. There have been reports of large rate increases for many specialized lines of liability insurance. These include medical malpractice insurance, day care insurance and municipal government liability insurance.¹ The data presented in Tables 5.1 and 5.2, although not a comprehensive analysis of all rates, tend to confirm these reports. We have also obtained data for medical malpractice insurance. In Table 5.4, we present annual rate increases for medical malpractice insurance by the Minnesota Medical Insurance Exchange, a major vendor of medical malpractice insurance in Minnesota. Table 5.4 indicates consistent and sizeable increases in medical malpractice rates since 1981, with the rate of increase accelerating in 1984 and 1985. For example, rates for neurosurgeons increased by 17.6 percent per year between 1981 and 1983 and have increased by over 25 percent per year since then. Similar patterns characterize rate increases for other medical specialties.

In some cases, categories of customers have been unable to obtain insurance from any source for a period of time. Examples of these groups are

¹Gendler, Neal, "Last Hearing on State Medical Malpractice Insurance is Today", *Minneapolis Star and Tribune*, August 12, 1985; McCartney, Jim, "Rampaging Insurance Rates Distress Cities", *St. Paul Pioneer Press and Dispatch*, November 4, 1985; Carlson, Scott, "Home Day Care Providers Say Insurance is a Problem", *St. Paul Pioneer Press and Dispatch*, August 28, 1985.

TABLE 5.4
ANNUAL RATE INCREASES FOR MEDICAL MALPRACTICE INSURANCE IN MINNESOTA^a

Year	Family Physician	Pediatricians and Internists	General Surgeons and Anesthesiologists	Neuro-Surgeons	Heart and Orthopedic Surgeons	Obstetricians and Gynecologists
1981	17.6%	12.8%	9.9%	17.6%	1.1%	10.1%
1982	17.6	17.7	17.6	17.6	17.6	17.6
1983	17.7	17.7	17.6	17.6	17.6	17.6
1984	24.8	24.4	25.3	25.4	25.3	0.0
1985 ^b	27.4	26.5	28.2	28.4	28.3	25.3

Source: Data supplied by the Minnesota Medical Insurance Exchange as reported in the St. Paul Pioneer Press and Dispatch, November 23, 1985.

^aAnnual percentage increase over rates for previous years.

^bAs of October 1, 1985.

nurse midwives, psychologists who counsel sex offenders, foster care providers, landfills and bars.²

The Department of Commerce argues that it has been hampered in its efforts to monitor this problem in commercial liability insurance because of the exemption of commercial policies from rate filing requirements. The department is also hampered by the fact that the annual reports of premium volume filed by insurance companies follow the National Association of Insurance Commissioners (NAIC) format. As we noted in Chapter 2, the NAIC forms do not break down the different types of liability insurance into specialized categories. As a result, when the department receives complaints about availability or extensive rate increases for a particular type of commercial liability insurance, it must survey the insurance industry to obtain data on the number of companies issuing insurance and the rates they charge.

Despite the absence of good information, we found many reports of businesses and professional groups which have been unable to purchase liability insurance or have experienced extensive rate increases to the point where they dropped their insurance or went out of business.³ In the next section, we discuss some of the factors underlying insurance rate increases in general, and commercial liability insurance in particular.

B. FACTORS UNDERLYING THE AVAILABILITY PROBLEM

The recent acceleration of insurance rate increases, including the availability crisis in commercial liability, are the result of two general factors. These factors are the escalation of damage awards and settlements and the current phase of the insurance underwriting cycle. In this section, we discuss these two factors and review the available data pertaining to them.

²"Nurse-Midwives Jeopardized by Lack of Insurance", *St. Paul Pioneer Press and Dispatch*, July 6, 1985; "Ruling Says Groups Eligible to Secure Malpractice Coverage", *St. Paul Pioneer Press and Dispatch*, October 2, 1985; Hoffman, Julie Ann, "Foster Homes Facing the Loss of Insurance", *St. Paul Pioneer Press and Dispatch*, October 22, 1985; McCartney, Jim, "Landfill without Insurance is Closed", *St. Paul Pioneer Press and Dispatch*, November 15, 1985; "Liquor Liability Insurance Drying Up", *Finance and Commerce*, May 1985.

³Carlson, Scott, "Insurance Costs Cited in Child Care Closing", *St. Paul Pioneer Press and Dispatch*, November 5, 1985; McCartney, Jim, "Landfill Without Insurance is Closed"; Berton, Lee, "As Accounting Firms Premiums Soar, Some Might Drop Liability Insurance", *The Wall Street Journal*, May 30, 1985; McCartney, Jim, "Rampaging Insurance Rates Distress Cities"; Andresky, Jill, Kuntz, Mary, and Kallen, Barbara, "A World Without Insurance?", *Forbes*, July 15, 1985.

1. ESCALATING DAMAGE AWARDS

Most discussions of the crisis in liability insurance point to a trend in escalating jury awards and injury settlements. Despite this general belief, we have been able to find little systematic evidence on increases in liability awards. The evidence which does exist comes from other states and is not specific to Minnesota. For example, Forbes magazine reports that 360 personal injury cases were settled in 1983 for over \$1 million, thirteen times as many as in 1975. During the same time period, the average product liability jury award went from \$345,000 to \$1,070,000.⁴

Nationwide, medical malpractice insurance claims have also been increasing, both in frequency and size. For example, the St. Paul Companies, with 14.6 percent of the national medical malpractice insurance market in 1983, reported 5,870 claims for physician malpractice in 1983, an 88 percent increase over the 3,113 claims reported in 1979. Hospital malpractice claims increased by 76 percent, from 2,112 to 3,541, during the same time period.

In Minnesota, the number of claims handled by the St. Paul Companies rose from 11.5 to 13.5 claims per 100 doctors between 1980 and 1984, a 17 percent increase. The average claim incurred by the two largest medical malpractice insurers in Minnesota has risen from about \$47,000 in 1981 to \$54,000 in 1984, a 14 percent increase.⁵

A study commissioned by the NAIC found that between 1975 and 1978, the average liability award increased from \$26,565 to \$45,187. The number of awards exceeding \$1 million rose from five in 1975 to 23 in 1978. Between 1977 and 1983, total awards paid by insurance companies increased from \$817 million to \$2 billion.⁶

In addition to the frequency and size of claims, there has also been a tendency for courts and legislatures to expand the limits of liability. For example, a recent Minnesota Court of Appeals decision refused to dismiss a lawsuit brought against Anoka County for an injury which occurred in a licensed day care home. The claimants maintain that the county is negligent since it licensed and inspected the day care home. The Court ruled that a law making the state and its employees immune from such lawsuits does not apply to counties. The court held that the issue of the county's negligence should be decided by a jury.⁷

⁴Andresky, Jill, et. al., "A World Without Insurance?", p. 40.

⁵American Medical Association, Special Task Force on Professional Liability and Insurance, "Professional Liability in the 1980's", October 1984, pp. 10-11; "Report of the Minnesota Commission on Professional Liability", November 1985, p. 15.

⁶American Medical Association, "Professional Liability in the 1980's", pp. 6-7.

⁷Rybin, Virginia, "Court Rules County Can Be Sued", *St. Paul Pioneer Press and Dispatch*, October 22, 1985.

Courts have also issued rulings holding bars responsible for damages incurred by patrons who injured others as a result of consuming an excessive amount of alcohol there. In Minnesota and other states, legislation has since been passed defining that liability. A similar pattern emerged with environmental impairment liability.

In the areas of medical malpractice and liability, courts and legislatures have determined that statutes of limitations do not begin for children until they reach the age of eighteen. Thus, in Minnesota, insurers are now liable for claims filed up to twenty years after an incident occurs. This is particularly germane for malpractice insurance for obstetricians and for day care liability.

The increasing numbers and size of claims and the expanding definitions of liability make it difficult to predict the future on the basis of past experience. Lines of insurance, such as medical malpractice and workers' compensation, have extended time periods over which claims are paid and before the full extent of the claims are known. As a result, insurance companies often view these lines as more risky than lines such as property damage where the extent of a loss is quickly determined. Since insurance companies succeed, to some extent, on their ability to evaluate risks, the inability to accurately predict future claims has made many companies reluctant to issue liability insurance to many professionals and businesses.

2. THE INSURANCE UNDERWRITING CYCLE

Insurance companies determine today's rates on the basis of expectations of future claims, or "losses". The "underwriting margin" or "underwriting profit" is the percent of premium remaining after losses and operating expenses are paid. For many lines of insurance, losses are not paid for many months or years after the premium is collected. This is particularly true for liability insurance, since lawsuits may be filed several years after an injury occurs and outcomes may take several years to determine. Thus, projections of future losses are estimates and actual experience will deviate from these estimates.

When future loss estimates are below actual experience, insurance company profits exceed expectations. Companies will likely have excess funds or "surplus" and will be in a position to write more premiums and increase their business. In a competitive market, companies will lower their premiums in order to attract more customers. These lower premiums, however, may not be sufficient to cover future losses and expenses. Thus, at some point in the future, companies begin to experience operating losses and must draw on their surplus to pay claims. When this occurs, companies begin to compensate by reducing the amount of new business they undertake and raising their rates. When profits are restored, competitive pressures once again drive rates down. This continuous process of expansion and contraction, with concomitant rate increases and decreases, is known as the "underwriting cycle." It is an integral aspect of the insurance industry.

The effect of the underwriting cycle on insurance availability is increased by the requirement that insurance companies maintain an adequate

level of surplus to pay larger than expected claims. Failure to maintain adequate surplus increases the risk of insolvency. When an insurance company experiences operating losses and has to use its surplus to pay claims, it must either raise new capital or issue less insurance in order to maintain an adequate level of surplus. Thus, it tends to withdraw from those lines of insurance which are perceived as being most risky and which have the lowest potential for profits.

Because of the unpredictability of jury awards and court interpretations of the extent of liability and the length of time it takes to settle claims, commercial and professional liability lines are viewed as very risky by insurance companies. In addition, insurers may lack the specialized expertise necessary to adequately evaluate risks for specialized lines of insurance such as day care, long haul trucking, or nurse midwives malpractice liability. Furthermore, it may not make economic sense to develop these skills and absorb other operating expenses for the relatively small amount of profits that can be earned in these specialized lines.

In 1984, losses in the property/casualty lines resulted in a three percent, or \$2 billion decline in surplus.⁸ As a result, in 1985, many insurance companies began withdrawing from specialty lines such as day-care, professional liability and municipal liability.

Another factor which influences the insurance industry's capacity to sell insurance is the availability of reinsurance. Insurers purchase reinsurance to transfer risks to other insurers. Reinsurance is often used to cover very large losses. By limiting an insurance company's exposure, reinsurance allows the insurance company to safely sell more insurance. Reinsurers also had poor operating results in 1984, and their surplus declined by seven percent.⁹ As a result, they have cut back on their business in 1985. Many insurance companies which would otherwise be willing to take on more business will not do so because they cannot purchase reinsurance to reduce their exposure.

Another important factor influencing the underwriting cycle in recent years has been fluctuating interest rates. Insurance companies invest money which is earmarked for future claim payments. During the late 1970s and early 1980s, when interest rates were very high, many companies were willing to accept relatively large underwriting losses because the income earned on invested premiums offset those losses and allowed companies to achieve overall profitability. However, as interest rates declined, insurance companies have had to face the realities of inadequate premiums and dwindling surpluses. In order to remain profitable (or in some cases, return to profitability), insurance companies have had to raise their rates.

⁸A. M. Best Company, *Best's Insurance Management Reports*, April 8, 1985.

⁹A. M. Best Company, *Best's Insurance Management Reports*, August 1985.

In Table 5.5, we present data on insurance industry loss ratios for selected lines of insurance for Minnesota and the U.S. as a whole. Figure 5.2 presents the total property/casualty insurance industry loss ratios for Minnesota and the U.S. for the years 1970 through 1984. Figure 5.2 shows the cyclical pattern discussed above. Loss ratios were low in 1972, peaked in 1975, declined again in 1978, and have risen steadily since then. If the theory of the underwriting cycle is correct, and ignoring major catastrophes such as the hurricanes that occurred in 1985, we would expect loss ratios to decline in 1985 or 1986 as a result of recent price increases and stricter underwriting criteria.

Table 5.5 also shows that the steepest and most consistent rise in loss ratios since 1980, both in Minnesota and the U.S. as a whole, has been for the commercial lines of insurance. For example, commercial multi-peril loss ratios in Minnesota have gone from .56 in 1980 to .96 in 1984. This means that for every dollar of premium taken in, 96 cents were incurred in claims. The corresponding loss ratios for the U.S. as a whole for commercial multi-peril insurance were .55 in 1980 and .87 in 1984. "Other liability" loss ratios have risen in Minnesota from .55 in 1980 to 1.07 in 1984. For the U.S. as a whole, the rise has been from .57 to .99. By contrast, loss ratios for homeowners insurance have remained stable for the U.S. as a whole (.67 in 1980, .68 in 1984) and even declined in Minnesota (.78 in 1980, .59 in 1984).

If other operating expenses were taken into account, it is clear that premiums alone were not sufficient to pay claims and meet expenses in commercial liability lines and that a considerable amount of investment income would be required to make those lines profitable. These data, together with the data we presented in Chapter 3, do not indicate that these lines have been excessively profitable in recent years.

The Department of Commerce is concerned that there is insufficient competition in several specialty lines of insurance to ensure that the rates are reasonable. Because there are few companies which issue insurance in specialized lines, it is possible for those companies to charge higher rates than are justified by projected claims. Administrative and overhead expenses necessary to gain expertise in these lines plus a limited volume of potential business might discourage other companies from entering these markets even if profits are currently excessive.

We believe there is sufficient reason to question whether adequate price competition exists in these specialized lines. However, because of the absence of data on rates and market shares in specialized lines (issues we discussed in Chapter 2), we cannot conclude that insurers are taking advantage of a non-competitive situation by charging excessive rates.

The department questions whether recent rate increases for certain specialized lines of insurance are justified by the level of claims in Minnesota. For example, it points to Insurance Services Office (ISO) data which indicate that day care insurance claims cost only 17 cents per dollar of premium between 1980 and 1983. This would indicate high profits if that loss ratio were expected to remain low in the future. Insurance industry officials contend, however, that day care insurance premiums cannot be

TABLE 5.5

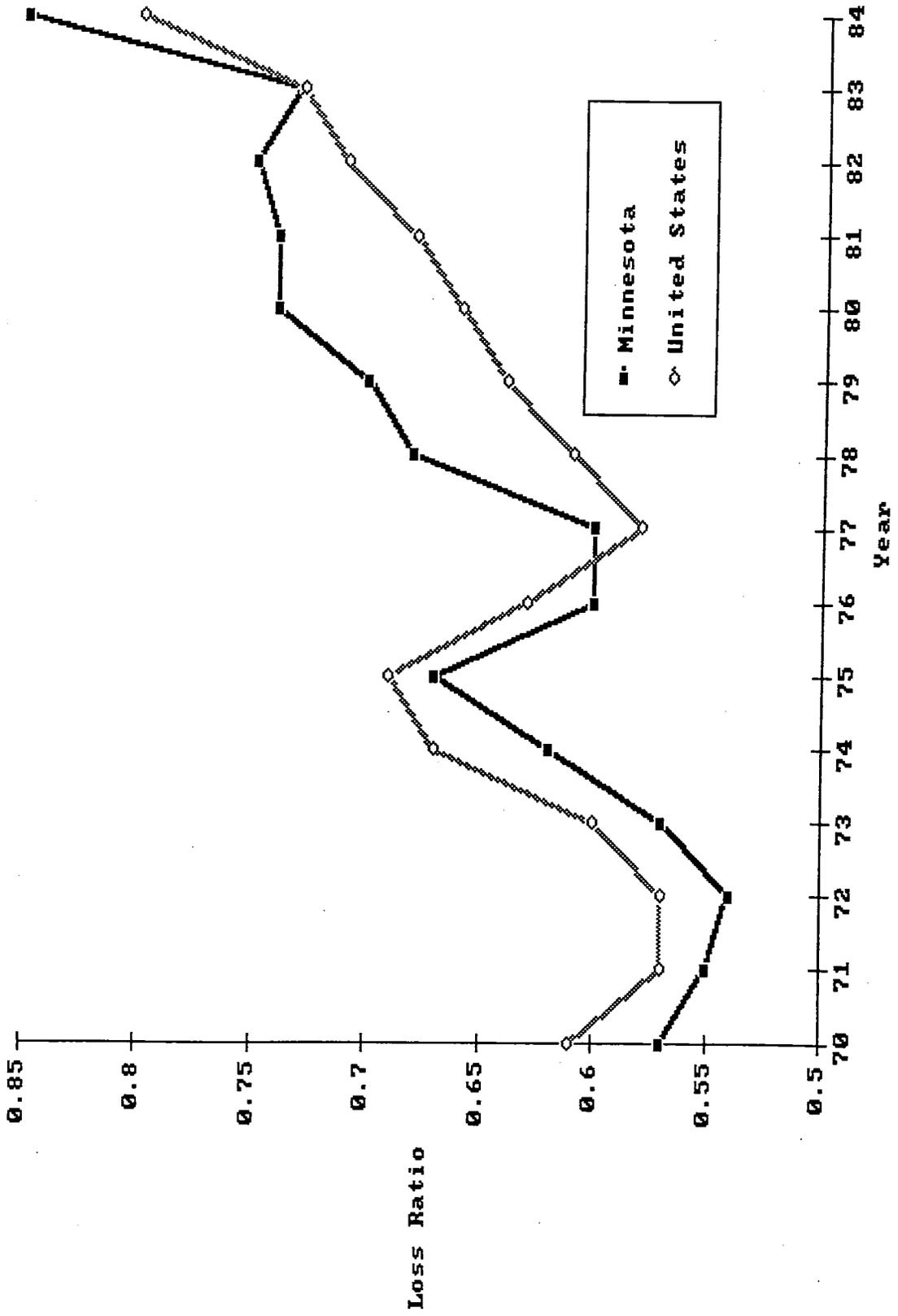
ADJUSTED LOSS RATIOS FOR SELECTED LINES OF INSURANCE^a

Line of Insurance	Minnesota					United States				
	1980	1981	1982	1983	1984	1980	1981	1982	1983	1984
Personal Auto Liability	.78	.74	.71	.77	.91	.66	.71	.73	.73	.78
Homeowners Multi-Peril	.78	.63	.57	.64	.59	.67	.63	.65	.66	.68
Farmowners Multi-Peril	.99	.78	.84	.96	.89	.77	.71	.80	.70	.81
Commercial Multi-Peril	.56	.59	.70	.65	.96	.55	.60	.67	.75	.87
Commercial Auto Liability	.66	.69	.81	.89	1.00	.69	.77	.85	.91	1.02
Medical Malpractice	.66	.57	.65	.60	.78	.83	1.00	1.11	1.06	1.11
Other Liability	.55	.60	.76	.89	1.07	.57	.64	.77	.83	.99
Workers Compensation	.87	1.00	1.04	.84	1.26	.70	.72	.70	.78	.92
Individual Accident and Health	.62	.72	.70	.72	.89	.73	.69	.68	.73	.73
ALL LINES	.74	.74	.75	.73	.85	.66	.68	.71	.73	.80

Source: Best's Executive Data Service.

^a Adjusted loss ratios are: $\frac{\text{incurred losses}}{\text{earned premiums} - \text{dividends to policy holders}}$ Expenses and investment income are not included in these ratios.

FIGURE 5.2
LOSS RATIOS FOR MINNESOTA AND THE U.S.,
1970-1984



Source: Best's Executive Data Service.

based on loss ratios for Minnesota alone because there are not enough policies to be statistically representative of true risk. For example, the ISO's ratio for Minnesota in 1983 was based on a premium volume of \$98,000. A single claim of \$300,000 would change the loss ratio from .16 to 3.24. Thus, industry officials argue that national data must be used to estimate the risk of major claims. ISO data show that nationally, day care losses grew from 70 cents per premium dollar in 1980 to \$1.33 per premium dollar in 1983.

ISO data for day care liability, municipal liability and dram shop liability insurance are shown in Table 5.6. Loss ratios for municipal liability insurance were 1.92 for Minnesota and 2.10 nationwide in 1983. These data suggest that rate increases are necessary to make this line of insurance profitable. However, the amount of increase which is reasonable depends on several factors which the available data do not address. These include operating expenses, investment income and current loss trends.

TABLE 5.6

1983 LOSS RATIOS FOR SELECTED LINES OF SPECIALTY INSURANCE

Line of Insurance	Minnesota			Nationwide		
	Total Premium (\$000s)	Number of Claims	Loss Ratio	Total Premium (\$000s)	Number of Claims	Loss Ratio
Day Care Liability	\$ 98	7	.16	\$ 3,995	607	1.33
Municipal Liability	2,449	441	1.92	59,396	10,164	2.10
Dram Shop Liability	1,380	28	1.04	14,073	277	0.42

Source: Data presented to the National Association of Insurance Commissioners by the Insurance Services Office, Inc.

In the context of the current phase of the underwriting cycle, where surpluses have been depleted by underwriting losses in commercial insurance, insurance companies are retrenching and abandoning some of the less profitable lines of insurance. In determining where to cut back, they focus on those lines of insurance where recent trends show increased losses, reduced predictability and increased risk. Accordingly, we find that:

- On the whole, there is no conclusive evidence that the current availability crisis for commercial liability insurance is the result of excessive rates and profiteering.
- To a large extent, the current availability crisis for commercial liability insurance has resulted from a period of rising claims, diminished profitability, and greater perceived risks in those lines.

C. PROSPECTS FOR THE FUTURE

A study by the Insurance Services Office (ISO) indicates that insurance availability problems will peak in 1987.¹⁰ The study indicates that the capacity shortage for property/casualty insurance will grow from five percent of the market in 1985 to 18 percent of the market in 1987. If accurate, such a shortage would be unprecedented for the insurance industry. However, during the last quarter of 1984 and the first half of 1985, surpluses grew faster than ISO had estimated despite continuing underwriting losses. Capital gains and infusions of new capital brought the total property/casualty surplus to \$68.7 billion on June 30, 1985.¹¹ ISO had predicted that the surplus would decline to \$58.1 billion by the end of 1985.

Whether the availability problem will become more severe during the next two years remains to be seen. Nevertheless, as price increases restore the industry's profits, the industry should be able to attract the capital it needs to meet insurance demands. ISO predicts, however, that an end to the general capacity shortage will not necessarily solve the problems faced in particular specialty lines.

D. ALTERNATIVES FOR ADDRESSING CURRENT AVAILABILTY PROBLEMS

Although prospects for the future availability of insurance will improve as profits are restored, there is still a legitimate need for the state to act to ensure that insurance is available, currently and in the future, where availability is vital to the public interest. In this section, we review the mechanisms currently being used to address availability problems and suggest some additional options which may be explored.

¹⁰Insurance Services Office, Inc., "The Coming Capacity Shortage", February 1985.

¹¹Insurance Services Office, Inc., "Operating Results: First Half 1985 Analysis", August 30, 1985.

1. SURPLUS LINES INSURANCE

Some lines of insurance are so specialized that few companies provide them. In order to facilitate the provision of these types of insurance, Minnesota law allows companies and agents to file as "surplus lines" insurers. Surplus lines are defined as those lines of insurance for which coverage is believed by the Commissioner of Commerce to be generally unavailable from licensed insurers. The Commissioner is required to provide a list of surplus lines every six months.¹² Surplus lines insurance is exempt from the rate and form filing requirements pertaining to other insurance except that rates shall not be discriminatory and forms shall not contain language which misrepresents the true nature of the policy.¹³

Examples of surplus lines insurance contained on the Commissioner's list are taxis, skydiving, auto racing, amusement park liability, dramshop liability, environmental impairment liability, liability for several professional groups including accountants, investment advisors, surveyors and public officials, and so on.

The surplus lines statute eases the regulatory burden on companies wishing to provide these lines of insurance and, in that sense, increases the likelihood that insurance will be available. However, there is no guarantee that it will be available for all lines or that the rates will be affordable for those wishing to purchase it. Nevertheless, surplus lines is a useful facilitator for making available those lines of insurance with low demand where public policy does not require that it be available to all consumers who desire it.

2. SELF INSURANCE AND POOLING

Large commercial establishments and governmental entities may be able to insure themselves, provided that they have sufficient resources to cover large claims. A less risky proposition would be to self insure and to then acquire reinsurance for claims in excess of a very high deductible. For example, a company called American Casualty Excess Insurance provides \$100 million of coverage in excess of \$100 million that the policyholder must provide in self insurance.¹⁴ Obviously, self insurance is only viable for large companies or governmental units and may be contingent on the availability of reinsurance.

Some professional associations and industry groups have resorted to insurance pools. These arrangements have been popular among public utilities, fuel distributors and professional groups such as lawyers and

¹²Minn. Stat. §60A.201, subd. 4.

¹³Minn. Stat. §60A.197.

¹⁴Andresky, Jill, et. al., "A World Without Insurance?", p. 43.

accountants.¹⁵ These pools provide sufficient resources to increase the viability of self insurance or attract insurance companies by offering a greater volume of business. Municipal governments and counties have also been forming self insurance pools. In Minnesota, the Minnesota League of Cities offers several lines of insurance to municipalities. Workers compensation insurance is offered by the Association of Minnesota Counties, which hopes to begin offering other lines of insurance in 1986.¹⁶

These pooling arrangements may prove to be viable alternatives for those groups and individuals that are eligible. Because they serve members of an organization, as opposed to strangers, and because members share in the losses of fellow members, there is the potential for greater efforts at risk management, such as improved security and safer facilities. Nevertheless, risk pooling is not a viable alternative for all consumers. In fact, some risk pools have their own underwriting criteria and exclude those who pose unacceptable risks. Thus, while risk pooling arrangements offer a solution for some consumers, other solutions are also required.

3. MARKET ASSISTANCE PLANS

Market assistance plans are voluntary arrangements in which insurance companies cooperate to make insurance available for those lines in which consumers are having trouble finding insurance. In most cases, surplus lines insurers and licensed property/casualty insurers form a committee to assist insurance agents and consumers in obtaining insurance. There may be an agreement among the companies to apportion among themselves those risks which cannot be placed by any other means.

Market assistance plans work only for those lines of insurance where some companies are willing to issue policies. If the line of insurance is truly unavailable, it means that the insurance industry considers that type of risk to be too great to insure. Under these circumstances, a voluntary plan would probably not work and a government mandated plan would be necessary to ensure that insurance is available.

Approximately twenty states have market assistance plans for one or more line of insurance. In Minnesota, there have been no formal market assistance plans but an informal plan has been in effect for dramshop insurance. The dramshop plan has been effective in locating insurance for all bars that seek the plan's assistance. It must be noted, however, that Minnesota also has an assigned risk plan for dramshop insurance. The existence of a fallback mandatory plan may provide an incentive to insurance companies to participate in the voluntary plan where they can maintain some control over the assignment of cases.

¹⁵Andresky, Jill, et. al., "A World Without Insurance?" p. 43.

¹⁶Adams, Jim, "Small Counties, Cities Hit Hard by Insurance Costs", *Minneapolis Star and Tribune*, October 24, 1985.

4. ASSIGNED RISK PLANS

An assigned risk plan is a method of ensuring that consumers who are unable to obtain insurance on the open market do not have to go without it. It is a mechanism primarily designed for those situations in which the state mandates insurance coverage or where the state determines that it is in the public interest that all consumers be able to obtain insurance. Before 1985, there were assigned risk plans for auto (Minnesota Automobile Insurance Plan), property owners (FAIR Plan), workers' compensation and health insurance (Minnesota Comprehensive Health Association).¹⁷ In 1985, an assigned risk plan for dram shop liability was created and a joint underwriting association for medical malpractice insurance was activated. As of November, 1985, only one policy had been issued by each of these two new assigned risk plans.

All of the assigned risk plans have, as a criterion for eligibility, a requirement that the purchaser has been denied insurance through the voluntary market. In the case of auto and workers compensation insurance, the coverage is the standard coverage available in conventional policies. In the case of the FAIR Plan, coverage is restricted to fire and property damage and is only provided in urban areas. The Minnesota Comprehensive Health Association issues two general health insurance policies (differing in deductible amounts) and a medicare supplement policy.

Rates for the auto and workers compensation plans are determined on an actuarial basis. Workers Compensation rates must be greater than rates available on the open market. Since these plans serve customers who present an above average risk, the rates would normally be higher than market rates. The FAIR Plan uses the rates suggested by the Insurance Services Office for dwellings of the same size and construction. It adds a 35 percent surcharge for rental and commercial property. The Minnesota Comprehensive Health Association charges 25 percent more than the average rates of the five largest health insurers in Minnesota.

The auto and workers compensation plans assign consumers to an insurance company in proportion to the company's premium volume in Minnesota. All insurance companies issuing that type of insurance are required to accept assigned risk customers. The FAIR Plan and the Minnesota Comprehensive Health Association (MCHA) issue policies themselves and assess insurance companies for any underwriting losses experienced by the plans. The assessment is in proportion to the company's premium volume in the respective line of insurance. In the case of MCHA, the assessment to insurance companies may be offset by a premium tax reduction equal to the assessment.

It is clear that these assigned risk plans have the potential for passing their costs along to other insurance customers or to taxpayers. For

¹⁷There is also a catastrophic health insurance plan and an "assigned claims plan" for parties such as pedestrians who are injured in automobile accidents and who do not have no-fault personal injury protection or uninsured motorist protection. We view these as social programs rather than assigned risk plans and have not reviewed them in this report.

example, MCHA assessed insurance companies \$4.8 million in 1983, and a total of \$14.6 million since 1980.¹⁸ Health insurance companies, however, are permitted to deduct their assessments from the premium taxes they pay the state. Thus, part of the cost of MCHA is borne by the taxpayers. The costs of the FAIR plan are assessed to Minnesota insurance companies. Although we were unable to determine the total amount of the assessments, data provided to us by the current administrator of the FAIR Plan indicate that, between 1979 and 1984, loss ratios for policies covered by the plan ranged from .84 to 1.71, considerably higher than the industry averages reported in Table 5.5. In the case of the auto and workers compensation plans, losses must be absorbed by insurance companies or recovered by increasing rates to other customers. Workers compensation incurred losses have not exceeded premiums since the department took over administration of the plan in 1983. Loss ratios for the auto assigned risk plan were higher than the industry average between 1979 and 1982, but slightly lower in 1983.

There are public benefits to these assigned risk plans which, it is argued, justify their costs. Individuals and businesses who cannot get property insurance could suffer severe hardships in the event of an uninsured loss. Uninsured health costs would also cause severe hardships and might necessitate some form of government assistance. The same could be said in the case of workers compensation and auto insurance. Here, the victim of an accident also benefits if insurance is available to all.

We believe that current availability problems for several lines of commercial insurance would be mitigated by the establishment of assigned risk plans. Accordingly, we recommend that:

- Under specific conditions, the Commissioner of Commerce be granted the authority to institute assigned risk plans for those lines of commercial insurance that are not available in the voluntary market.

We offer this recommendation with some concern that assigned risk plans not be viewed as an easy solution to all availability and affordability problems. As noted above, assigned risk plans impose a cost on other consumers or taxpayers and should not be established in every instance in which an individual or business cannot obtain insurance. Unless it decides otherwise, the state does not have an obligation to obtain insurance for every person or business simply because they want it. The costs and benefits of a mandatory assigned risk plan should be carefully weighed by the Legislature before it is established.

We offer the following guidelines for the Legislature in considering whether to establish assigned risk plans:

- Assigned risk plans usually increase costs to other consumers or taxpayers. Accordingly, they should be viewed as a plan of last resort.

¹⁸Minnesota Comprehensive Health Association, "Financial Statements and Supplemental Data".

- The department should encourage the creation of a voluntary market assistance plan before establishing a mandatory assigned risk plan.
- Assigned risk plans should only be established after an administrative hearing which finds that a particular line of insurance is unavailable. They should not be used as a remedy for high rates in a line of insurance that is readily available.
- Assigned risk plans should be limited to those lines of insurance that are mandated by the state or where a clearly articulated public purpose is served by maintaining the availability of insurance.
- If assigned risk plans are established for commercial liability lines, steps should be taken to ensure that the price of insurance is actuarially sound. In some instances, it may be reasonable to establish a surcharge to assigned risk customers to reduce the likelihood that their losses will be subsidized by other consumers or taxpayers.

5. CHANGING THE REGULATORY FRAMEWORK

The Department of Commerce has recently proposed legislation which would have the effect of instituting prior approval of property/casualty insurance rates. The department's proposal would impose a 30-day period between the time that a rate change is filed and its effective date. The proposal would allow the Commissioner of Commerce to request information supporting the proposed rates, in which case the 30-day suspension period would not begin until all the information is supplied. If the Commissioner is not satisfied that the proposed rates are in compliance with the law, he could order that a hearing be held and further suspend the effective date of the rates until 30 days after the final hearing order, including any orders after reconsideration or appeals, is rendered. In other words, no property/casualty rate change would become effective until the Commissioner of Commerce allowed it to be approved or a hearing determined that the rate was reasonable.

Our discussion of rate and forms review, presented in Chapter 2, indicated that most lines of insurance are competitive. We see no economic reasons, therefore, for instituting a system of prior approval for most lines of insurance. We also noted in Chapter 2 that the Commissioner of Commerce already has the authority, after a hearing, to institute prior approval of rates for those lines of insurance where competition is found to be insufficient. Short of that, the department can disapprove any rate increase that is excessive. We believe that the recommendations we offered in Chapter 2, aimed at improving the department's ability to monitor competition and to deal with those situations in which competition is not sufficient, would be more effective and efficient than undertaking major changes in the regulatory system.

There is no basis to conclude that a prior approval system would solve the availability problem. Many of the specialty lines which have experienced

rapid rate increases are provided by surplus lines insurers that are not subject to rate filing requirements. Furthermore, there is no persuasive evidence that prior approval results in lower rates. Studies which have attempted to compare loss ratios across states have produced contradictory results as to whether prior approval states have higher loss ratios (and, therefore, lower profits) than competitive states.¹⁹ Finally, if a prior approval system were effective in reducing profits, it might exacerbate the availability problem. Insurers might simply choose not to issue insurance in Minnesota for lines it believes are unprofitable.

The availability problem is confined to a relatively small portion of the insurance market. We believe that the crisis will abate as the underwriting cycle begins to turn toward greater profitability. Therefore, we conclude that:

- Major changes in the regulatory framework, such as reinstating prior approval for all lines of property/casualty insurance are, in our opinion, unnecessary.

6. TORT REFORM

Another approach to the problem of high insurance rates and limited availability of commercial liability insurance is to enact measures to reduce the frequency and size of damage awards. Many states have tried to do this by enacting changes in the tort liability system. These "reforms" seek to reduce the number and amount of awards by making it more difficult to prove liability, making it more difficult to sue, or limiting the amount of damages that can be recovered in a lawsuit. In this section, we discuss some of the major tort reforms and review the extent to which they have survived attacks on their constitutionality. We also look at some studies which have examined the effectiveness of tort reforms in reducing claims.

This section is not offered as a thorough analysis of tort liability issues, nor have we conducted independent legal research. Nevertheless, we believe the issue of tort reform is of sufficient importance that the Legislature should consider major tort reform approaches and their effects. Below, we present a short list of tort reforms that have been tried around the country. These are not offered as recommendations but as a list of options to consider in a serious study and debate of this subject. This list was drawn principally from studies of the medical malpractice situation but many of the proposals have broader applicability.

¹⁹For a review of the pertinent literature, see Harrington, Scott, "The Impact of Rate Regulation on Prices and Underwriting Results in the Property Liability Insurance Industry: A Survey", *Journal of Risk and Insurance*, Vol. 51, pp. 577-623, December 1984.

a. *Caps on Liability*

Seventeen states have imposed limits on the amount of damages that can be recovered through a civil action. Some states limit total damages and some states impose a limit on non-economic damages, such as pain and suffering. The purpose of these limits is to remove the emotional appeal that the victim of an accident or malpractice has suffered enormously and restrict a jury to a consideration of actual economic damages with a smaller compensation for pain and suffering. At least two state supreme courts have struck down these caps as unconstitutional because they applied only to specific types of lawsuits, such as medical malpractice, and deny groups, such as medical patients, equal protection under the law.²⁰

A study by the Rand Institute for Civil Justice of jury awards between 1975 and 1978 found that, within two years of enactment, states with caps on damages had an average decrease of 19 percent in the size of awards.²¹ The long term effects of caps on liability have not been ascertained.

b. *Reducing Attorneys' Fees*

The most common arrangement for payment of the plaintiff's attorney fees in a personal injury or liability case is the "contingent fee" whereby the attorney receives a percentage (usually between 33 and 50 percent) of the award or settlement made to the plaintiff. Twenty-three states have imposed some form of restriction on attorneys fees. The two most common types of restrictions are a requirement for court review of attorneys fees to determine whether they are reasonable, and the establishment of fixed limits on the percentage of the award that the attorney can claim as a fee. Limits are most often based on a sliding scale, with the percentage decreasing as the award increases.

The rationale behind limits on attorney fees is that it will cut down on frivolous lawsuits and reduce the amount of damages requested. On the other hand, it is argued that the contingent fee system itself deters attorneys from accepting cases that they do not think they will win, since they receive no fee if they lose. Contingent fees might also encourage attorneys to settle cases rather than risk losing them.

Limits on attorneys fees have, for the most part, withstood court challenges. An exception is New Hampshire, where the state's supreme court ruled that a sliding scale fee limit interfered with the freedom of contract between plaintiffs and lawyers.

²⁰Information on court rulings concerning the constitutionality of tort reform is drawn from American Medical Association Special Task Force on Professional Liability and Insurance, "Professional Liability in the 80's", October 1984.

²¹Danzon, Patricia M., *The Frequency and Severity of Medical Malpractice Claims*, Santa Monica, CA, the Rand Institute for Civil Justice, 1982.

c. *Shortening Statutes of Limitation*

Statutes of limitation are fixed limits on the length of time following an injury that a person has to file a lawsuit. All states have statutes of limitation applicable to all tort actions. Shorter statutes of limitation make writing professional liability insurance more actuarially predictable, thereby reducing insurance companies' reluctance to issue such insurance. In Minnesota, the statute of limitation for most tort actions is six years. For medical malpractice, the statute of limitation is two years, except that the two year period does not begin for minors until they reach the age of majority.

In most states, statutes of limitation have withstood court challenge. However, some courts have struck down statutes of limitation for minors since the extent of their injuries may not be known for some time. In some cases, courts have also ruled that the statutory period only begins when the injury is discovered.

d. *Pre-trial Screening Panels*

Pre-trial screening is used by many states in medical malpractice lawsuits. Typically, this entails review of all medical liability claims by a panel of doctors, lawyers and laypersons. The panel's decision is not binding, but it can be introduced into evidence at a trial. The purpose of these panels is to reduce legal costs, by encouraging the loser of a panel's decision to drop or settle a case, and to quicken case dispositions.

A study by researchers at George Washington University found that pre-trial screening is effective in speeding up disposition of claims only in states where it is mandatory.²² Voluntary systems were found to be often inactive and underutilized. The Rand study found that neither pre-trial screening nor arbitration had any effect on size and frequency of claims.²³ Pre-trial screening has been found to be constitutional by ten state supreme courts and unconstitutional by four.

e. *Eliminating the Collateral Source Rule*

The collateral source rule of evidence prevents a jury from learning that a plaintiff has been compensated from another source, such as health insurance or worker's compensation. This presents a potential for double recovery, although an insurance company may have a clause in its policy that it can get its money back from any award the victim receives. Nineteen states have either allowed juries to consider other sources of compensation to a defendant or required that the award be reduced by the amount of collateral compensation.

²²Carlin, Peter E., "Medical Malpractice Pre-trial Screening Panels: A Review of the Evidence," Intergovernmental Health Policy Project, George Washington University, October 1980.

²³Danzon, Patricia M., *The Frequency and Severity of Medical Malpractice Claims*, p. 31.

The Rand study cited above found that in states where a mandatory offset of collateral was imposed, the severity of awards dropped by 50 percent over a two-year period.²⁴ The long-term effect of this reform has not been measured. In general, collateral source rule changes have survived court tests.

f. *Periodic Payment of Damages*

Seventeen states have passed statutes which either require or permit courts to award damage payments periodically, rather than in a lump sum. The purpose of these statutes is to compensate victims for actual medical payments as they are incurred, rather than speculating on the total future loss and requiring a defendant to make a lump sum payment on that basis.

g. *Changes in Procedural or Evidentiary Requirements of Trials*

In an effort to impose greater burdens on the plaintiffs of a personal injury case, several states have changed evidentiary and procedural aspects of trials. For example, twelve states have abolished the doctrine (known as *res ipsa loquitur*) in medical malpractice suits that certain injuries are presumed to be the result of negligence on the part of a physician or hospital. Ten states have established qualifications for expert witnesses in medical malpractice cases. Eighteen states have established standards of care which different medical professionals are expected to provide to their patients. Thirty-one states have prohibited any mention in a claim of the dollar amount demanded in damages, fearing that it may generate publicity which prejudices a jury. Because these reforms are specific to medical malpractice, they are subject to a constitutional challenge that they do not provide for equal protection to all citizens.

Purchasers of commercial liability insurance such as physicians and other professionals, governmental units and manufacturers, have experienced rapid increases in insurance costs. One cause of these increases has been escalating damage awards and settlements. Many states have attempted to reduce the size and frequency of damage awards by reforming the tort liability system. Although the evidence is inconclusive, it indicates that some of these efforts have met with success.

In Minnesota, a debate has emerged between the proponents and opponents of tort reform. A recent report by the Minnesota Commission on Professional Liability, a commission established by the Minnesota Medical Association, recommends that several tort reforms be instituted in Minnesota. These include shortening the statutes of limitation applicable to minors, eliminating punitive damages from medical malpractice lawsuits, limiting awards for pain and suffering, abolishing the collateral source rule, allowing periodic payments of awards and informing juries that awards for personal injuries are not taxable.²⁵

²⁴Danzon, Patricia M., *The Frequency and Severity of Medical Malpractice Claims*, p. 31.

²⁵"Report of the Minnesota Commission on Professional Liability", pp. 20-22.

On the other hand, a report recently issued by the Minnesota Trial Lawyers Association questions the suggestion that medical malpractice awards have been skyrocketing. This report attributes much of the blame for the rapid increase in medical malpractice insurance premiums to mismanagement and profiteering by insurance companies. The report notes that only a small fraction of medical malpractice cases go to juries and that defendants (doctors) win the majority of those cases. The report concludes that proposed tort reforms will punish victims of medical malpractice while having a minimal impact on malpractice insurance rates.²⁶

Minnesota has experimented less than other states in introducing tort reforms. We believe that an effort needs to be undertaken, concurrent with action on other recommendations of this report, to study and debate these and other changes to the tort liability system. We are aware that fundamental constitutional issues are involved in many of the reforms listed above, and that the remedies found to be most effective may be highly controversial. For this reason, we believe that it is the Legislature, not the Department of Commerce, that should take the lead in debating and evaluating the rights of individual plaintiffs and the public as a whole.

²⁶Minnesota Trial Lawyers Association, "The Insurance Industry: A Crisis?" December 1985.

Data Processing Support

Chapter 6

In this chapter, we pull together some observations, most of which have been alluded to elsewhere in this report, about the effectiveness of the Department of Commerce's data processing support for its insurance related functions.

The department has sizeable record keeping, clerical and analytical functions that require effective and efficient data processing systems. The nature of the department's insurance related operations is such that an effective performance rests in part on how well its data processing and information requirements are being handled.

In our interviews with staff and management, we asked questions about data processing support, particularly the adequacy of the department's computerized systems. Responses to these questions indicated a general frustration and concern on the part of management and staff with the department's computers and information management systems. We discuss this concern in the context of each of the three organizational sections that use automated data processing systems.

A. COMPLAINT INVESTIGATIONS

The department has been keeping computerized records of all investigations opened since 1983. Department staff are limited, however, in their ability to analyze data and have extreme difficulty producing useful reports. For example, our interviews with investigators revealed instances of more than one investigator working on the same case due to an inability to use the computer to cross reference cases. We observed file clerks waiting at a computer terminal for over 15 minutes for the system to clear so they could gain access to computer records of a case. In fact, of the 22 investigators we interviewed, 17 said that their data processing system was inadequate, four said they do not use it, and only one said it was adequate.

Problems with the system are also illustrated by the department's difficulty in providing us with requested summaries of cases filed in 1984

and 1985. The system was designed to provide reports on cases filed by line of insurance, type of complaint, the region in which the complaint was filed as well as alphabetical listings of files by complainant and by insurance company. The department was unable, over a period of months, to provide us with the specific reports we requested. We were also informed that, as of June 10, 1985, the system reached maximum storage capacity and could no longer handle additional cases unless other cases were deleted. These problems render the system inadequate as a tool for coordinating efforts among investigators or for assisting the department in uncovering systematic patterns of unfair trade practices.

The department has recognized the inadequacy of its current system and has stopped using it for enforcement records. A new computer has been acquired and is currently being used for FY 1986 cases. This system is supposed to be more flexible than the former system and is expected to produce timely reports upon request.

B. POLICY ANALYSIS

The policy analysis section is also hampered by an inadequate data processing and management information system. For example, although the department has been keeping computerized records of all rate and form filings, it can no longer produce summary reports. Thus, the system cannot be used to track company activities or industry trends. The inadequacy of the department's data management system also limits the department's ability to monitor competition and rate increases. This will be even more important after the filing exemption for commercial policies is lifted in 1986. Currently, surveys of availability and affordability must be individually analyzed on personal computers. A centralized information system would be more efficient and allow the department to accomplish its monitoring activities more effectively.

C. LICENSING

The major role of the department's computer system is to maintain an active file of licensed agents. Department staff from the Enforcement and Policy Analysis Divisions attribute their information processing difficulties to the fact that the computer system was programmed primarily to process licenses. Thus, insufficient memory and processing time are available to the other functions of the department. However, the Licensing Division has also encountered problems with data processing. For example, the system cannot currently handle all licensees at one time. Thus, some license records must be referenced from a printed copy. The system is also inflexible. Changes in messages printed on renewal notices require a contractor to be hired to reprogram the computer. Although the Licensing Division has so far been able to perform its duties despite these problems, an effective system would allow the Division to perform its role more efficiently.

D. CONCLUSIONS AND RECOMMENDATIONS

As a result of the deficiencies in the department's information processing and management capabilities noted above, we conclude that:

- Management information and data processing is a problem in the department in the insurance related functions we studied.

Data processing support in the department has not developed from a comprehensive study of department information and data processing requirements. Rather, the system has been put together in a piecemeal fashion. As a result, it is out of date almost as soon as modifications are made. At present, the Enforcement Division is developing its own system and the Policy Analysis Division is planning to do the same. The Licensing Division is willing to cope with the existing system. The department has not directed its efforts towards developing a management information system that is suited to the department as a whole. Thus, the separate computer systems planned by department divisions would make it difficult for the department to target its market conduct studies to companies with high complaint ratios, as we recommended in Chapter 4. The complaint summaries and premium volume necessary to compute a ratio would be on two separate information systems. We believe that the department should undertake a coordinated effort to meet its information processing needs.

- The department does not currently possess sufficient expertise to develop data processing systems that are effective and fit together.

Our discussions with department management and staff have convinced us that the department does not possess sufficient expertise in systems analysis to develop and maintain an adequate data processing and management information system. In the past, a consultant was hired to write computer programs so that an existing computer could be used by the different divisions of the department. That consultant designed an inflexible system which cannot be easily adapted to the department's changing requirements. Furthermore, the consultant has been unable to adequately maintain the system when problems developed and it does not perform as needed. The Enforcement Division has now assigned the responsibility for designing its new system to an insurance investigator with no formal computer or information management training.

The department needs to conduct a systematic study of its information and data processing needs. These undoubtedly go beyond the insurance related functions we are familiar with. Our assessment of in house capabilities suggest that an outside consultant will need to be engaged. The consultant should be totally independent of specific hardware or software vendors. The object of this first effort is a plan for the next few years. Part of the product of this planning process should be a study of the department's data processing staffing needs, although it seems probable to us that the department needs at least some greater capability in this area.

Responsibility for department wide data processing support needs to be assigned to a manager in the department. This does not mean that a

separate data processing division should be created. Nor does this mean that the best data processing approach will be an expensive large processor which requires a specialized staff to operate and which is inaccessible to most other staff. We simply suggest that there should be a person responsible for coordinating the selection of a consultant, implementing the consultant's recommendations and managing the data processing system once it is developed.

The needs of the department, judging from the area of insurance regulation with which we are familiar, are for:

- adequate planning so that data processing capacity is not exceeded almost as soon as the system is up and running;
- better support for research and analysis, so that management can receive essential information on how best to allocate resources;
- better automation of substantially clerical functions such as license renewal and record keeping.

Despite the problems it has encountered with data processing support, the department is, on the whole, adequately performing its regulatory functions. Improvement of its data support system would improve both its efficiency and its effectiveness.

STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

1977

1. Regulation and Control of Human Service Facilities
2. Minnesota Housing Finance Agency
3. Federal Aids Coordination

1978

4. Unemployment Compensation
5. State Board of Investment: Investment Performance
6. Department of Revenue: Assessment/Sales Ratio Studies
7. Department of Personnel

1979

8. State-sponsored Chemical Dependency Programs
9. Minnesota's Agricultural Commodities Promotion Councils
10. Liquor Control
11. Department of Public Service
12. Department of Economic Security, Preliminary Report
13. Nursing Home Rates
14. Department of Personnel: Follow-up Study

1980

15. Board of Electricity
16. Twin Cities Metropolitan Transit Commission
17. Information Services Bureau
18. Department of Economic Security
19. Statewide Bicycle Registration Program
20. State Arts Board: Individual Artists Grants Program

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill
24. State Designer Selection Board
25. Corporate Income Tax Processing
26. Computer Support for Tax Processing
27. State-sponsored Chemical Dependency Programs: Follow-up Study
28. Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights
29. Individual Income Tax Processing and Auditing
30. State Office Space Management and Leasing

1982

31. Procurement Set-Asides
32. State Timber Sales
33. *Department of Education Information System
34. State Purchasing
35. Fire Safety in Residential Facilities for Disabled Persons
36. State Mineral Leasing

1983

37. Direct Property Tax Relief Programs
38. *Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes
39. *Community Residential Programs for Mentally Retarded Persons
40. State Land Acquisition and Disposal
41. The State Land Exchange Program
42. Department of Human Rights: Follow-up Study

1984

43. *Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf
44. The Administration of Minnesota's Medical Assistance Program
45. *Special Education
46. *Sheltered Employment Programs
47. State Human Service Block Grants

1985

48. Energy Assistance and Weatherization
49. Highway Maintenance
50. Metropolitan Council
51. Economic Development
52. Post Secondary Vocational Education: Follow-Up Study
53. County State Aid Highway System
54. Procurement Set-Asides: Follow-Up Study

1986

55. Insurance Regulation
Tax Increment Financing (in progress)
Programs for Mentally Retarded People: The Impact of *Welsch* (in progress)
Programs for Mentally Ill People: The Linkage Between State Hospitals and the Community (in progress)
Public Employee Pensions (in progress)
Fish Management (in progress)

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.