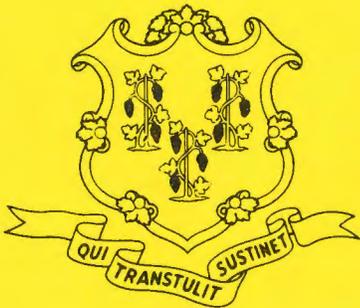


# Insurance Regulation In Connecticut

Connecticut

General Assembly



LEGISLATIVE  
PROGRAM REVIEW  
AND  
INVESTIGATIONS  
COMMITTEE

JANUARY 1988

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements where indicated. In 1975 the General Assembly expanded the committee's function to include investigations and changed its name to the Legislative Program Review and Investigations Committee. During the 1977 session, the committee's mandate was again expanded by the Executive Reorganization Act to include "Sunset" performance reviews of nearly 100 agencies, boards, and commissions, commencing on January 1, 1979.

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INSURANCE REGULATION IN CONNECTICUT

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## SUMMARY

The Legislative Program Review and Investigations Committee conducted a study of insurance regulation in Connecticut and a performance audit of the Department of Insurance. The primary goal of the committee's recommendations, contained in this report, is to ensure that Connecticut consumers are adequately protected yet maintain a competitive insurance marketplace.

The Connecticut Department of Insurance is currently organized into 7 divisions, and the department had been proposing to further expand the agency to 11 divisions. The program review committee found that the current span of control in the department is too broad, resulting in fragmented planning and coordination, and that there was lack of regulatory consistency in overseeing insurance rates, policy forms, and the handling of complaints.

Further, the department has no separate division responsible for information systems and data processing. Consequently, the department lacks adequate data bases to perform its monitoring of insurance markets, rate review, complaint processing, or other regulatory functions efficiently.

The committee examined market competition in Connecticut through several different measures and found that, for most products, a competitive market exists. However, the committee found that the department has not taken an active role in monitoring competition. The committee also found that barriers to market entry do exist in two areas. First, there is a two to three year wait for companies prior to being considered for licensure. Second, a company must first be licensed in an adjoining state before being eligible to do business in Connecticut.

The committee found that the department's record at detecting and protecting against financially insolvent companies is commendable. However, the program review committee concluded that these efforts could be enhanced by using a computerized system and by imposing a late filing fee for those companies delinquent with filing quarterly or annual reports.

In the rate regulation area, the committee determined that no department-wide guidelines exist for reviewing rates, and that methodologies differ from division to division. Also, the department has not linked underwriting guidelines with rate information to assess the true impact of rate increases. Finally, the program review committee considered the setting of rates by rating organizations in the commercial property/casualty area to be an anti-competitive practice.

Similarly, the current policy forms review system lacks department-wide guidelines for ensuring that new policy provi-

sions are treated the same, fostering regulatory inconsistency. The committee also determined that the number of staff in the Life and Health Division was insufficient to meet its forms review workload.

One of the major focuses of the study was on the department's activities in protecting the consumer, especially in handling consumer complaints. Here, the committee found that no one division had responsibility for handling complaints, and the divisions performing that function each processed and recorded complaints differently. The committee found that the department is not currently compiling and using complaint data either to target market conduct reviews or to publish the results as an information source for consumers.

The Legislative Program Review and Investigations Committee also determined that the department has made some efforts in disseminating information on insurance products and pricing to the consumer, but those measures need to be strengthened.

One deficiency the committee found with the department's consumer protection role is the lack of statutory authority to arbitrate disputes between consumers and insurance companies. While the department does have authority to mediate, the program review committee determined, both from its review of complaints and from public hearing testimony, that often mediation cannot resolve claims settlement disputes.

The department's funding mechanism was examined, and the committee determined that the removal of the cap on funding by Public Act 87-515 was a positive step but that the current assessment system remains flawed. For example, because the assessments are based on direct premiums written in Connecticut, one company, Blue Cross and Blue Shield of Connecticut, pays 40 percent of the department's expenses. The program review committee proposed two options designed remedy this flaw.

To correct these deficiencies found during the study, the Legislative Program Review and Investigations Committee makes the following 17 recommendations.

### Insurance Department Reorganization

1. The Legislative Program Review and Investigations Committee proposes a streamlining of the department into five major divisions that are organized along distinct functions. One division, information systems, would coordinate all the department's business administration and information systems. Another division, Consumer Affairs, would handle all consumer protection matters for the department, including consumer information, public inquiries, and complaints. It would also be responsible for examining and investigating the business practices of licensed agents and insurance companies. A third major unit, the Exam-

ination Division, would be responsible for all regulatory activities relating to the licensing of new companies and insurance lines, and the maintenance of financial solvency of companies doing business in Connecticut. Finally, two divisions, organized along product lines, would be responsible for all activities relating to the regulation of rates and review of insurance policy forms. The two product lines are life and health insurance, and property and casualty insurance.

The office of legal counsel would remain separate and report directly to the commissioner.

The Legislative Program Review and Investigations Committee recommends that the insurance department be organized into five divisions based upon the following organizational structure. This structure should be adopted by the Department of Insurance by regulation.

#### Information Systems

2. The Legislative Program Review and Investigations Committee recommends that the department establish and develop various systems in order to integrate financial and statistical information by company, both in Connecticut and country-wide. The system should be capable of:

- conducting the financial tests on companies for solvency;
- determining competitiveness of the market through analysis of market share, pricing information, and other relevant data;
- developing a tracking system for policy submissions, rate submissions, underwriting guidelines and licensure of companies; and
- compiling and analyzing the financial data for selected commercial lines that the legislature has required.

#### Department Funding

3. The Legislative Program Review and Investigations Committee recommends that either of the following be adopted:

A. The current system of assessing insurance companies to fund the department's operating expenses should be abolished. The department would be funded from the General Fund revenues;

or

B. A cap of 20 percent should be placed on the amount any one company, or group of companies under a parent company, could be assessed if the current system is continued.

## Market Competition, Financial Solvency and Rate Regulation

4. The Legislative Program Review and Investigations Committee recommends that the department be required to review and determine every three years whether markets are or are not competitive.

5. To implement this system the department must publish guidelines that define a market and set standards for determining market competitiveness.

The Legislative Program Review and Investigations Committee recommends that the following action be taken to improve the application process and reduce barriers to market entry.

First, the Examinations Division should hire a senior examiner to assist the assistant division chief in reviewing the applications for new companies requesting a license. Secondly, the current regulations should be revised to establish time guidelines for the review procedure similar to the following:

The department should determine if the application is complete within 60 days. If the application is incomplete then it should be returned to the company indicating why it is not being placed on the wait list. No application shall be kept pending unless it is complete. Upon determining that the application is complete, the department shall have 12 months to approve or reject the application. If an application is rejected, the company may request a hearing. Any company whose application is rejected may resubmit the application without prejudice at any time.

6. The Legislative Program Review and Investigations Committee recommends that the regulatory requirement that a company be licensed in a state contiguous to Connecticut be deleted.

7. The Legislative Program Review and Investigations Committee recommends that the department introduce a computerized system using NAIC data in conducting its financial examinations of companies writing insurance in Connecticut.

8. The Legislative Program Review and Investigations Committee recommends that the Financial Examination Division have statutory authority to impose a late filing fee of \$100 for each day a quarterly or annual report is not filed on time.

9. The Legislative Program Review and Investigations Committee recommends that several changes be made to the current rate regulatory system as follows:

The department shall establish two systems of rate review: a system of file and use; and a prior approval system. The file and use system shall be used for all lines of insurance for which a competitive market has been determined to exist by the insurance department. A prior approval system shall be used for insurance products sold in a non-competitive market and for those products sold in the assigned risk markets.

Under the file and use system, the department would have the authority to disapprove rates within a 30-day period, if it determined that the rates were discriminatory or inadequate. The department would have no authority to review rates for excessiveness if the market has been determined to be competitive. To implement this system the department must publish guidelines that define the criteria used to determine discriminatory or inadequate rates.

Rating organizations shall only be allowed to compile and distribute rating information relating to loss costs, loss development, and loss trends.

The department should also maintain a computerized system for tracking and maintaining personal lines insurance guidelines. Notices should be sent to companies annually reminding them to update guidelines. If guidelines remain in effect from a previous year, a company should send a letter attesting to that, otherwise, new guidelines should be filed. A check should be made by the department after 30 days to ensure compliance.

#### Policy Forms Review

10. The Legislative Program Review and Investigations Committee recommends that the Policy and Rating Divisions, for both property/casualty and life and health products should establish a timely review procedure in regulation, as follows:

Any submission for policy approval should be on file with the department not less than 30 calendar days prior to the policy's stated effective date. The department shall have 15 calendar days to determine whether the application is complete or not. If the submission is determined to be incomplete, the submission shall be returned to the company.

If the application is determined to be complete, the department shall have 75 calendar days from the date it was deemed to be complete to make a determination on the application. If no decision has been made at the end of 90 calendar days from the time the policy was initially submitted, the submission will be deemed to be approved.

If the application is disapproved for any reason during the 90-day period, the submission will be returned to the company

with a letter of transmittal stating the reason(s) for denial. The company may resubmit the policy, without prejudice, for approval at any time.

The department should also develop guidelines on methods and criteria for policy review, and division directors should meet monthly to establish the department's position on all new policy provisions and products.

11. The Legislative Program Review and Investigations Committee recommends that the Department of Insurance be authorized to hire three additional examiners in the Life and Health Division, to conduct policy and rate reviews.

#### Consumer Affairs

12. The Legislative Program Review and Investigations Committee recommends that the department:

Consolidate all complaints within the newly created Consumer Affairs Division and process and computerize complaints uniformly.

Establish guidelines and procedures for processing and investigating complaints. Specifically, require insurance companies to respond directly to the department within a certain time. The department should establish performance standards for examiners to meet in processing complaints.

13. The Legislative Program Review and Investigations Committee recommends that the Market Conduct Section, within the newly created Consumer Affairs Division, use the computerized complaint system to analyze complaints by company's volume of business, and use the results to target companies for market conduct reviews.

14. To provide the consumer with information that will assist them in choosing an insurance company, the Legislative Program Review and Investigations Committee recommends the following:

The department should compile and publish quarterly the number and type of complaints received against insurance companies. Complaint statistics should be weighted to adjust for the premium volume of an insurance companies.

15. The Legislative Program Review and Investigations Committee recommends that the department:

- publish an annual pamphlet containing pricing information for personal lines insurance;
- distribute brochures, pamphlets, and information guides according to the distribution plan

previously developed by the department, including procedures for disseminating information through public service announcements, news releases, brochures, libraries, the motor vehicle department, consumer groups, and local government offices;

- publish a consumer guide regarding more specific complaint areas such as nonrenewals and cancellations, claims settlement practices, and mandated coverages listing statutory provisions insurance companies and agents must comply with;
- make consumers aware of the governor's toll-free telephone number which refers insurance complaints to the insurance department; and
- develop a computerized system to update rates, so they would always be current and easily accessible.

16. The Legislative Program Review and Investigations Committee recommends that the department require insurance companies to state for renewal policies the prior year's premium on a consumer's bill.

17. The Department of Insurance shall establish an arbitration procedure for the settlement of disputes between consumers and insurance companies. The arbitration procedure shall apply to automobile physical damage claims only. Any company licensed to write private passenger automobile physical damage (collision, comprehensive and theft) insurance in Connecticut shall participate in the arbitration process.

The arbitration procedure shall be operated within the Consumer Affairs Division, within the Department of Insurance. The department shall be authorized to hire one additional person to oversee and administer the arbitration process.

The commissioner shall prepare a list of at least 10 attorneys, who have not been for at least one year employees of the department or of insurance companies, to serve as arbitrators in the settlement of such disputes. The arbitrators shall be members of the American Arbitration Association. The arbitrators shall be paid on a per diem basis as established by the insurance commissioner. One arbitrator shall be appointed to hear and decide each complaint. Appointment shall be based solely on the order of the list. If an arbitrator is unable to serve on a given day, or if either party objects to the arbitrator, then the next arbitrator on the list will be selected. The department shall schedule arbitration hearings as often, and in the locations, as it deems necessary.

Procedure. The commissioner of insurance shall adopt regulations, in accordance with the provisions of Chapter 54 of

the Connecticut General Statutes, to carry out the arbitration process including provisions for the following. Only those disputes that have first been referred to the department's Consumer Affairs Division, and where attempts at mediation have failed, will be accepted as arbitrable. The referral of the complaint to arbitration shall be made by the department examiner who investigated the complaint.

Parties to the dispute shall be notified of the hearing, at least 10 days prior to the hearing date. The commissioner may issue subpoenas on behalf of the arbitrator to compel the attendance of witnesses and the production of documents, paper and records relevant to the dispute.

Decisions shall be made on the basis of the hearing testimony and materials presented at the arbitration hearing. Where the arbitrator believes that technical expertise is necessary to decide a case, she/he may consult with such experts.

The arbitrator shall, as expeditiously as possible, but not later than 15 days after the arbitration hearing, render a fair decision based on the information gathered and disclose the findings and the reasons to the parties involved. If the decision favors the consumer the decision shall provide specific and appropriate remedies.

The decision shall specify a date for performance and completion of all awarded remedies. Notwithstanding any provisions of the general statutes or any regulation to the contrary, the Department of Insurance shall not amend, reverse, rescind, or revoke any decision or action of any arbitrator.

The department shall contact the consumer within 10 working days after the date for performance, to determine whether performance has occurred.

Either party may appeal the arbitrator's decision. However, if it is determined by the court that the insurance company or consumer has acted without good cause in bringing the appeal, the court, in its discretion, may grant to the consumer or the company their costs and reasonable attorney's fees.

The department shall maintain records of the disputes, including names of parties to the arbitration, decisions, compliance, appeals and appeal outcomes. Annually, the department shall compile these statistics and send a copy to the Insurance and Real Estate Committee of the General Assembly. This report shall be considered a public document.

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CHAPTER I      INTRODUCTION

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## INTRODUCTION

In February 1987, the Legislative Program Review and Investigations Committee authorized a review of insurance regulation in Connecticut. The scope of the study encompasses two major areas: 1) an analysis of the state's regulatory policies and their effect on the insurance business climate, and whether the insurance department's authority is being fully exercised; and 2) a performance audit of the Department of Insurance to determine if it is managed, organized, and funded in the most appropriate manner to provide services efficiently and effectively. The study contains descriptive information and analysis conducted on these major areas. Findings and recommendations are presented in the final chapter of this report.

The Legislative Program Review and Investigations Committee has developed a comprehensive package of recommendations that are primarily intended to strengthen the Connecticut Insurance Department's role in providing assistance and protection for the insurance consumer. The committee's goal is to ensure that consumers are protected through the stringent application of financial solvency tests, while also being afforded the opportunity to purchase insurance products in a competitive market that offers adequate information. To achieve this goal the committee is recommending a reorganization of the department that will improve its ability to service the insurance consumer. Further, recommendations are made to give the consumer better information about the insurance market and to ensure that a healthy and growing industry continues to operate in Connecticut.

The major areas affected by the committee's recommendations include the organization of the insurance department along functional lines, the regulation of rates and policy forms, the handling of consumer complaints, consumer education, market competition, and the licensing of insurance companies. The reorganization will reduce the number of staff directly reporting to the commissioner and consolidate similar functions under five divisions and the office of legal counsel. This will lead to better coordination among department activities that have an effect on the delivery of services and regulatory oversight.

This report is divided into four chapters: I) Introduction; II) Insurance Regulation; III) the Connecticut Department of Insurance and its Regulatory Functions; and IV) Findings and Recommendations.

## Methodology

To develop a clear understanding of the insurance industry, the marketplace, insurance products, and the forms of regulation used, program review consulted a wide range of books, articles, reports, and publications. A list of the literature reviewed is provided in a bibliography in Appendix A. A glossary of insurance terms is contained in Appendix B.

In addition to the general literature, the program review committee also examined insurance market data for Connecticut for the most recent six years. To supplement information in the material, program review conducted extensive interviews of insurance company and industry representatives, department personnel, and others knowledgeable in insurance.

In conducting the review of the department's performance, the following methods were used:

- a review of insurance statutes, regulations, and department bulletins;
- interviews with department personnel, insurance company personnel, and industry representatives, (a listing is contained in Appendix C);
- an examination of the department's written complaint files;
- a review of policy submission logs, and a sample of policies submitted for department approval;
- a review of company audit files, applications for licensure files, financial examination reports, and company insolvencies since 1985;
- an examination of the department's data processing report, market conduct reports, legal decisions, and other documents in the department; and
- an examination of disciplinary procedures, including sanctions imposed for 1985 and 1986.

Actual and appropriated budgets for the period FY 80 to FY 87 were analyzed to determine funding patterns and trends. Staffing for the same period was also examined. A variety of information on insurance departments in other states was gathered for comparative purposes. In addition, three public hearings were held, two in Hartford, and one in Norwalk, to discern how Connecticut citizens and the insurance industry regard the performance of the Department of Insurance. A listing of the persons who testified at these public hearings is contained in Appendix C.

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CHAPTER II            REGULATION AND THE INSURANCE INDUSTRY

SECTION I        Background

SECTION II       Regulation and the Insurance Marketplace

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## SECTION I

### BACKGROUND

Insurance is a device that provides the insured with the reduction of uncertainty of economic ruin caused by an unexpected event. By transferring risks to the insurance company, the company is then able to pool those risks, predict the losses that will occur, and compensate those who suffer a loss, thus enabling the insured to maintain economic security. Insurance contracts can be traced back as far as 1750 B.C., with the development of social (or welfare) and marine insurance. In more recent history, fire, life, and marine insurance coverage was offered during the 1600s and 1700s in Europe.

Similar lines of insurance were being offered in the United States during the 1700's, and by the mid 19th century the insurance industry in America gained a foothold and began to grow. The impetus for insurance regulation came early, an outgrowth of the 1835 Great Fire of New York, which destroyed over 700 buildings. The fire bankrupted the vast majority of insurance companies at the time because they lacked the necessary reserves to pay claims. This gave rise to the need for some regulation of the industry to prevent future insolvencies. In 1837, Massachusetts required companies to establish funds for fulfillment of contracts. Massachusetts was the first state to create an insurance department. Several other states followed soon after. In 1871, the National Convention of Insurance Commissioners, predecessor of the current National Association of Insurance Commissioners (NAIC) met for the first time, with the goal of promoting uniformity in insurance regulation.

The primary concern of both insurance companies and the regulatory authorities was to guard against insurance rates being too low. Regulating authorities wanted companies to charge adequate rates to build sufficient reserves for future claims. Competition was viewed by the industry and its regulators as leading to instability and insolvencies among fire insurance companies. To prevent insolvencies, regulatory bodies encouraged joint rate-making activities among insurance companies although such activities were prohibited by federal anti-trust laws for other commercial ventures.

In an 1869 landmark case, Paul v. Virginia, the U. S. Supreme Court held that insurance was not interstate commerce and, therefore, not subject to federal regulation. For the next 75 years, the industry operated under this exemption, until 1944, when the Supreme Court reversed itself in U.S. v. Southeastern Underwriters Association. In this case, the Court decided that insurance was indeed interstate commerce and, as

such, should be subject to anti-trust laws that prohibited such activities as price-fixing and the joint collection of loss experience.

The effects of this decision were never really felt. Early in 1945, under pressure from insurance companies and individual states, Congress passed the McCarran-Ferguson Act, exempting insurance companies from federal regulation provided the industry was regulated by the states. Consequently, each state has the authority to decide how it will regulate insurance within its boundaries. As will be noted later, regulation of the industry varies significantly from state to state -- from those that use strict government controls to those where competition regulates the market. Regulation can also vary within the state depending upon the product being regulated.

Recently, Congress began holding hearings on whether to repeal the McCarran-Ferguson Act and subject the industry to anti-trust laws that apply to most other areas of commerce. Until a decision is forthcoming, however, the states continue to regulate the insurance industry and the insurance business is exempt from certain provisions of the federal anti-trust laws.

Connecticut. Connecticut's first chartered insurance company was the Mutual Assurance Company of the City of Norwich, incorporated in 1795. Laws regulating insurance first appeared in 1833. By 1859, concern about companies' financial conditions prompted the legislature to require them to deliver annual statements of their assets and liabilities to the state's comptroller and swear to their efficacy. The comptroller was required to publish abstracts of the statements in newspapers where the companies were located. All expenses related to these activities were borne by the insurance companies.

In 1865, the legislature created a position of insurance commissioner, a gubernatorial appointment for a three-year term. The commissioner's responsibilities were to ensure that companies complied with the statute, and to refer those who did not to the State's Attorney.

Several laws affecting insurance were passed during the 1850s and 1860s including the requirement that all out-of-state insurance companies establish reserves to pay off claims if any company should become insolvent.

In 1879, the Connecticut General Assembly passed a major piece of insurance legislation. Some of the significant facets of the law included:

- giving the insurance commissioner authority to examine an insurance company's books;
- specifying what must be included in a company's annual statement;

- requiring agents to report annually premiums collected for the previous year and to pay two percent of those premiums in taxes;
- regulating the loans and investments of life insurance companies; and
- authorizing the commissioner to revoke a company's license if it were found to be financially unsound.

Throughout Connecticut's history of regulating the insurance industry, the state's major pieces of insurance legislation have, to a large extent, mirrored model acts adopted by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. Examples of these acts have been: the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance; the Model Insurers Supervision, Rehabilitation and Liquidation Act; and the NAIC Unauthorized Insurers Model Statute.

One of the most significant pieces of legislation adopted in Connecticut was the deregulation of insurance rates for personal lines. In 1982, the Connecticut General Assembly passed Public Act 82-353, which was similar to the NAIC model deregulation act. The legislative intent was to deregulate personal lines such as homeowners and automobile insurance, as well as to prohibit noncompetitive behavior by insurers. The legislation further contained protections for policyholders and the public in the event of a finding by the commissioner that competition did not exist in the marketplace. The overall goal of the legislation was to promote competition among insurers. The act authorized cooperative action among insurers in the rate-making process but prohibited other activities to prevent practices that tend to substantially reduce competition or create a monopoly.

Legislative measures enacted since the 1982 act have tended to provide the commissioner with additional regulatory controls. Those measures, which the legislature has taken in response to constituent problems with insurance availability, rising insurance rates, and a lack of data on which to base regulatory and policy decisions, have included the following:

- requiring companies to notify the department at least 60 days prior to withdrawing from or substantially reducing a line or subline of business;
- increasing the prior notification periods for non-renewal and cancellation of policies, and establishing statutory grounds for cancellation of commercial insurance policies;

- requiring insurance companies to submit data on premiums actually charged compared to premiums that would have been collected using the unmodified rates on file with the department; and
- requiring the commissioner to establish a medical malpractice data base including all incidences of medical malpractice, settlements, awards, etc.

Current Connecticut law regulating insurance is extensive, covering 25 separate chapters in statute. The provisions of the state's insurance law are contained in Title 38 of the Connecticut General Statutes.

While insurance is regulated at the state level, there are several national entities that do play a role in insurance and the way it is regulated. These organizations will be mentioned throughout this report, and the description provided here will help in identifying who these organizations are and what they do.

National Association of Insurance Commissioners. Established in 1871 as the National Convention of Insurance Commissioners, the organization is comprised of the heads of all state insurance regulatory agencies. The goal of the association is to promote uniformity in regulation. To achieve this, the NAIC has established committees and task forces to meet and develop model statutes and regulations for use by all the states. Commissioners meet regularly (usually quarterly) to discuss insurance issues and to adopt any model legislation developed by committees. States in turn may adopt these acts untouched, or change them to conform to state needs.

The NAIC also collects financial information on all licensed companies, and compiles the data in a computerized data base. This information is then made available to states for solvency surveillance. The association also runs a series of tests on the data that provide early detection of companies experiencing financial difficulties.

Other information collected and made available to the individual state regulators include: state disciplinary actions taken against companies, and financial information on insurance companies that are located outside the United States.

The association is largely funded through appropriations made from individual states. The organization has a small permanent staff, but relies heavily on temporarily assigned state staff to perform its functions.

Insurance Services Office (ISO). This organization is a nonprofit corporation with regional offices throughout the country. The ISO makes available advisory rating, statistical, actuarial, policy form, and other services to any property and

casualty insurer who is a member. Companies are assessed dues, depending on the services purchased. The office collects data from insurance companies on premiums collected, claims paid, and expenses incurred. The compiled information is analyzed and forms the basis for company and industry loss experience, trends, and rate filings on behalf of member companies.

A. M. Best & Co. A compiler of insurance information, this company analyzes data on insurance companies, issues ratings of companies based on the analysis, and distributes lists of companies that have been put in rehabilitation or are insolvent. This organization also publishes information on industry trends.



## SECTION II

### REGULATION AND THE INSURANCE MARKETPLACE

#### Why Regulate?

The competitive pressures of the marketplace should provide the consumer with a range of choices when deciding what product or service to purchase. These competitive pressures should also force producers to sell goods and services at their lowest cost. If there are low barriers to entry into the market and consumers have adequate information to make buying decisions, then inefficient producers offering unwanted products will eventually be forced out of the marketplace. This defines what economists call perfect competition, which for a number of reasons is not always present in many areas of the economy. In the absence of its existence, government regulation is imposed to correct the market failure that has occurred.

The rationale for regulating the marketplace can take different forms. A major reason for regulation occurs when a single firm has no competitors resulting in monopoly control of the supply of the product. The regulation of monopolies has a long history of government intervention to protect the interest of consumers. Other factors that lead to government regulation are for the purposes of protecting public health and safety, as with the licensing of medical professions, and controlling of public hazards, such as water and air pollution. In these situations a regulatory body is used to set standards that must be met in order to operate in the marketplace.

For a competitive market to function well, buyers must have sufficient information to evaluate competing products. Markets may fail to provide adequate information for the consumer to make a knowledgeable decision and regulatory mechanisms may be put into place to overcome this deficiency. Further, to prevent deception in the marketplace when a complex product is involved, regulatory action may be required to prevent false or misleading statements from being made.

Government can also decide there is not an inequitable distribution of the goods or services provided by a particular market and will focus its regulatory activity on price. Another reason that has been commonly used in the past as a rationale for regulation is excessive competition, which was believed to drive out businesses in a particular market and result in a monopoly. This reason has not been given much weight in the 1970s and 1980s by regulators. Finally, some regulation is in place to protect the suppliers of products from competition by restricting entry into the market or supporting suppliers through price support mechanisms.

The regulation of insurance began with the need to assure policyholders that the product they had purchased would pay the

benefits outlined in their contracts. Because insurance is unique in the sense that the consumer pays for a service now that may be rendered at some future date, the insurer must be capable of providing that future service. A principal feature of the insurance regulation has been to guarantee the consumer that the company has adequate funds reserved to pay the future claims of its policyholders. As was noted in the previous section, the earliest regulation of insurance occurred when companies were unable to pay claims for policies sold. The financial solvency of insurance companies continues to be an important regulatory goal in Connecticut.

A second area of regulatory activity deals with the concern for adequate consumer information. The insurance product comes to the consumer in the form of a legal contract that defines the losses covered by the company and what compensation will be provided in the event of loss. For consumers to compare products they must have knowledge of how one legal contract compares with another. Because insurance contracts can be complex, this comparison may be very difficult. Insurance departments have developed regulatory mechanisms to review all contracts or policies and may have the power to approve or disapprove a contract. Connecticut's system for conducting reviews of policy forms will be explained in the next chapter.

Another activity involves monitoring and regulating insurance rates. Initially, rate regulation sought to ensure the financial solvency of companies. Regulators wanted to make sure rates were adequate to cover reserves for future claims payments. Organizations were developed to assist in the collective setting of rates for various lines of insurance. Today, the criteria used to review rates include excessiveness and discriminatory practices, as well as inadequacy. These activities will also be examined in the next chapter.

This section examines the market structure of insurance in Connecticut. This data here attempts to assess the competitiveness of the market using three measures for determining market structure and competition. One is a measure of the market share held by companies for a particular line of business. Another assesses the entry and exit of companies doing business in Connecticut. The third measures the level of profitability for firms operating in Connecticut compared to other states.

### The Insurance Marketplace

The insurance market is usually separated into two broad industry groups: life and health insurance, and property and casualty insurance. Life insurance companies insure individuals against death, with some policies containing savings and investment elements. Health insurance pays for medical claims made by individuals or groups purchasing an insurance contract. The property and casualty industry includes companies selling fire, marine, automobile, homeowners', commercial multi-peril, property and liability insurance, and workers' compensation.

Insurance companies generally market their products in two ways. The first method, and the oldest, is through the independent agent. These agents are licensed to sell products of several unrelated companies, and are independent contractors, not employees of the company. In the second method, companies market their products directly, with company employees selling the insurance.

In 1984, the American property/casualty industry generated approximately \$118 billion in premiums, and life and health produced about \$141 billion for a total of \$259 billion in premiums. There are more than 5,500 insurance companies operating in the United States.

The Market in Connecticut

The Connecticut insurance industry generated a total of over \$7 billion in premiums in 1986. A breakdown of the industry by premium volume is presented in Table II-1.

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Table II-1. Direct Premiums Written in Connecticut by Industry

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Industry	Total Market	% Written by Conn. Domiciled Companies
Life Insurance	\$1,925,435,785	23%
Health	\$1,589,371,225	76%
Property/Casualty	\$3,544,072,030	29%

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There were 920 companies selling insurance in Connecticut as of March 1987. However, when defining the marketplace to examine market concentration and competition, insurance should be broken down by product line such as homeowners, medical malpractice, and personal automobile. Program review used several lines in examining market-share concentration. For the property/casualty and life and health insurance areas the program review committee obtained five years of data (1982-1986) on premiums written by companies in Connecticut from the National Association of Insurance Commissioners (NAIC).

From these data, the committee analyzed the market share of companies writing over \$100,000 in premiums a year for nine major lines: accident and health; life; commercial multi-peril; commercial general liability (other liability); medical malpractice; homeowners; personal auto; workers compensation;

and commercial fire. With the exception of medical malpractice, and to a certain extent, accident and health, the data indicate a very competitive market in all lines over the five-year period.

Using 1986 premium dollars, program review selected seven major lines of insurance -- accident and health, life, commercial multi-peril, commercial general liability (other liability), medical malpractice, homeowners, and personal auto -- and ranked the top 10 companies' market share in each of these lines. The results of this analysis are presented in Tables II-2 through II-8. (Percentages may not equal 100 due to rounding).

Table II-2. Accident and Health -- Group and Individual-1986 Business. Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Blue Cross & Blue Shield of CT*	\$915,097,409	49%
2. Health Maintenance Organizations**	264,263,337	14%
3. Aetna Life Ins. Co.*	91,825,816	5%
4. Conn. General Life Ins. Co.*	81,597,583	4%
5. Travelers Ins. Co.-Life Dept.*	81,373,019	4%
6. Prudential Ins. Co. of America	38,465,401	2%
7. Guardian Life Ins. Co. of America	35,994,871	2%
8. Continental Assurance Life	23,777,434	1%
9. Metropolitan Life Ins. Co.	20,079,851	1%
10. Phoenix Mutual Life Ins. Co.*	19,095,016	1%
		<u>83%</u>
All Other Companies	291,501,381	16%
Total Companies/Premiums Written: 158	<u>\$1,863,071,118</u>	<u>99%</u>
Health Maintenance Organizations: 10		
* Connecticut-domiciled companies.		

Table II-3. Life -- Group and Individual - 1986 Business.  
 Direct Premiums and Annuities over \$100,000.  
 Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Equitable Life Assoc. Soc. of U.S.	\$166,170,264	8%
2. John Hancock Mutual Life Insurance Co.	130,524,614	7%
3. Metropolitan Life Insurance	97,602,370	5%
4. Travelers Insurance Co. - Life Dept.*	87,395,582	4%
5. Prudential Insurance Co. of America	82,046,583	4%
6. Mass. Mutual Life Insurance Co.	75,549,246	4%
7. Connecticut General Life Insurance*	74,211,928	4%
8. Northwestern Mutual Life Insurance Co.	62,319,623	3%
9. Aetna Life Insurance Co.*	60,727,368	3%
10. Teachers Ins. & Ann. Asn. of America	58,087,952	3%
		45%
All Other Companies	1,064,628,359	55%
Total Companies/Premiums Written: 260	\$1,959,263,889	100%

\* Connecticut-domiciled company

Table II-4. Commercial Multi-Peril -- 1986 Business.  
 Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Hartford Fire Insurance Company*	\$38,126,310	11%
2. Aetna Casualty & Surety Company*	26,919,637	8%
3. Insurance Company of North America	22,662,111	6%
4. Federal Insurance Co.	11,530,320	3%
5. Royal Insurance Company of America	10,691,365	3%
6. Middlesex Mutual Assurance Company*	9,511,667	3%
7. Firemen's Fund Insurance Co.	8,196,516	2%
8. American National Fire Insurance Co.	7,589,038	2%
9. Hartford Accident and Ind. Co.*	7,322,144	2%
10. Covenant Insurance Co.*	6,567,447	2%
		42%
All Other Companies	208,220,593	58%
Total Companies/Premiums Written: 141	\$357,337,148	100%

\* Connecticut-domiciled Company

Table II-5. General Liability -- 1986 Business.  
Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. National Union Fire Ins. Co. of Pitt.	\$68,431,962	11%
2. Hartford Accident and Ind. Co.*	68,215,119	11%
3. Aetna Casualty & Surety Company*	55,265,009	9%
4. Insurance Company of North America	40,569,820	7%
5. Travelers Indemnity Co.*	26,381,635	4%
6. Federal Insurance Co.	22,705,905	4%
7. Liberty Mutual Insurance Co.	21,424,531	4%
8. Pacific Employers Ins Co.	18,583,517	3%
9. Continental Casualty Co.	14,487,845	2%
10. Lexington Ins. Co.	10,495,401	2%
		<u>57%</u>
All Other Companies	252,969,738	43%
Total Companies/Premiums Written: 160	<u>\$599,530,482</u>	<u>100%</u>

\* Connecticut-domiciled Company

Table II-6. Medical Malpractice -- 1986 Business  
Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Ct. Medical Ins. Co.*	\$30,106,764	33%
2. Continental Casualty	21,066,110	23%
3. St. Paul Fire & Marine Ins. Co.	18,247,091	20%
4. General Accident Ins. Co. of America	4,646,176	5%
5. Aetna Casualty & Surety Co.*	3,277,450	4%
6. Hartford Accident & Indemnity*	3,022,580	3%
7. National Union Fire Ins. Co. of Pitt.	2,773,351	3%
8. Travelers Indemnity Co.*	2,165,075	2%
9. Standard Fire Ins. Co.*	1,091,007	1%
10. National Fire Ins. Co. of Hartford*	756,565	1%
		<u>95%</u>
All Other Companies	3,635,378	5%
Total Companies/Premiums Written: 20	<u>\$90,787,547</u>	<u>100%</u>

\* Connecticut-domiciled Company

Table II-7. Homeowners Insurance -- 1986 Business.  
Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Middlesex Mutual Assurance*	\$26,323,849	9%
2. Allstate Insurance	24,819,274	9%
3. Standard Fire Insurance Co.*	23,557,662	8%
4. Nationwide Mutual Fire Insurance	12,503,702	4%
6. Aetna Casualty & Surety Co.*	9,579,050	3%
5. American National Fire Ins. Co.	8,422,748	3%
7. Liberty Mutual Fire Ins. Co.	7,936,104	3%
8. Amica Mutual Insurance Co.	7,936,104	3%
9. Vigilant Insurance Co.	7,698,554	3%
10. Phoenix Insurance Co.	7,225,479	2%
		<u>47%</u>
All Other Companies	156,301,526	53%
Total Companies/Premiums Written: 114	<u>\$292,304,052</u>	<u>100%</u>

\* Connecticut-domiciled Company

Table II-8. Private Passenger Auto -- 1986 Business.  
Market Share -- Top 10 Companies.

Company	Premiums Written	% of Market
1. Allstate Insurance Co.	\$ 126,245,704	11%
2. Aetna Casualty & Surety Co.*	87,295,948	8%
3. Nationwide Group	67,201,111	6%
4. Liberty Mutual Insurance Co.	44,585,372	4%
5. Government Employees Ins. Co.	39,020,879	4%
6. Amica Mutual Insurance Co.	32,960,000	3%
7. Automobile Insurance Co. of Hartford*	27,665,919	3%
8. Metropolitan Property & Liab Ins. Co.	27,219,481	2%
9. Hartford Casualty Insurance Co.*	26,756,049	2%
10. Travelers Indemnity Co.	26,080,351	2%
		<u>45%</u>
All Other Companies	600,676,671	54%
Total Companies/Premiums Written: 160	<u>\$1,105,707,485</u>	<u>99%</u>

\* Connecticut-domiciled Company

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Table II-9. Four-company Market Concentration Percentages.

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1. Accident & Health*	72%
2. Life	24%
3. Commercial Multi-peril	28%
4. Commercial Liability	38%
5. Medical Malpractice	81%
6. Homeowners	30%
7. Private Auto	29%

\* Ten HMOs are included as a single group.

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Tables II-2 through II-8 portray a highly competitive market for the major lines of insurance in Connecticut. Aggregate market concentration for the top 10 companies in the 7 lines examined ranged from a high of 95 percent in medical malpractice, to a low of 42 percent in the commercial multi-peril lines. Most markets are split between the top 10 producers having approximately 50 percent, and many companies sharing the other 50 percent of the market.

Table II-9 shows the four-company market concentration percentages for the eight lines ranked from the highest to the lowest market share. Only two of the seven product lines show four-company market concentrations in excess of 50 percent. Further, one of those lines, accident and health, includes 10 HMOs as a single group. Analysis also indicates that the dominant company, Blue Cross and Blue Shield of Connecticut, has steadily been losing market share over the five-year period.

Beyond market concentration, another indicator of competition is the ease of entry and exit in the marketplace. If barriers to entry are very high, then companies within the market will not have to face new competitors and may earn excess profits or operate inefficiently. The requirements for entering the insurance market in Connecticut are fully described in Chapter III. To gain an indication of market entry, program review examined the number of companies operating in Connecticut in each year from 1980 through 1985. The results are shown in Table II-10 below.

As the table indicates, the number of companies grew by 20 percent in the 6-year period. While this does not show the increase in companies offering products by line of insurance, it indicates a steady growth in the number of companies operating in Connecticut.

Table II-10. Licensed Companies in Connecticut -- FY 81-86.

Year	Number of Companies	Number Increase	% Increase
FY 81	736	13	2%
FY 82	768	32	4%
FY 83	814	46	6%
FY 84	848	34	4%
FY 85	875	27	3%
FY 86	884	9	1%
Total FY 81-86		<u>161</u>	<u>20%</u>

Source: Department of Insurance Annual Reports.

Further analysis was done to examine the growth in specific insurance markets. Table II-11 shows the number of companies writing insurance for four product lines: homeowners; personal automobile; commercial multi-peril; and general liability. As the data indicate, for three out of four lines there has been a steady growth in the number of companies writing premiums, the exception being homeowners insurance, which shows very little growth in the number of new companies entering the market.

Table II-11. Number of Companies Writing Insurance in Selected Product Lines (over \$100,000 in premiums only): 1982-1986.

Year	Homeowners	Personal Auto	Commercial Multi-peril	General Liability
'82	111	114	125	129
'83	114	122	136	128
'84	115	129	137	132
'85	115	132	141	149
'86	114	139	141	160

Source: NAIC Computer Files.

### Profitability

Two major components of insurance profitability are underwriting profit and operating profit. Profitability can be determined in a number of different ways depending upon how a company's assets and liabilities are treated. The differences are generally due to the use of two different types of account-

ing methods, statutory accounting practices (SAP) and generally accepted accounting practices (GAAP). The difference between SAP and GAAP arises from the differing emphases and objectives of the two systems. GAAP is intended to report financial and operating results on a going-concern basis that are of interest to investors and shareholders, while SAP is designed to demonstrate the stability and solvency of a company, which is of interest to policyholders and a requirement of insurance regulators. The use of SAP methods is considered to be a more conservative approach to accounting than the use of GAAP. The profitability figures reported here are based on statutory accounting practices (SAP).

Underwriting profits are defined as the premiums earned by an insurer minus all costs relating to the settlement of claims, expenses relating to the operation of the business, and dividends returned to policyholders within a fixed period. Operating profit is the net profit based upon investment gains added to underwriting profits less federal taxes. The results for the property/casualty industry are issued each year in a report by NAIC and take the form of operating profits as a percentage of the premiums earned. A comparison of the profitability of the industry in each state is presented in Table II-12. It should be noted that these data are reported for property/casualty companies only; no similar data currently exist for the life and health industry.

The program review committee analyzed the profitability of Connecticut's insurance industry in relation to that of other states for a four-year period, from 1983 to 1986. If profits are excessive as compared to other states, then questions might be raised as to the competitiveness of the marketplace. In each of the four years examined the profitability of Connecticut companies is above the national average. For 1983 through 1986, the average profitability was 1.6, -2.7, -3.1, and 2.4 percent respectively, while Connecticut had a profitability level of 2.9, 4, -2.8, and 2.8 percent for those same years.

However, when Connecticut's average is compared to the standard deviation for the national data, Connecticut's profitability does not show a statistically significant difference. The standard deviation is a measure of how the values are distributed around the average. In 1983, 1985, and 1986 Connecticut was within one standard deviation of the mean (actually three-tenths, five-hundredths, and one-tenth of a standard deviation above the mean for each year). Approximately 68 percent of the states lie within plus or minus one standard deviation from the mean. In 1984, the Connecticut average was nearly one and a half standard deviations above the mean. Ninety-five percent of the states lie within plus or minus two standard deviations. A state which consistently placed two or three standard deviations above the national average would require constant oversight in terms of excessive profitability.

## Consumer Demand

The measures of competitiveness just discussed examine the supply side of the market. The demand or consumer side needs further analysis to present a complete picture. It is generally accepted that demand for insurance, especially personal insurance, is highly inelastic -- that is demand is constant irrespective of price and supply. In many cases insurance is required by law or by banks for financing for both businesses and individuals. There are not many substitutes for insurance. Self insurance, for example, is possible only for large corporate or governmental entities.

Program review studied the relationship between changes in price and whether those changes resulted in an increase or decrease in the number of policyholders a company had in its auto insurance line. The analysis is based on data for the top 20 auto insurance writers from 1982 through 1986. A composite price change for each year was compared to the change in the number of policyholders for the entire next year.

For each year program review found there was not a significant correlation between changes in price and change in the number of policyholders a company had. This would indicate that the demand for auto insurance is not sensitive to price alone. Other factors may play an important role in prompting consumers to change insurance companies, such as service, consumer knowledge of the product, and marketing techniques interacting with price. However, when specific companies' data were examined over the 5-year period, program review did find that large rate increases -- in the range of 15 to 25 percent -- resulted in a significant drop in policyholders. For instance, one company had annual rate increases greater than 13 percent for 4 out of the 5 years, and lost over 27,000 auto insurance customers from 1982 to 1986. Thus, auto insurance appears to be inelastic when rate increases are relatively small, but much more elastic as price changes become more significant.

Table II-12. Profitability by State for All Lines--1983-1986.

STATE	1983	1984	1985	1986	AVERAGE
Alabama	1.0	-0.1	-2.7	4.4	0.7
Alaska	4.8	3.1	-1.9	3.4	2.4
Arizona	-4.4	-8.5	-5.1	0.3	-4.4
Arkansas	0.4	-7.6	-1.2	4.0	-1.1
California	-3.7	-4.1	-4.7	1.0	-2.9
Colorado	-5.0	-14.4	-1.8	0.6	-5.2
Connecticut	2.9	4.0	-2.8	2.8	1.7
Delaware	5.6	-3.6	-2.9	3.4	0.6
Florida	-3.8	-3.7	-4.9	0.0	-3.1
Georgia	-1.5	-6.3	-4.9	1.9	-2.7
Hawaii	-1.8	5.7	6.2	10.3	5.1
Idaho	0.8	-5.5	-3.2	5.3	-0.7
Illinois	0.3	-6.7	-4.0	6.1	-1.1
Indiana	-1.5	-2.9	-0.5	1.8	-0.8
Iowa	7.1	3.5	5.6	5.0	5.3
Kansas	5.0	0.0	1.3	5.1	2.9
Kentucky	1.8	-4.5	-1.7	2.4	-0.5
Louisiana	-2.6	-8.2	-9.6	-4.8	-6.3
Maine	-1.8	-4.3	-9.6	-7.0	-5.7
Maryland	3.1	0.5	-2.3	2.7	1.0
Massachusetts	3.8	1.4	-2.8	-3.0	-0.2
Michigan	-5.6	-8.3	-6.4	2.0	-4.6
Minnesota	0.0	-6.1	0.7	5.4	0.0
Mississippi	-0.3	-2.9	-26.8	0.6	-7.4
Missouri	-0.6	-8.9	-3.3	6.4	-1.6
Montana	-1.0	-4.6	-18.8	1.9	-5.6
Nebraska	9.0	4.5	6.5	2.2	5.6
Nevada	0.8	-2.0	2.1	5.5	1.6
New Hampshire	5.5	4.3	-2.4	2.2	2.4
New Jersey	2.5	-0.2	-0.4	4.2	1.5
New Mexico	0.3	0.6	-4.3	4.1	0.2
New York	0.6	-0.6	-0.6	3.2	0.7
North Carolina	6.6	-2.0	-1.9	6.1	2.2
North Dakota	6.1	7.4	2.4	-7.7	2.1
Ohio	5.6	0.4	-1.9	1.6	1.4
Oklahoma	-0.5	-8.0	-5.1	1.8	-3.0
Oregon	-2.2	-8.9	-5.9	0.3	-4.2
Pennsylvania	-1.1	-5.8	-5.2	-7.0	-4.8
Rhode Island	2.5	0.0	-8.3	-1.6	-1.9
South Carolina	1.8	-6.3	-3.5	0.2	-2.0
South Dakota	9.6	-0.3	2.5	4.0	4.0
Tennessee	2.7	-1.7	-1.6	3.3	0.7
Texas	-10.1	-5.5	-6.5	-3.3	-6.4
Utah	0.5	-7.9	-9.5	5.0	-3.0
Vermont	8.6	3.7	5.9	7.1	6.3
Virginia	12.0	1.7	-1.0	3.3	4.0
Washington	-0.9	-2.2	-1.6	3.7	-0.3
West Virginia	3.2	-1.7	-5.4	4.2	0.1
Wisconsin	4.0	-2.1	-1.0	6.1	1.8
Wyoming	8.5	-6.9	-0.3	7.9	2.3
NATIONAL AVERAGE	1.6	-2.7	-3.1	2.4	-0.5
STANDARD DEVIATION	4.3	4.6	5.5	3.7	3.3

Source: NAIC Profitability Data.

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CHAPTER III	THE CONNECTICUT INSURANCE DEPARTMENT AND ITS REGULATORY FUNCTIONS
SECTION I	Department Organization and Resources
SECTION II	Financial Examination For Licensed Companies
SECTION III	Insurance Rate Making
SECTION IV	Policy Forms Review
SECTION V	The Department's Role In Consumer Protection
SECTION VI	Information Systems

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## SECTION I

### DEPARTMENT ORGANIZATION AND RESOURCES

The Connecticut Department of Insurance, created in 1865, is charged with monitoring financial solvency of companies selling insurance, protecting consumers against unfair trade practices by enforcing statutory standards, responding to complaints from consumers, and ensuring that insurance is made available for those who need it.

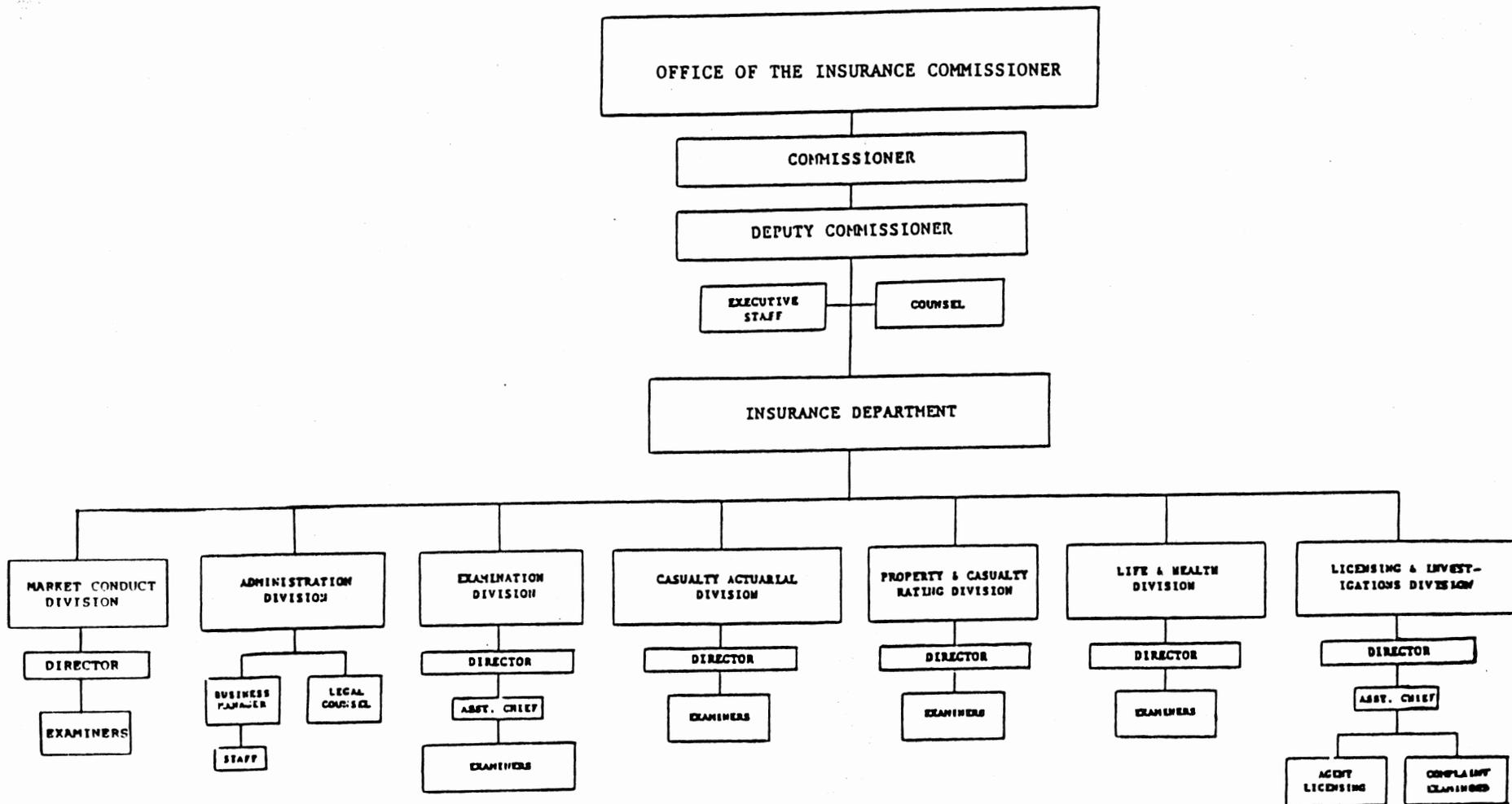
To accomplish these goals, the Department of Insurance is organized into seven divisions -- Administrative, Casualty Actuarial, Examination, Licensing and Investigations, Life and Health, Market Conduct, and Property and Casualty Rating. Each division is headed by a director. The department also has a legal office staffed by two attorneys. The organizational structure of the department is depicted in Figure III-1. The major functions of each division are described below.

Administrative Division. This division is responsible for all accounting, business and fiscal transactions. This includes preparing the annual report to the governor, compiling the department's annual budget, and assessing insurance companies to cover the department's expenses. All personnel matters are also handled in this division.

Casualty/Actuarial Division. The Casualty/Actuarial Division is responsible for automobile insurance regulation as well as the data processing function within the department. The automobile market is split into two sections -- the voluntary market, and the involuntary market (i.e. assigned risk) where there is stricter regulation. Policy forms for both markets are reviewed in this division and approved. Rates are submitted for both markets, but only in the involuntary pool are they specifically approved or disapproved. The division reviews insurance company underwriting guidelines but has no disapproval authority. Complaints are also received and processed by this division.

Examination Division. The major function of this division is to monitor the financial solvency of insurance companies. By statute, in-depth financial examinations of Connecticut-chartered insurance companies are conducted at least once every five years. In practice, the division schedules exams at least once every four years. If the examination indicates financial problems within the company, remedial action may be initiated. As a further safeguard against insolvency, quarterly and annual statements from all insurance companies licensed to do business in the state are reviewed. This division also licenses companies selling insurance in Connecticut.

Figure III-1. Department of Insurance -- Organization.



Licensing and Investigations Division. This division is split into two sections; one responsible for the issuance and renewal of all agent, broker, adjuster, appraiser and consultant licenses; the other responds to insurance complaints from the public. Each licensee applicant must provide background and character information on the application, and, in certain cases, this information is checked by division staff. Enforcement action against agents or companies is often initiated here, usually as a result of a complaint. The division is also responsible for overseeing excess-lines brokers, who offer insurance products unavailable in the customary marketplace.

Life and Health Division. This division approves policies, endorsements, and forms for both life insurance and group accident and health insurance before use. Individual accident and health insurance forms and rates are reviewed. The division also receives and responds to complaints and inquiries dealing with life and health products.

Market Conduct Division. The Market Conduct Division's major function is to protect policyholders by detecting patterns and practices that indicate a company is operating contrary to laws or regulations. Claims settlement, cancellation, and pricing practices are closely investigated. This division also monitors the financial solvency of surplus lines -- insurance for unique types of risks.

Property/Casualty Rating Division. This division oversees personal and commercial property and liability insurance for individuals, businesses, and professionals. Policy forms and rates are reviewed for personal and commercial lines and homeowner underwriting guidelines are also reviewed in this division. Complaints concerning property/casualty insurance are received and processed here.

Legal Office. This is the department's legal counsel. Duties include drafting bulletins and regulations, providing legal services in departmental hearings, and issuing legal opinions on insurance matters.

### Resources Analysis

An important part of any performance audit is to evaluate whether the resources allotted to the department are sufficient to conduct its responsibilities. To assess this, program review examined the budget and staffing levels for the Department of Insurance for FY 80 through FY 87. As described below, current resources as well as budget and staffing trends were analyzed.

Current budget. The department's budget for FY 87 was \$2,963,090. Personal services accounted for \$2,626,307 or 89 percent. "Other expenses" consumed \$253,240 (9 percent), and \$83,543 (3 percent) was budgeted for equipment.

Table III-1. Department of Insurance Budget by  
Division and Function for FY 87.

<u>Division/Function</u>	<u>Expenditure</u>
Administrative	
Personnel	394,208
Other Expenses	67,600
Total	<u>461,808</u>
Licensing and Investigations	
Personnel	684,181
Other Expenses	98,600
Total	<u>782,781</u>
Examination	
Personnel	749,828
Other Expenses	25,700
Total	<u>775,528</u>
Casualty/Actuarial	
Personnel	249,014
Other	19,400
Total	<u>268,414</u>
Property/Casualty	
Personnel	192,218
Other Expenses	9,400
Total	<u>201,618</u>
Life and Health	
Personnel	195,602
Other	14,000
Total	<u>209,602</u>
Market Conduct	
Personnel	161,256
Other Expenses	18,540
Total	<u>179,796</u>
Equipment	<u>83,543</u>
Grand Total	\$2,963,090

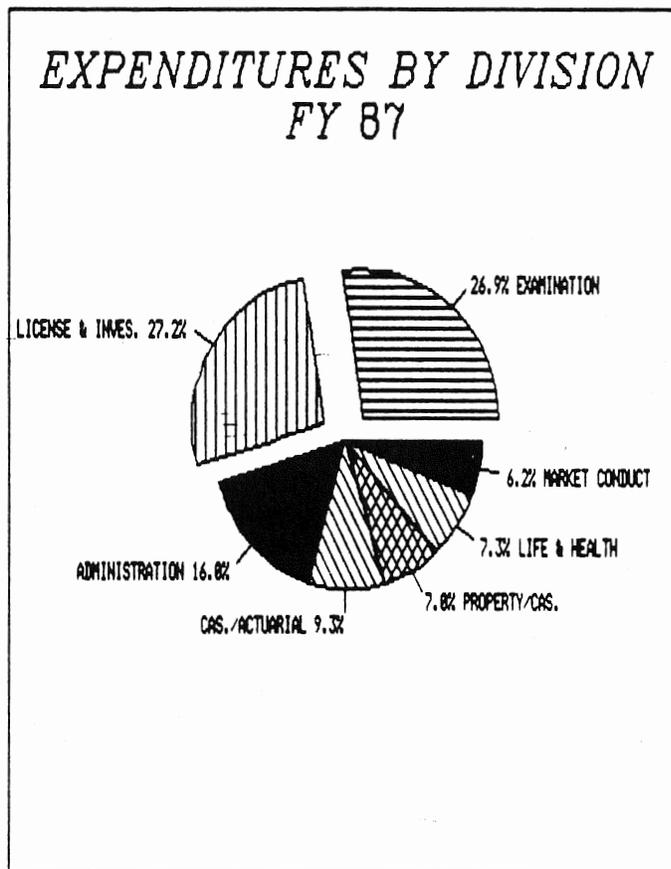
Source: Connecticut Department of Insurance.

Table III-1 presents a detailed breakdown of the department's expenditure categories by division. The personal services category includes all funds expended for full-time,

part-time and temporary employees, plus overtime. "Other expenses" contains such items as consultant fees, leases, rents, office supplies, fuel, telephones, postage and travel. The equipment category includes any item the department buys for long-term use.

The Licensing and Investigations Division and the Examination Division each received about 27 percent of the department's budget. The Market Conduct Division had the smallest percentage (6 percent) of the budget. The percentage breakdown of divisional expenditures by category, excluding equipment expense, are shown in Figure III-2.

Figure III-2. Expenditures by Division -- FY 87\*



\* Excluding Equipment Expense

The program review committee compared monies appropriated to the department with its actual expenditures for FY 84 through FY 86 to determine if the department was over- or underspending its budget. The committee found that the department spent 97

percent of its appropriated budget in FY 84, 94 percent in FY 85 and 92 percent in FY 86. Personal services appears to be the area where funds are underspent. Although underexpending has increased it does not appear to be significant.

Funding. The Department of Insurance is funded by all the Connecticut-chartered insurance companies, which numbered 74 in FY 86. Each company is assessed a fee, and when paid, the monies are deposited into the General Fund. The assessment formula is based on premiums written and taxes paid in Connecticut. Until June 30, 1987, there were two different methods for calculating the department's expenditures to determine the overall assessment. Insurance companies paid the lower cost of the two:

- the actual expenses of the department plus fringe benefits as estimated by the state comptroller; or
- the preceeding year's assessment plus the annual percentage increase or decrease of the state's net general fund. The base year was FY 83 at which the amount was set at \$2.5 million.

This dual method of assessment was abolished during the past legislative session through P.A. 87-515, and now the companies must pay the department's actual expenditures plus the cost of fringe benefits.

Budget trends. The budget for the Department of Insurance has steadily increased during the eight years analyzed. As shown in Table III-2, the department's budget in constant dollars was \$1,262,022 for FY 80 and rose to \$1,917,003 for FY 87. With the exception of FY 82, when the department had a decrease in real dollars, the department's budget grew by varying annual increases from a low of 1.9 percent in FY 81 to a high of 20.2 percent for FY 87. For the entire period (FYs 80-87), the department's authorization increased, in deflated dollars, by 52 percent.

Current staffing. As of November 30, 1987, the department had a total of 91 established full-time positions. Of those, 81 are currently filled and 10 are vacant.

Table III-3 illustrates the breakdown of staff by functional category within each division. Examiners constitute 54 percent (49) of the department's 91 positions. Most examiners have an accounting or financial background, particularly in the Examination Division. The department trains Connecticut Career Trainees to become examiners. Clerical employees comprise a third of the department's staff. The remaining 12 positions are located in the Office of the Commissioner, the Administrative Division, or are directors of divisions.

Table III-2. Department of Insurance Budget: FY 80 - FY 87.

	FY79-80	FY80-81	% Change	FY81-82	% Change	FY82-83	% Change	FY83-84	% Change	FY84-85	% Change	FY85-86	% Change	FY86-87	% Change
<b>OPERATING BUDGET</b>															
Personnel															
Services	\$1,189,338	\$1,317,601	11%	\$1,363,476	3%	\$1,531,123	12%	\$1,794,237	17%	\$1,967,004	10%	\$2,150,845	9%	\$2,626,307	22%
Other Expense	\$66,080	\$108,279	64%	\$103,841	-4%	\$121,787	17%	\$169,711	39%	\$143,730	-15%	\$193,274	34%	\$253,240	31%
Capital Outlay						\$20,604		\$19,116	-7%	\$34,401	80%	\$36,212	5%	\$83,543	131%
<b>AGENCY TOTAL</b>															
General Fund	\$1,255,418	\$1,425,880	14%	\$1,467,317	3%	\$1,673,514	14%	\$1,983,064	18%	\$2,145,135	8%	\$2,380,331	11%	\$2,963,090	24%
Other Funds	\$5,604														
<b>GRAND TOTAL</b>	<b>\$1,261,022</b>	<b>\$1,425,880</b>	<b>13%</b>	<b>\$1,467,317</b>	<b>3%</b>	<b>\$1,673,514</b>	<b>14%</b>	<b>\$1,983,064</b>	<b>18%</b>	<b>\$2,145,135</b>	<b>8%</b>	<b>\$2,380,331</b>	<b>11%</b>	<b>\$2,963,090</b>	<b>24%</b>
<b>GRAND TOTAL DEFLATED</b>															
79=100	\$1,261,022	\$1,285,277	2%	\$1,220,669	-5%	\$1,300,320	7%	\$1,471,672	13%	\$1,513,869	3%	\$1,594,411	5%	\$1,917,003	20%

Source: LPR&IC Staff Analysis.

The Licensing and Investigations Division is the largest within the department, employing 29 people or 32 percent of the total staff (see Table III-3). However, almost 60 percent of staff are clerical. In contrast, examiners make up 89 percent (23) of the 26 positions in the Examination Division, which constitutes 29 percent of the department's total staff. The remaining divisions, much smaller in size, range from 5 to 7 employees.

Staffing trends. The number of filled full-time positions within the Department of Insurance has increased over the past eight years. Table III-4 shows staffing changes from FY 80 to FY 87. As of June 30, 1987, the department had 85 filled full-time positions, a 33 percent increase from the 64 filled, full-time positions at the end of FY 80. When established positions are included in the 7-year analysis, insurance department full-time staff increased 18 percent, from 77 in FY 80 to 91 in FY 88.

Moreover, the department is on the verge of considerable expansion and reorganization due both to legislative direction and internal department initiatives. During 1987, the General Assembly adopted Public Act 87-515, which added two new divisions to the department. First, the department is required to establish a Division of Consumer Affairs, and is authorized to hire four additional staff. The division will handle complaints, including claim disputes and serve as a mediator between residents and insurance companies.

The department is also mandated to create a Rate Review Division staffed by seven persons, including one actuary and four persons with actuarial experience. The division will be responsible for reviewing rates and supplementary rate information for compliance with the statutes.

In its FY 88 budget options, the department requested that the current Property/Casualty Rating Division be separated into two divisions, one for general liability and worker's compensation, and the other responsible for personal and commercial property insurance. The department also requested that a new subdivision be created within the Life and Health Division to review and approve applications for health maintenance organizations. The department asked for eight new positions to staff these units. The legislature agreed to the number but only appropriated funding for a half year, citing the agency's space shortage as an impediment to filling the positions quickly.

Table III-3. Departmental Staffing Levels.

	# of Filled Positions	# of Vacant Positions	Total Authorized
Commissioner's Office			
Total	5	0	5
Legal Office			
Total	2	0	2
Administrative Division			
Total	4	1	5
Financial Examinations			
Director	1	0	1
Examiners	21	2	23
Clerical	1	1	2
Total	<u>23</u>	<u>3</u>	<u>26</u>
Life and Health			
Director	1	0	1
Examiners	4	0	4
Clerical	1	0	1
Total	<u>6</u>	<u>0</u>	<u>6</u>
Licensing & Investigations			
Director	1	0	1
Examiners	9	1	10
Analyst	1	0	1
Clerical	13	4	17
Total	<u>24</u>	<u>5</u>	<u>29</u>
Casualty/Actuarial			
Director	1	0	1
Examiners	4	0	4
Clerical	1	0	1
Total	<u>6</u>	<u>0</u>	<u>6</u>
Property/Casualty			
Director	1	0	1
Examiners	2	1	3
Clerical	1	0	1
Total	<u>4</u>	<u>1</u>	<u>5</u>
Market Conduct			
Director	1	0	1
Examiners	5	0	5
Clerical	1	0	1
Total	<u>7</u>	<u>0</u>	<u>7</u>
Grand Total - Full-Time	81	10	91

Source: Department of Insurance Personnel Status Report, as of November 30, 1987.

Table III-4. Department of Insurance Staff Summary: FY 80 - FY 87.

	FY79-80	FY80-81	% Change	FY81-82	% Change	FY82-83	% Change	FY83-84	% Change	FY84-85	% Change	FY85-86	% Change	FY86-87	% Change
STAFF SUMMARY															
Filled	64	65	1.56%	60	-7.69%	70	16.67%	72	2.86%	77	6.94%	77	0.00%	85	10.39%
Vacant	13	13	0.00%	18	38.46%	12	-33.33%	8	-33.33%	5	-37.50%	5	0.00%	6	20.00%
Requested/Change								2				1		0	-100.00%
TOTAL	77	78	1.30%	78	0.00%	82	5.13%	80	-2.44%	82	2.50%	83	1.22%	91	9.64%

Source: LPR&IC Staff Analysis.

## Comparison with Other States

The program review committee compared the Connecticut insurance department's resources with those of other states. Comparative information on states is collected annually by the Ohio Insurance Institute, and its most recent data were used for this study.

All states have some form of insurance regulatory program, although individual agencies differ, and financial and personnel resources allotted for insurance regulation vary widely. Table III-5 below compares resources in all 50 states and the District of Columbia and Puerto Rico. State aggregates and state ranking from highest to lowest are listed for the following categories:

- the total number of companies licensed to do business in each state;
- the total premium volume collected from all companies for the calendar year 1984;
- the funds spent for operation of the departments for FY 85; and
- the total personnel assigned to each state's department.

As the table shows, Texas and Arizona have the most companies licensed to do business in their states, each with over 2,000. Connecticut ranks fifth from the bottom in terms of companies licensed to do business, with 875 authorized companies. However, in terms of premiums generated, Connecticut's ranking jumps to 18th, with almost \$5 billion in insurance business. The leading states in this category are the most populous states, as one would expect. California and New York companies generated more than \$30 billion in each state, and companies writing in Texas collected almost \$20 billion in premiums there.

Connecticut also ranks midway (23rd) in total dollars spent, slightly over \$2 million, on insurance regulation. New York headed the list spending \$34 million, while South Dakota spent less than half a million during FY 85 regulating its insurance business.

Finally, Table III-5 lists the total number of staff allotted to each state's insurance regulatory agencies. It should be noted that these numbers may be somewhat misleading, since some departments contract with outside firms to conduct financial examinations, rate reviews, etc. All regulatory services in Connecticut are provided by department employees.

Table III-5. Regulatory and Resource Information: A State Comparison.

State	Licensed Companies 1984	Premium Volume 1984	Budget for Dept. FY 84-85	Personnel Total
Alabama	1,280 (20)	3,854,258,455 (21)	2,326,870 (24)	63 (31)
Alaska	1,004 (33)	829,606,000 (43)	949,085 (39)	15 (48)
Arizona	2,130 (2)	3,389,425,810 (25)	1,623,531 (31)	58 (34)
Arkansas	1,371 (15)	N/A	2,205,133 (25)	67 (28)
California	1,717 (4)	31,597,947,000 (1)	19,476,715 (3)	417 (4)
Colorado	N/A	2,362,661,000 (29)	N/A	72 (27)
Connecticut	875 (37)	4,800,000,000 (18)	2,145,133 (28)	77 (25)
Delaware	1,321 (16)	603,376,346 (46)	2,157,035 (27)	24 (43)
Dist. of Columbia	1,149 (29)	901,476,950 (40)	742,720 (43)	22 (47)
Florida	1,416 (11)	12,162,533,785 (6)	18,267,129 (4)	550 (3)
Georgia	N/A	5,436,945,420 (12)	N/A	122 (14)
Hawaii	730 (41)	952,813,972 (38)	839,814 (41)	29 (41)
Idaho	1,417 (10)	994,534,000 (37)	1,288,000 (33)	31 (40)
Illinois	1,689 (5)	13,779,091,333 (5)	7,741,535 (7)	247 (6)
Indiana	1,677 (6)	5,716,576,000 (11)	2,169,982 (26)	91 (23)
Iowa	1,468 (8)	3,609,110,498 (22)	2,962,851 (20)	94 (22)
Kansas	1,280 (20)	2,926,713,000 (27)	3,806,109 (15)	139 (12)
Kentucky	1,232 (25)	3,435,045,920 (24)	3,729,977 (16)	107 (19)
Louisiana	N/A	N/A	N/A	149 (10)
Maine	699 (42)	1,027,835,461 (35)	1,063,795 (35)	34 (38)
Maryland	N/A	4,165,595,103 (20)	N/A	172 (9)
Massachusetts	N/A	N/A	4,600,000 (12)	140 (11)
Michigan	1,299 (19)	12,007,926,000 (7)	5,092,960 (10)	122 (14)
Minnesota	1,270 (22)	4,933,272,000 (16)	3,279,300 (19)	76 (26)
Mississippi	N/A	2,195,067,603 (30)	N/A	60 (33)
Missouri	1,474 (7)	6,278,279,438 (9)	3,502,727 (18)	114 (16)
Montana	1,219 (28)	662,080,000 (45)	604,072 (45)	17 (47)
Nebraska	1,276 (21)	2,105,737,609 (31)	2,109,123 (29)	64 (30)
Nevada	1,230 (26)	897,346,971 (41)	1,092,500 (34)	29 (41)
New Hampshire	773 (40)	910,000,000 (39)	1,025,000 (37)	37 (36)
New Jersey	1,002 (34)	5,502,346,000 (13)	8,480,000 (5)	319 (5)
New Mexico	1,372 (15)	1,275,665,260 (34)	1,042,110 (36)	32 (39)
New York	908 (35)	31,110,498,000 (2)	34,013,076 (1)	668 (2)
No. Carolina	1,055 (31)	4,991,582,744 (15)	7,843,587 (6)	222 (7)
No. Dakota	1,235 (24)	873,138,148 (42)	576,308 (46)	21 (45)
Ohio	1,444 (9)	11,980,144,290 (8)	4,706,596 (11)	113 (17)
Oklahoma	1,723 (3)	3,554,339,777 (23)	2,429,111 (22)	66 (29)
Oregon	1,376 (14)	3,300,000,000 (26)	2,752,311 (21)	62 (32)
Pennsylvania	1,383 (12)	15,333,186,000 (4)	7,268,000 (8)	219 (8)
Rhode Island	821 (38)	1,318,900,356 (33)	874,445 (40)	26 (42)
So. Carolina	1,255 (23)	2,913,766,372 (28)	4,248,505 (13)	110 (18)
So. Dakota	1,102 (30)	741,037,616 (44)	477,853 (47)	20 (46)
Tennessee	1,306 (18)	4,219,128,550 (19)	2,408,481 (23)	88 (24)
Texas	2,258 (1)	19,911,371,981 (3)	29,745,724 (2)	783 (1)
Utah	1,318 (17)	89,220,928 (48)	1,630,368 (30)	42 (35)
Vermont	890 (36)	408,663,200 (47)	657,989 (44)	21 (45)
Virginia	1,228 (27)	5,211,713,324 (14)	5,123,352 (9)	115 (15)
Washington	1,363 (10)	4,924,805,000 (17)	3,654,833 (17)	98 (20)
W. Virginia	1,026 (32)	1,590,299,475 (32)	1,020,075 (38)	35 (37)
Wisconsin	1,354 (13)	5,863,933,543 (10)	3,814,864 (14)	97 (21)
Wyoming	809 (39)	10,371,135 (49)	824,049 (42)	21 (45)
Puerto Rico	254 (43)	1,009,083,370 (36)	1,393,262 (32)	129 (13)

Connecticut department staffing for 1985 number 77, ranking it 25th among the 46 states providing data.

In comparing Connecticut with other states relative to premium volume and number of licensed companies, program review developed two ratios and ranked the states from highest to lowest. The ratios, shown in Table III-6 include: 1) funds expended on regulation to premiums generated; and 2) the amount spent on regulation to the number of companies regulated.

The first ratio, which measures each state's expenditure on regulation per premium dollar generated in the state, shows wide variation among the states. Wyoming, for example, spent approximately 8 cents for every dollar the companies generated in premiums, the highest in the nation. Utah ranked second among the 45 states with available data, spending about 2 cents for every premium dollar. Connecticut ranks 42 out of 45, spending less than one-hundredth of a cent for each premium dollar. Only Michigan, Ohio and Indiana spent less than Connecticut to regulate their insurance industries.

However, Connecticut ranked much higher with the second ratio: dollars spent on regulation divided by the number of companies regulated. That is, this ratio determines dollars spent regulating each company doing business in each state. New York tops this list, spending \$37,459 for each licensed firm in that state. South Dakota, which spends about \$434 to regulate each company, ranked at the bottom of the list. Connecticut appears 18th on the list of the 46 states and, as the table indicates, spent approximately \$2,452 to oversee each company licensed in Connecticut.

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Table IV-6. Two Selected Regulatory Ratios: A State Comparison

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<u>Funds to Premium Ratio</u>		<u>Funds to Company Ratio</u>	
WYOMING	0.079456	NEW YORK	37,459
UTAH	0.018273	TEXAS	13,173
DELAWARE	0.003575	FLORIDA	12,901
VERMONT	0.001610	CALIFORNIA	11,343
NEW JERSEY	0.001541	NEW JERSEY	8,463
FLORIDA	0.001502	PUERTO RICO	5,485
TEXAS	0.001494	PENNSYLVANIA	5,255
SOUTH CAROLINA	0.001458	ILLINOIS	4,584
PUERTO RICO	0.001381	VIRGINIA	4,172
KANSAS	0.001300	MICHIGAN	3,921
IDAHO	0.001295	SOUTH CAROLINA	3,385
NEVADA	0.001217	OHIO	3,259
ALASKA	0.001144	KENTUCKY	3,028
NEW HAMPSHIRE	0.001126	KANSAS	2,974
NEW YORK	0.001093	WISCONSIN	2,817
KENTUCKY	0.001086	WASHINGTON	2,681
MAINE	0.001035	MINNESOTA	2,582
NEBRASKA	0.001002	CONNECTICUT	2,452
VIRGINIA	0.000983	MISSOURI	2,376
MONTANA	0.000912	NORTH CAROLINA	2,269
HAWAII	0.000881	IOWA	2,018
OREGON	0.000834	OREGON	2,000
DIST.OF COLUMBIA	0.000824	TENNESSEE	1,844
IOWA	0.000821	ALABAMA	1,818
NEW MEXICO	0.000817	NEBRASKA	1,653
WASHINGTON	0.000742	DELAWARE	1,633
OKLAHOMA	0.000683	ARKANSAS	1,608
MINNESOTA	0.000665	MAINE	1,522
RHODE ISLAND	0.000663	OKLAHOMA	1,410
NORTH DAKOTA	0.000660	NEW HAMPSHIRE	1,326
WISCONSIN	0.000651	INDIANA	1,294
SOUTH DAKOTA	0.000645	UTAH	1,237
WEST VIRGINIA	0.000641	HAWAII	1,150
CALIFORNIA	0.000616	RHODE ISLAND	1,065
ALABAMA	0.000604	WYOMING	1,019
TENNESSEE	0.000571	WEST VIRGINIA	994
ILLINOIS	0.000562	ALASKA	945
MISSOURI	0.000558	IDAHO	909
NORTH CAROLINA	0.000480	NEVADA	888
ARIZONA	0.000479	ARIZONA	762
PENNSYLVANIA	0.000474	NEW MEXICO	760
CONNECTICUT	0.000447	VERMONT	739
MICHIGAN	0.000424	DIST.OF COLUMBIA	646
OHIO	0.000393	MONTANA	496
INDIANA	0.000380	NORTH DAKOTA	467
		SOUTH DAKOTA	434

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## SECTION II

### FINANCIAL EXAMINATION FOR LICENSED COMPANIES

A major regulatory responsibility of all insurance departments is to review the financial condition of insurance companies. Maintaining financial solvency is important in this industry because companies sell a product for which they are paid first and are expected to deliver a service -- the settlement of a claim -- sometime in the future. It is important that a company remain solvent to pay off future policyholder claims. The Connecticut Insurance Department oversees insurance companies in several ways to ensure they remain financially sound.

In determining financial solvency, the department covers two separate areas: examining companies seeking a Connecticut license; and monitoring companies already doing business here. This section will first describe the process and procedures for obtaining a license and then describe the department's ongoing financial examination of companies operating in Connecticut.

#### Licensing Requirements and Procedures

There are two types of insurance companies conducting business in Connecticut. The first type of company is the Connecticut-domiciled (domestic) company. The other type of company is domiciled in another state or country, but is authorized to write insurance in Connecticut. Neither type of insurance company may write business in the state unless it receives a license or certificate of authority from the commissioner of insurance. Further, any company seeking to be licensed as a Connecticut company (domestic) must first receive a charter from the General Assembly before applying to the department. In order for any company to be licensed the department must first review each application to determine if the firm meets the established statutory and regulatory requirements. Companies are required to seek approval for each line of insurance they want to write in the state. Each company's license (certificate of authority) will list the types of insurance it is authorized to sell.

Statutory and regulatory requirements for licensure. Any company seeking a license must first demonstrate that it meets statutory requirements concerning the amount of capital and/or surplus it possesses (see Table III-7). A company is also required to be licensed in the state where it is domiciled and must present its charter to the commissioner. As part of the application, a company must also submit the following:

- its plan of operation, bylaws, corporate charter, and biographical information on owners, officers, and directors;

- its financial statements, including annual statements, quarterly statements, financial audits and any NAIC financial examinations that have been done; and
- a list of other states where the company is also applying for a license.

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Table III-7. Minimum Capital & Surplus Requirements.

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	Life and Health Companies	Property/Casualty Companies
Minimum Capital	\$1,000,000	\$2,000,000
Minimum Surplus	\$2,000,000	\$2,000,000
Minimum Combined	\$3,000,000	\$4,000,000

Source: Connecticut Department of Insurance.

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In addition to reviewing a company's financial condition before licensure, an examiner must assess two other important criteria before allowing a company to be licensed. First, a company must demonstrate "an orderly pattern of growth in its marketing territories in th[is] geographic region" (C.G.S. Sec. 38-20). Specifically, department regulations require that a non-Connecticut company be licensed in one or more states contiguous to Connecticut. Also, the department must evaluate the company's rate of growth, business persistency, supporting surplus resources, business acquisition costs, and investment policies.

Second, the department must be satisfied that the company has expertise in marketing and servicing the lines of insurance it desires to write, and that the company has the ability to provide continuous and timely claims settlements. To meet this standard, the company must show it is writing business in the lines it seeks to sell in Connecticut in sufficient volume in its home state, and other states where it is licensed, to adequately market and service those products here.

Based on all these factors, the commissioner then makes a determination as to the company's ability to be initially licensed or to have its license expanded to write new products.

Licensing procedure. The company first requests an application package from the department and submits it to the

Examination Division for review. Applications are generally reviewed chronologically based upon the application date. An exception to this procedure is made for Connecticut companies. They are not listed as part of the department's pending applications but rather are reviewed upon receipt.

Normally, applications are reviewed by the assistant chief of the Examination Division. The department believes that initial licensure is one of the most important functions the division performs, and therefore, assigns this task to the assistant chief, a person with considerable examination experience. He examines the information contained in the application to ensure the application's documents are current and all the criteria are met.

The department receives a significant number of applications for licensure each year. Table III-8 below shows the number of applications pending at the beginning of calendar years 1985 and 1986, those received during those years, and department action taken.

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Table III-8. Disposition of Applications for Licensure:  
1985-1986

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Year	<u>Applications</u>		Total For Year	<u>Action for the Year</u>		
	Pending	Received		Licensed	Rejected	Pending Year End
1985	128	53	181	25	21	135
1986	135	45	180	53	20	107

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As the table indicates, the number of companies approved for licensure in Connecticut more than doubled during 1986 over 1985. This was due to a streamlined review procedure for certain companies because of the growing backlog. To cut down on that backlog, the division did an abbreviated review of those companies with a licensed affiliate in Connecticut.

The table indicates a number of companies' applications are rejected for licensure each year. The reasons for rejections are listed in Table III-9. The most frequent reason for rejection is failure to keep the application current, which means that while the application was pending the company did not update its financial statements and other relevant documents as

Table III-9. Rejections for Applications for Licensure - 1985 and 1986  
Reasons Cited.

Total Companies Rejected/Withdrew	<u>1985</u> 20	<u>1986</u> 20
Not current with filings during application period	9	7
Not writing enough volume to have gained expertise in product area	1	4
Inadequate capital reserves and/or surplus	6	4
Orderly geographic growth not indicated	2	4
Biographical data on owners, officers, directors missing	2	1
Unsatisfactory NAIC reviews	6	4
Recent sale of company or sale pending	1	1
No recent financial exam done	2	2
Retaliatory law*	—	4
Indications of a fronting operation	1	—
Overdependence on a financially insolvent reinsurer	1	—
Companies became insolvent during application process	3	—

\* Retaliatory law - when another state fails to license a "qualified" Connecticut company, state statute allows Connecticut to take similar action. Two of the four companies cited here were later licensed, after the Connecticut company in question had been licensed.

Reasons for rejection total more than the total numbers of rejections due to multiple reasons for some companies.

Source: LPR&IC Staff Analysis of Department Application Files.

required. Other reasons often cited for rejection are inadequate capital or surplus reserves, or unsatisfactory results from an examination conducted by NAIC.

The time taken to review an initial application can be lengthy, and generally only one person is assigned to this function. This situation has resulted in a considerable backlog. For example, in June 1987, the division had 114 applications awaiting processing. The division usually reviews the applications in batches of 10. Of the 10 reviewed in June 1987, the majority were received in 1984, and one application had been submitted in 1981. To emphasize the significance of the backlog, Table III-10 below categorizes all current applications by year of submittal.

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Table III-10. Current Licensure Applications By Year of Submittal.

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YEAR	NUMBER OF COMPANIES
1981	1
1982	1
1983	7
1984	24
1985	31
1986	29
1987	21

Source: Insurance Department Examination Division Data

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The department also analyzes the financial statements of a company if it applies for a license amendment -- usually a request to write business in a line for which it was not previously licensed. The department does not keep a log of amendment applications; thus program review was unable to determine if a backlog exists or evaluate final actions taken.

#### Financial Examination for Licensed Companies

Once a company is licensed in Connecticut, it continues to be examined for financial solvency -- both in this state and other states where the company is licensed. The Connecticut Department of Insurance Examination Division oversees licensed companies doing business here in several ways to ensure that they remain financially sound. These oversight mechanisms include: 1) field audits conducted on-site; 2) ongoing examination and analysis of the companies' financial statements; and 3) rehabilitation of a company in financial difficulty.

The two major types of examinations are the field audit and the desk audit, both conducted by the Examination Division. Only those companies headquartered in Connecticut (domestic companies) receive field audits, which are conducted on company premises. Desk audits involve an analysis of insurance companies' quarterly and annual statements, and are carried out at department offices. This type of review is similar to an application examination for companies seeking licensure in Connecticut.

In addition to the audits, the department will take informal measures to protect Connecticut policyholders and help restore financial viability if a company appears in financial difficulty. Such efforts include restricting the company's underwriting here or requiring the company to make additional security deposits in Connecticut. If these efforts fail, the commissioner may take a series of formal statutory steps to rehabilitate the company or liquidate the company and make provisions for payments of policyholder claims.

Financial examinations: statutory responsibilities. The insurance department has statutory responsibility to examine domestic insurance companies every five years. All insurance companies licensed to do business in Connecticut must submit quarterly and annual statements to the department in a form prescribed by the department. Companies must also keep the department informed of any significant changes affecting its operations, such as a change in management or a company merger.

Field audit procedures and analysis. In practice, the department has established a schedule of examining domestic insurance companies every four years. The department's examiners conduct on-site formal audits to measure the company's financial condition against its quarterly and annual statements. The division conducted 12 field audits in each of 1985 and 1986. The department follows guidelines set forth by the National Association of Insurance Commissioners (NAIC) for conducting financial examinations of a company. Insurance regulators from other states are also invited to participate in the examination.

The NAIC guidelines are intended to assist the department in establishing and operating an effective examination system to detect as early as possible those insurers in financial trouble, and to develop information that is needed to take appropriate regulatory action. For companies other than domestic companies, the department can accept an examination done by the regulatory agency of the state where the company is domiciled.

An examination can last from a few weeks to several months depending upon the size of the company. The department targets its examinations to cover areas having the greatest impact on a company's solvency. For example, examiners place additional emphasis on development of loss reserves or reinsurance contracts, if these have been problems for the company in the

past. Examiners also give special attention to a particular line of insurance if it represents a significant portion of a company's total business.

A typical financial examination report includes a description of the company's management and organization, financial statements, a verification of the company's larger assets, a determination of its liabilities, and a review of the adequacy of its loss reserves. Department staff will also randomly sample claims to make sure the claims reported by their automated data processing systems accurately reflect actual losses paid.

Upon completion of a financial examination, the department discusses its findings with company management. Once finalized, the report becomes available to other state regulatory agencies and the public.

#### Desk Audits and Financial Statement Analysis

The department conducts desk audits of all companies licensed in Connecticut. The Examination Division compiles an audit file on each company giving staff an historical picture of the company's financial condition since the time it first applied for licensure to the present. The audit file contains correspondence between the examiners and company management, newspaper and trade journal articles relating to the company's operations, NAIC warnings and financial test ratios, as well as a list of disciplinary actions taken against the company by other state regulatory agencies.

An important document in the file is the audit memorandum, which includes the department's analysis of the company's quarterly and annual statements. The department has an extensive list of guidelines examiners follow when reviewing the statements. They pay particular attention to historical trends, and reviewing such items as the five-year historical data in annual statements, the company's surplus position, operating results, premiums, loss reserves, and assets. Departmental guidelines set forth indicators for reviewing these items. For instance, if premiums grow substantially over the review period, then an explanation is sought for the reason. Surplus would be examined if it grew by more than 30 percent or declined by more than 15 percent. A major emphasis is placed upon erratic fluctuations in any of the above elements, as they may indicate a problem with the company's financial condition.

Companies deviating from the guidelines are placed on a "watch" list. For example, a new firm would be on the list until it gained enough experience and established a record for doing business. Also, a company experiencing a large amount of losses or one appearing to be growing too fast would also be identified as a "watch" company. Those companies receive more detailed reviews of their quarterly statements. Currently,

about 20 percent of companies doing business in Connecticut are on the list.

Beyond placing the company on a watch list, the department has a number of options for companies considered to be financially unsound. First, the department may request an explanation of any extraordinary items found in the audit. If the response is not satisfactory, or the department believes that the company's operations need further discussion, then the two meet and the company may be required to develop a plan to improve its financial status. If informal actions do not succeed, and the company continues to deteriorate, the department has two statutory options. The commissioner can order that the company be rehabilitated, effectively putting him in charge of the company, or that it be liquidated. Hearings must be conducted and certain grounds for action exist before such orders can be issued.

### Performance Indicators

The program review committee used two methods for evaluating the department's insolvency identification and protection efforts. First, the committee examined payments made from the state's property/casualty guaranty fund. Second, it compiled a list of all companies liquidated since late 1985. Data on the status of those financially troubled companies in Connecticut at the time they became insolvent were received from the department.

The two guaranty funds -- one for life and health, and the other for property/casualty insurance -- are statutorily established mechanisms for paying off claims against insolvent companies. All insurance companies must pay into the funds, based on the premium amounts collected in the state. The assessments are determined by the amount needed to cover claims against insolvent companies. The program review committee obtained data on all guaranty fund assessments for the property/casualty industry for the years 1983 through 1985 from the National Committee on Insurance Guaranty Funds. The data -- including total payments made, total premiums written, and a ratio of payments made to premiums written -- for 49 states and 2 territories are presented in Table III-11. New York assesses its companies differently and data for that state are not presented in the table.

The lower the ratio the less a state has paid into the guaranty fund, weighted by the premiums written in that state. The states are ranked from lowest ratio to highest, and Connecticut ranks sixth for the three-year period. Furthermore of those states that actually made payments during the period, Connecticut ranked third, or had the third-lowest ratio. These statistics suggest that Connecticut compares very favorably with other states in overseeing the financial solvency of insurance companies.

The second area reviewed involves analysis of all companies listed by the A.M. Best Company -- a major compiler of insurance company information -- as insolvent since 1985. Of the 26 companies listed, only 3 were licensed in Connecticut, while 3 had requested license applications but never applied, and 3 companies had applied but were rejected or withdrew.

Of the three that were licensed, two were restricted to servicing current policies at the time of insolvency, and were not allowed to write new or renewal business, while the third company was licensed to conduct reinsurance business only. The actions taken to limit the companies' licenses in Connecticut predated the insolvencies in all cases. For example, in one case the department initially suspended the company's license two years prior to insolvency, but 10 months later, after the company put up \$250,000 in bonds to cover any additional claims in Connecticut, the department restored its license for reinsurance business only. Actions taken with the other 2 companies preceded the insolvencies by nine months and seven months respectively.

Table III-11. Guaranty Fund Assessments, Premiums Written, Ratio, and State Rank.

State	Assessment Payments (1983-85)	Premiums Written (1983-1985)	Assessment/ Premium Ratio	Rank
UTAH	\$0	\$1,611,745,000	0.000000	1
ALASKA	\$0	\$1,392,298,000	0.000000	2
ARIZONA	\$0	\$4,749,957,000	0.000000	3
SOUTH DAKOTA	\$14,320	\$910,395,000	0.000016	4
TENNESSEE	\$150,000	\$5,371,207,000	0.000028	5
CONNECTICUT	\$991,000	\$6,874,460,000	0.000144	6
INDIANA	\$2,510,000	\$9,617,459,000	0.000261	7
NORTH DAKOTA	\$295,286	\$1,007,117,000	0.000293	8
NEW MEXICO	\$694,118	\$2,031,971,000	0.000342	9
KANSAS	\$1,489,105	\$3,835,020,000	0.000388	10
NEW JERSEY	\$7,114,795	\$14,487,341,000	0.000491	11
SOUTH CAROLINA	\$2,555,355	\$4,792,593,000	0.000533	12
COLORADO	\$2,776,067	\$5,170,312,000	0.000537	13
WASHINGTON	\$3,325,725	\$5,411,531,000	0.000615	14
NORTH CAROLINA	\$4,148,584	\$6,524,369,000	0.000636	15
RHODE ISLAND	\$1,140,257	\$1,597,320,000	0.000714	16
TEXAS	\$19,999,999	\$27,227,712,000	0.000735	17
LOUISIANA	\$5,500,000	\$7,462,689,000	0.000737	18
MISSOURI	\$5,405,000	\$6,921,149,000	0.000781	19
PENNSYLVANIA	\$15,699,289	\$18,546,825,000	0.000846	20
ILLINOIS	\$15,104,110	\$17,692,452,000	0.000854	21
IOWA	\$3,480,000	\$4,053,374,000	0.000859	22
OHIO	\$13,150,000	\$15,161,435,000	0.000867	23
MISSISSIPPI	\$2,563,044	\$2,903,393,000	0.000883	24
MICHIGAN	\$12,341,776	\$13,935,174,000	0.000886	25
VIRGINIA	\$6,769,054	\$6,962,131,000	0.000972	26
MAINE	\$1,852,348	\$1,776,090,000	0.001043	27
MASSACHUSETTS	\$12,915,809	\$11,505,266,000	0.001123	28
D.C.	\$1,452,711	\$1,203,865,000	0.001207	29
GEORGIA	\$10,862,032	\$7,817,191,000	0.001390	30
KENTUCKY	\$5,957,671	\$4,186,333,000	0.001423	31
WISCONSIN	\$8,997,510	\$6,178,073,000	0.001456	32
NEW HAMPSHIRE	\$2,606,635	\$1,768,368,000	0.001474	33
CALIFORNIA	\$79,630,913	\$49,951,627,000	0.001594	34
NEBRASKA	\$3,928,461	\$2,391,776,000	0.001642	35
MONTANA	\$2,003,210	\$1,187,071,000	0.001688	36
WEST VIRGINIA	\$3,375,000	\$1,899,382,000	0.001777	37
MARYLAND	\$12,601,010	\$6,897,442,000	0.001827	38
IDAHO	\$3,224,556	\$1,289,977,000	0.002500	39
OKLAHOMA	\$13,405,401	\$5,262,178,000	0.002548	40
OREGON	\$10,733,984	\$4,146,440,000	0.002589	41
ALABAMA	\$11,578,956	\$4,469,714,000	0.002591	42
NEVADA	\$4,443,846	\$1,435,735,000	0.003095	43
ARKANSAS	\$9,395,326	\$2,760,925,000	0.003403	44
VERMONT	\$2,742,422	\$794,221,000	0.003453	45
WYOMING	\$1,772,434	\$477,614,000	0.003711	46
MINNESOTA	\$27,383,336	\$7,223,679,000	0.003791	47
DELAWARE	\$3,954,077	\$1,018,558,000	0.003882	48
FLORIDA	\$74,558,933	\$17,010,274,000	0.004383	49
HAWAII	\$19,405,027	\$1,812,263,000	0.010708	50
PUERTO RICO	\$11,109,217	\$1,031,176,000	0.010773	51

## SECTION III

### INSURANCE RATE MAKING

Rate making in the insurance industry is directed toward one major objective: the determination of the proper premium to be charged to each insured and each line of business based upon the probability and amount of losses. The premium involves developing a rate and applying that rate or rating plan to an individual risk or exposure. These activities are collectively referred to as pricing.

Pricing of insurance contracts has the same objective as the pricing of any other product offered for sale. It is to cover the provider's cost and provide a margin of profit for financial strength, growth, and dividends to stockholders and/or policyholders.

In insurance pricing there is a unique difference between the insurance industry and other businesses. The cost of the product sold will not be known until after the policy expires, sometimes several years afterward. It is this element of uncertainty that makes it difficult to establish a price for an insurance product. Past loss data are used to predict and develop present rates to pay future expenses, the largest portion of which are losses.

Insurance pricing is accomplished through a company's underwriting policies. Underwriting is defined as the process of hazard recognition and evaluation, selection of insureds, determination of policy terms and conditions, and ultimately the price. From a company's perspective, the purpose of underwriting is to help the insurer maintain solvency and earn an underwriting profit, so it can service its policyholders and raise capital in financial markets. A company's underwriting practices will determine who it will insure, how many risks it will insure, and the rate or premium the company will charge for the policies it sells. The three major components that determine a rate are: 1) actual losses paid; 2) projected losses that will need to be paid; and 3) expenses involved in the sale of the product and servicing of the policyholders.

#### A Brief History of Rate Making and Statistical Bureaus

Rating and statistical bureaus have a long history of involvement in the development of prices for insurance products, particularly in the area of property and casualty insurance. To understand how current pricing and regulatory policies have developed, a look at the past is important.

Cooperative rate making goes back to the beginning of the 19th century, starting as early as 1819, with the organization of a local board in New York. A national board, the National Board of Fire Underwriters, was organized in 1866 to establish uniform rates and control agents' commissions. While members were supposed to adhere to the boards' rates, during profitable periods companies violated their agreements by cutting prices. In 1877, the board was discontinued and replaced with local and regional rating organizations. These organizations replaced the national board because it was not able to provide the industry with stability and prevent insolvencies, which was considered its main purpose. The local and regional boards were supposed to develop a system by which local agents agreed to uniform rates set by the system's managers. Many states disagreed with this type of price-fixing activity and prohibited it.

By the late 19th century, proposals for regulation of insurance rates were made in several states. New York passed a law in 1911 that permitted the setting of rates by rating bureaus as long as the rates were submitted to the insurance department. The primary concern of both the companies and insurance regulators was that the rates not be too low causing companies to become insolvent. Competition was viewed as resulting in the financial instability of the industry. These coordinated rate-setting activities would have been considered an anti-trust violation except that an earlier Supreme Court decision exempted insurance from being considered interstate commerce, a requirement under the federal anti-trust legislation. The 1869 Paul v. Virginia decision contained language that was interpreted for the next 75 years as meaning insurance could not be classified as interstate commerce and thus not regulated by the federal government. State regulation of insurance flourished under this decision.

In 1944, a dramatic shift in the Supreme Court's view of insurance resulted in the loss of the general exemption. In the United States v. Southeastern Underwriters decision, the Court ruled that insurance was interstate commerce and, by implication, combinations of insurance companies designed to fix rates would be a violation of the Sherman Antitrust Act.

This decision prompted Congress to pass the McCarran-Ferguson Act in 1945, which declared the regulation and taxation of the insurance industry to be of public interest and that federal antitrust laws were to be applied to the insurance industry only when insurance was not regulated by the states. The act allowed the industry to jointly collect loss and expense information and to set rates uniformly based upon the data collected. However, the McCarran-Ferguson Act does state that the exemption does not apply to the Sherman Act provisions against agreements to boycott, coerce, or intimidate. The National Association of Insurance Commissioners (NAIC), working

with industry representatives, drafted model legislation that established state regulation of insurance and precluded the application of the antitrust statutes against the industry. Eventually 44 states enacted new laws or amended existing laws to conform to the NAIC-sponsored model legislation.

#### The Current Role of Rating and Statistical Bureaus

The bureaus still play a dominant role in the collection and dissemination of premium and loss information in the area of property and casualty insurance. However, bureaus have not developed in the life and health industry for several reasons. In the life area, there is greater predictability in terms of mortality classification systems. The risks associated with different classes have largely been developed by the professional actuarial society. With health insurance, group contracts are negotiated between the employer offering coverage and the insurance company. These policies are usually priced based upon the claims experience of the companies' employees. Because claims are filed within a specific period of time, usually within the policy year or a short time after, it is easier to determine the cost incurred in insuring a particular company. Premiums can also be adjusted in successive years to reflect an actual increase or decrease in the cost of claims paid.

In the property/casualty area, loss experience is more difficult to determine because claims made against a policy may take several years to develop. Also, it is more difficult to determine the probability of risk because of the diverse nature of the exposures that can include groups, individuals, businesses, homes, and other insured entities. The program review committee examined the operations of the largest rating bureau, the Insurance Services Office (ISO). It provides services to about 80 percent of the property/casualty industry.

The Insurance Services Office collects statistical data on all policies issued by its member companies. The data are derived from the individual business transactions conducted by an insurance company, and contain information about insurance coverages and the premium and loss experience related to those coverages. Most states require that statistical data be reported to the insurance department, where it is used to determine the adequacy or excessiveness of rates. Another major service provided by ISO is the filing of rates and forms with the state's regulatory authority on behalf of a member company.

States have applied varying restrictions to the collective activities of rating bureaus. For example, Massachusetts does not allow the ISO to provide any of its services in the personal or commercial automobile lines of insurance. Rather, the state collects its own loss data and sets the rates.

Generally, in states with competitive rating laws, ISO does not distribute rate information, but only the loss costs or loss

experience. In areas where there are not competitive rating laws but rather a prior-approval system, rates are distributed to companies or filed with the regulatory agency on behalf of the companies. The various rate regulation systems will be explained in the next section.

In Connecticut, rating bureaus are involved in providing a full range of services to the industry. Only in the area of personal insurance, auto and homeowners, are bureaus not allowed to submit rate filings on behalf of a company. However, they can provide policy forms and develop classification systems, such as territories, and loss information for these lines of business.

### Rate Regulation

The regulation of insurance rates can take several forms, ranging from state-made rates to no state involvement. The rate-making process varies from state to state and product to product within a state. Table III-12 outlines the different methods employed by the states to regulate rates.

Generally, the six rate-making categories used by states are as follows:

1) State-made rates. This system represents total control of insurance rates whereby the insurance department sets the rates to which an insurer must adhere. Massachusetts uses this system for automobile rates.

2) Mandatory rate bureau systems. These states require that an insurer obtain membership in a rating organization before writing a particular line of insurance. Insurers are required to adhere to the bureau-set rates. While this system was in wide use before 1970, only a few states currently have mandatory rate bureaus, sometimes coupled with a prior approval system. Five states, Texas, Louisiana, North Carolina, Mississippi, and Washington, use this system, but it is generally limited to property/casualty only.

3) Prior approval laws. Prior approval requires the insurance department to take action on rates before they can be used by an insurance company. This system is widely applied in most states for various lines of insurance. Prior approval systems can differ but generally follow these steps.

- a. Rates and supporting data are filed with the department.
- b. Rate filings become effective upon affirmative approval or are deemed approved if no action is taken within a specified period of time (depending upon statutory provisions).

Table III-12. Rate Regulation by State.

Alabama.....	Modified prior approval; need approval for change in expense ratio, otherwise file and use
Alaska.....	Prior approval
Arizona.....	File and use, noncompetitive market, use and file in competitive market
Arkansas.....	File and use
California.....	No file
Colorado.....	No file, except prior approval when noncompetitive market, and prior approval of workers' compensation
Connecticut....	File and use, except prior approval for personal lines in a noncompetitive market
Delaware.....	Prior approval
District of Columbia	Prior approval, property; file and use, casualty
Florida.....	Use and file
Georgia.....	Use and file
Hawaii.....	Prior approval except use and file for auto
Idaho.....	No file
Illinois.....	No file; Reg. 754.20 requires filing of certain lines
Indiana.....	Modified prior approval; file and use except need prior approval if change in relationship between rates and expenses
Iowa.....	Prior approval
Kansas.....	Prior approval
Kentucky.....	Use and file in competitive market, file and use in noncompetitive market
Louisiana.....	Modified prior approval; file and use except when change in expense ratio
Maine.....	File and use
Maryland.....	File and use except medical malpractice needs prior approval
Massachusetts..	File and use except medical malpractice set by Commissioner
Michigan.....	File and use; alternate method for filing is prior approval
Minnesota.....	File and use
Mississippi....	Prior approval
Missouri.....	Use and file
Montana.....	File and use
Nebraska.....	Prior approval
Nevada.....	File and use; temporary Regulation 686B Sections 2 to 4 require prior approval of commercial rates (expires 7-1-87)
New Hampshire..	File and use except prior approval for auto
New Jersey.....	Use and file for commercial unless no competition, prior approval for all else
New Mexico.....	Use and file
New York.....	Prior approval for certain lines, flex-rating for most commercial lines
No. Carolina...	File and use, except for some noncommercial lines, rating bureau for homeowners, auto and workers' compensation
No. Dakota.....	Prior approval
Ohio.....	File and use for casualty, motor vehicle and prior approval for other lines
Oklahoma.....	Prior approval, except file and use for homeowners
Oregon.....	File and use, except commercial casualty use flex-rating (prior approval required if increase or decrease of more than 25 percent)
Pennsylvania...	Prior approval except special rule for auto
Rhode Island...	Prior approval
So. Carolina...	Prior approval
So. Dakota.....	Prior approval, except file and use for auto
Tennessee.....	Prior approval, personal lines; use and file for commercial lines
Texas.....	Prior approval, Board sets rates for some lines
Utah.....	Use and file
Vermont.....	Use and file in competitive market, prior approval if non-competitive market in personal lines; no file for commercial lines
Virginia.....	File and use except medical malpractice, uninsured motorists require prior approval
Washington.....	Prior approval except regulation allows flex rating for commercial lines
West Virginia..	Prior approval
Wisconsin.....	Use and file
Wyoming.....	No file if competitive market; order of Insurance Commissioner dated March 25, 1985 requires use and file

Source: National Association of Insurance Commissioners.

- c. Rate approval is based upon three broad criteria; rates may not be excessive, inadequate, or unfairly discriminatory.
- d. Rates may be filed cooperatively through a rating bureau by an individual company, or a company may file an application to deviate from the bureau filed rates. (Some states prohibit cooperative rate-making in certain or all lines of insurance).

4) File and use systems. These systems do not require prior approval but follow many of the same procedures as the prior approval systems. This process generally requires a rate review to determine if they are excessive, inadequate, or unfairly discriminatory. If rates are found not meeting these standards, then they can be disapproved. Most file and use systems allow rates that are filed to be used immediately. Some systems allow the regulatory authority 30 or 60 days in which to disapprove rates. This is similar to prior approval if the rates are not allowed to be used within the waiting period.

In practice, however, this system may not work this way because some companies do not want to expend the cost putting rates in effect only to later have them disapproved. For example, ISO indicated that it awaits approval before notifying a company that the rates ISO has filed in its behalf can be used.

A modification of the file and use system is the use and file system where a company is allowed to use rates before they are filed but is required to file the rates within a specified time after the rates are introduced.

5) Flex-rating system. Flex-rating is a system that permits price variations within limits without having prior approval, similar to file and use, but rate increases that go beyond the limits are subject to review and approval. The system is applied to both increases and decreases in rates and is intended to stabilize price fluctuations. New York, Oregon, and Washington currently have this type of system in place for certain lines of insurance.

6) No file system. This process does not require any filing of insurance rate information. California uses this system for many lines of insurance. To ensure companies are charging fair rates, the insurance department performs audits rather than require rate filings.

#### Rate Regulation in Connecticut

Connecticut does not set rates for any line of insurance nor are there any mandatory rate bureau requirements. Connecti-

cut has four basic systems in place: 1) no filing requirements; 2) file and use without any requirements for department approval; 3) file and use with a provision that the department has 30 days to disapprove a rate before it can be put into effect; and 4) prior approval of rates before they can be used. The following table provides a regulatory matrix displaying the type of system used and the line of insurance it covers. This matrix also includes information on the type of system used to regulate changes in policy forms (i.e. the documents related to a policy contract must be reviewed by the department before being used). A more detailed description of the policy form review process will be covered in the next section.

If rate approval is required, the basic criteria used are the same for all lines of insurance, with the exception of the personal lines, though the methodology for reviewing rates may differ. The statutory criteria state that rates shall not be excessive, inadequate, or unfairly discriminatory. A rate that is not "excessive" is generally defined as that which would cover the company's operating expenses and includes a certain level of profit. The department does not set any level of profit or rate of return on investment as is done with public utility regulation, nor does it have any set percentage for determining what constitutes an excessive rate. "Inadequacy" is defined as a rate which, along with investment income, is not sufficient to cover a company's claims payments after expenses are paid. Finally, "unfairly discriminatory" means that an insurer cannot charge a significantly different rate for two people who are classified as the same type of risk. Individuals can only be charged different rates if there is an actuarially sound basis for doing so. Application of these criteria can differ from product to product.

For personal lines, the statute states that if a competitive market exists for the product, such as homeowners or automobile insurance, then the rate cannot be judged excessive by the department. In other words, the department cannot use the criterion of excessiveness when reviewing these rates.

The department has detailed guidelines for the filing of all rate applications. The typical rate application will include the proposed rates, rating plans, classification systems, and territories. The applicant must also include supporting information on loss experience, an interpretation of the statistical data relied upon to justify the increase, and a description of the methods used in the making of new rates.

For example, the applicant in a personal auto rate filing is required to show what the rate should be, given its current and estimated future loss experience, as well as the rate the company intends to adopt. The filing must also detail rate level changes by each territory. (The state is divided into

Table III-13. Regulatory Matrix Covering Rate and Policy Form Regulation by Line of Insurance.

Line of Insurance	No Filing	File & Use	File & Use: 30 Days	Prior Approval
<u>Life</u>				
Individual	R			F
Group	R			F
Credit			R/F	
<u>Accident &amp; Health</u>				
Individual			R/F	
Group	R			
Credit			R/F	
<u>Auto (voluntary)</u>				
Private			R/F	
Commercial			R/F	
Territorial Changes				X
<u>Auto (assigned risk)</u>				
Private				R/F
Commercial				R/F
<u>Property/Casualty</u>				
Personal Risk			R/F	
Commercial			R/F	
FAIR Plan (assigned risk)				R/F
Title				R
Credit				R

R = Rates

F = Forms--including policies, endorsements, riders, revisions.

X = Special reviews of territorial boundary changes are conducted.

different regions or territories, which, because of different loss cost experience, are charged different rates for insurance). To allow the department to confirm the accuracy of methodologies used to compute the rate, the department guidelines require the applicant to provide a set of examples showing what the rates would be for a given set of insurance coverages. This information is also used to develop comparative pricing for use by consumers.

## Rate Review Administration

Rate reviews are conducted in three divisions: Life and Health; Casualty/Actuarial; and Property and Casualty Rating. While all divisions use the basic statutory criteria, additional standards may be used for some lines.

Rate analysis in the Life and Health Division is largely based upon two factors -- the percentage increase since the last rate change, and the ratio of claims paid to the premium charged (loss ratio). For accident and sickness policies, the loss ratio cannot be less than 50 percent for an individual and 60 percent for a group. For medicare supplement policies, the allowed ratio is 60 percent for individuals and 70 percent for groups. Insurance policies for long-term health care cannot be sold for premiums with loss ratios less than 55 percent for individuals and 60 percent for group policies. The intent of these statutory limits on such insurance policies is to return 50 to 70 cents of every premium dollar to the customer in the form of claims payments and limit the size of the premium. If the appropriate percentage is not being returned then the premium would be deemed excessive.

The problem with this rate-setting approach is that, at a minimum, the claims paid will not be known until the end of the policy period while the rate payment is made at the beginning. This means that a critical factor in the department's review of rates is based upon the accuracy of the company's loss estimations. This problem is found throughout the rate review process and exists for all lines of insurance.

In the property and casualty rating division, an examiner has a list of components that must be used for review. The examiner must consider the following:

- the market affected by the rate change;
- the market share of the company proposing the increase;
- the percentage and dollar increase or decrease in the rate;
- the current market conditions and trends;
- the existence or absence of market competition; and
- the company's overall financial condition.

The examiner will review the methodology used by the company to determine rates in the past to see if any changes have been made. Also reviewed are the company's expense

components such as loss adjustment expenses, commissions, taxes, operating expenses, and target profits. Other factors entering rate analysis are loss development trends, and patterns in the frequency and severity of claims.

The information concerning the insurer's Connecticut business is also compared with national averages for any unusual deviations that would require an explanation. The rates are also compared with those of other companies and bureau-filed rates for an indication of how the company stands competitively. As noted earlier, the most important considerations are the losses experienced by a company and its projected losses when determining if the rate level meets or exceeds the statutory criteria of excessiveness or inadequacy. An exception occurs when the division is reviewing personal lines of insurance, such as homeowners, where the criterion of excessiveness does not apply if the department has determined the market for this product to be competitive.

A similar procedure is followed in the Casualty/Actuarial Division for auto rates. The department requires exhibits showing: the indicated and adopted rate level changes by each territory; premium dollar breakdowns identifying fixed and variable expenses; annual trend factors for claim frequency and severity, and their impact on rates; and a set of rate examples that can be used by the department to provide consumer information.

Companies are required to file detailed rate information even though the department cannot deny a rate increase based upon the statutory criterion of "excessive", if the market is determined to be competitive. The statute requires the commissioner to assume, for personal lines, that a competitive market exists and must hold hearings before ruling to the contrary. The commissioner may use several tests as prescribed by statute including the size and number of firms actively engaged in business in the market, market shares of firms offering the product, ease of entry and exit in the market, investment income earned, and availability of consumer information.

The statute also requires the commissioner to monitor competition in the state. The chief indicator used by the department to determine market competition is the market share held by each company doing business in Connecticut. While there are no statutory or regulatory criteria for what constitutes a non-competitive market, the department has indicated that if two companies wrote more than 50 percent of the total premiums in a particular market, then competition would not exist.

Indicated rates are those that the company needs to charge based upon its estimated loss experience and expenses. A company may choose not to charge the indicated rates, but rather adopt rates that are more in line with its competitors' prices. For instance, a Connecticut company, in a recent rate filing,

stated that its loss experience indicated the need for a 5.8 percent increase in its auto rates, but decided to increase rates by 1.9 percent to remain competitive. This portion of the filing only needed to be accepted or rejected by the department because prior approval is not required. However, the company also filed a redefinition of its territories, which did require approval by the department. The company requested this territory realignment after conducting a town-by-town review of the firm's automobile experience and finding that certain towns had consistently better experience than others.

#### Rate Increase Histories for Connecticut

The rate that is filed with the department is only an estimated average rate and can differ greatly for the individual or business being insured. In commercial insurance there are more than 1,000 different classifications for the type of business to be insured, each having a different rate structure. Other factors affecting the rate include proximity to fire service, number of employees in the business, number of patrons served, square footage, and age of the building. The business's past claims experience could also be used to determine a rate. All of these factors are used to arrive at a composite rate for the type of insurance desired by the business. It is therefore difficult to do rate comparisons unless one compiles the actual premiums charged and is able to relate them to some common unit of risk exposure.

For auto insurance the rating system is somewhat less complicated although there are still a number of factors taken into consideration when rating a driver. The driver's age, marital status, miles driven, and length of driving experience may be used to classify the risk of insuring the individual. Once classified, the rate will be based upon the driver's place of residence, past loss experience, and driving record.

The department supplied program review with rate increases that occurred over the past few years in Connecticut for five different lines of insurance. Tables III-14 and III-15 present the increases for the following: commercial multi-peril; commercial general liability; homeowners; auto insurance for the voluntary market; and auto insurance for the assigned risk pool.

The information concerning homeowners insurance is based on ISO rate filings for loss costs only. The rates concerning the voluntary auto market are derived from the 10 largest insurers in Connecticut whose total composite market share is greater than 50 percent.

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Table III-14. Percentage Rate Increases for Commercial Insurance by Year.

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	'83	'84	'85	'86
General Liability	14.4%	8.8%	39.5%	24.3%
Commercial Multi-Peril	0.0%	0.0%	.6%	3.9%

Source: Conn. Department of Insurance (ISO filed rates).

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Table III-15. Percentage Increase for Personal Insurance.

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Year	Homeowners	Auto-Voluntary	Auto-Assigned Risk
'76	No Change	21.0%	10.3%
'77	-3.4%	6.4%	17.9%
'78	No Change	1.2%	No Change
'79	-4.4%	5.4%	10.6%
'80	No Change	5.9%	11.6%
'81	3.5%	8.6%	12.1% & 2.3%
'82	1.9%	14.3%	10.8%
'83	No Change	3.7%	8.0% & 16.9% *
'84	-5.1%	5.7%	12.3%
'85	No Change	9.8%	11.2%
'86	No Change	10.7%	No Change
'87	No Change	7.5%	8.4%

\* Two rate increases in one year.

Source: Connecticut Department of Insurance.

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## SECTION IV

### POLICY FORMS REVIEW

Insurance is a service provided to the purchaser which protects him/her from economic loss due to the occurrence of an unpredictable event. When the purchaser agrees to buy this service he/she is provided a legal contract, the insurance policy. The policy form is usually written in two parts, the declarations page or cover sheet, and the contract itself. The cover sheet provides the pertinent information such as the name and address of the insured, a description of what's covered by the policy, the amount of insurance purchased, and the cost or premium being charged for the policy. The second part, the insurance contract, contains all the conditions of the coverage and any exclusions from the policy.

The average person views an insurance policy as being a wordy, complicated document, difficult to understand, and confusing. To ensure that consumers are protected against ambiguous or misleading policies, all states regulate policy forms, applications and endorsements to some extent. However, similar to rate approval, statutory and regulatory requirements for policy forms approval vary from state to state, as well as within a state, depending on the product.

All policy forms must be filed with the department prior to use in Connecticut. Table III-16 below, shows the major lines of insurance, along with the type of policy approval required by statute. The same definitions concerning regulatory approval mechanisms for rates, described in the previous section, apply to this table.

As the table indicates, depending on the insurance product, companies may be statutorily prohibited from selling a product unless it has been approved by the department, while with other products, the policy must be on file before its effective date, but the company does not need specific approval before it sells the policy. In practice, however, few companies will begin marketing a product unless it has been approved. The costs of changing an already marketed product without department approval would be prohibitive.

Who must comply. Any company wishing to introduce a new policy, change a policy, or add new forms related to a policy must file with the department. In addition, many companies -- especially those in the commercial lines of insurance -- use forms developed by bureaus, such as the Insurance Services Office, as discussed earlier. Those organizations must also have policy forms approved on behalf of member companies. Any member

company may then use those approved forms. However, a company wishing to change them in any way must file the changes with the department.

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Table III-16. Policy Forms Review. Department's Statutory Authority.

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<u>Product</u>	<u>Regulatory Authority</u>
Individual Life or Annuity	Prior approval--no time limit
Group Life or Annuity	No statutory authority--in practice prior approval
Individual Health	Prior approval--if not specifically disapproved within 30 days, it is deemed approved
Casualty Actuarial (auto)	File and use. Commissioner may disapprove at any time
Group Health	Prior approval--no time limit
Property and Casualty	File and use. Commissioner may disapprove at any time
Credit Life and Credit Accident and Health	Prior approval--if not specifically disapproved within 30 days, it is deemed approved

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Policy forms are reviewed by examiners in the following three divisions of the department: 1) the Life and Health Division reviews life, and accident and health policies, including those offered by health maintenance organizations; 2) the Property/Casualty Division reviews homeowners, workers' compensation, commercial property and liability, and professional liability insurance policies; and 3) the Casualty/Actuarial Division examines both commercial and personal automobile policies.

Several thousand policy forms are submitted each year for review. Table III-17 below shows the number of forms submitted each year since fiscal year 1982, and which division received them. As shown in the table, the Life and Health Division receives a far greater number of forms for review than do the other two divisions. This is mainly because individual

companies do most of the filings in this area, while with property/casualty insurance, companies use ISO or other bureau filings.

Table III-17. Policy Submissions By Division. FY82 - FY86. \*

Division	FY82	FY83	FY84	FY85	FY86
Casualty/Actuarial (auto)	883	1,084	1,214	891	821
Property/Casualty	2,300	2,432	2,667	2,950	---
Life and Health	13,346	9,522	8,627	13,984	13,975

\* The statistics for the Life & Health Division include only policy forms, while the other two divisions' include both policy and rate submissions.

Source: Department of Insurance Annual Reports.

The number of examiners and the amount of time each devotes to the policy review function varies among the three divisions. From interviews with division staff, program review determined that the following staff time is devoted to forms review as shown in Table III-18 below.

Table III-18. Staff Assigned to Forms Review -- by Division.

Division	No. of Staff	Full-time/Part-time Function
Casualty Actuarial	1	Full-time Function
Property Casualty	3	Part-time Function
Life and Health	4	Part-time Function

Process. While there are differences in the way divisions check policy forms, there are two basic factors that guide all examiners in their review. First, the policy must comply with all statutes, regulations, or department bulletins. Second, the policy must not contain provisions that are discriminatory or unfair.

Specifically, examiners check to ensure that policies:

- contain any statutory mandates for coverage and in the amounts required;
- do not lessen coverage from the industry standard unless an accompanying rate reduction is included;
- provide the coverage it purports, and is not misleading to the policyholder;
- are written in a certain format, if the law requires, as with fire insurance; and
- contain a certification of readability.

Examiners in each of the three divisions identified for program review staff the procedures used when reviewing forms. None of the divisions has developed a comprehensive checklist for forms review, as department staff indicated that the variety of policy submissions does not lend itself to a checklist approach. Instead, examiners use a combination of documents -- statutes, regulations, bulletins and, in some cases, division review sheets -- to aid them in their examination.

The time it takes to review a policy varies greatly depending on the type of submission, the product, and the division reviewing the policy. A minor policy change might take less than an hour to review, while a new policy may require one or two days. However, the process becomes much more lengthy if an examiner finds an incomplete submission or a problem with the policy. The examiner then communicates those questions to the company and awaits its response. This process can often take six months, and sometimes -- as was the case with the ISO major commercial filing in 1985 -- more than a year.

The program review committee examined the processing times in the Life and Health Division, which keeps a card file of each submission by: company; date filed; and the date of final action. A random sample of 171 cards of 1986 submissions were examined to assess processing times. The results of this analysis are shown in Table III-19 below. Program review was unable to collect similar information in the other two divisions as it was not readily available. In the Property/Casualty Division, a log of all submissions is maintained by date filed; however, in most cases it does not indicate the date final action was taken. No log is kept in the Casualty/Actuarial Division.

Table III-19. Processing Times in the Life and Health Division.

Number of Days	Number of Submissions	Percent
0-30	48	29%
31-60	15	9%
61-90	22	13%
91-120	32	19%
121-160	17	10%
160 +	33	20%

As the table indicates, almost 30 percent of the filings are acted on within 30 days. However, a large percentage of the filings take several months to process. For example, almost 50 percent of the filings took more than 3 months to process, and final action was not taken for more than 5 months in one out of 5 cases. It should be noted here that in one-third of the filings, there was an indication that the department had taken some interim action. This usually involves communicating with the individual company and can add considerably to the processing times.

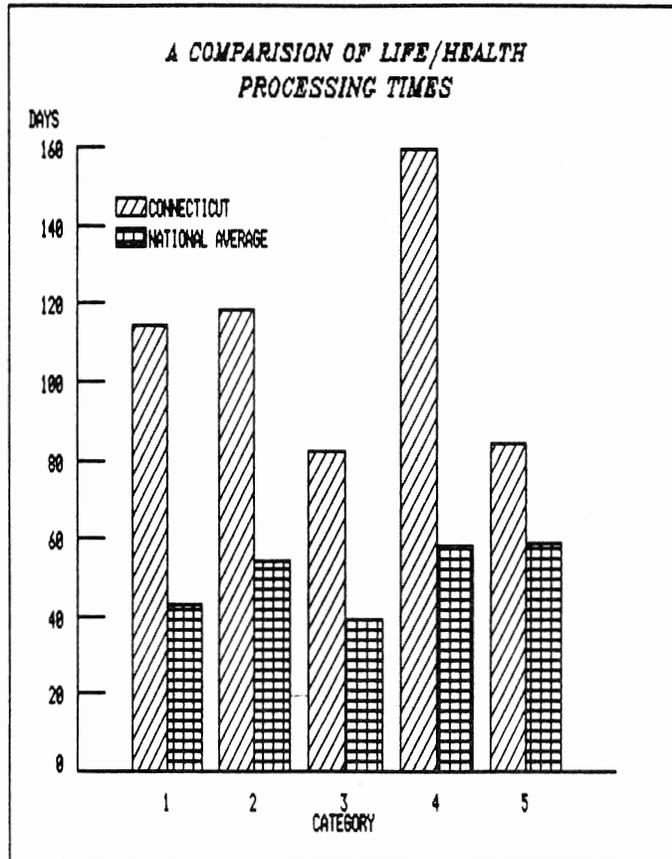
However, even discounting that, the times seem lengthy compared to other states. A survey was conducted by the Kemper Life Insurance Companies of life and health insurance carriers who participate in the Life and Health Compliance Association. One hundred and three (34%) of the companies responded. The program review committee compared Connecticut's results with the national average in five separate categories: individual life; universal life; annuity products; variable life products; and accident and health products. The results of the comparison are displayed in Figure III-3.

The last area program review examined in the forms review process was the final action taken with the submissions. In the Life and Health Division, program review examined the final action of the same random sample of 1986 cards mentioned previously. The examination showed that 101 submissions (59%) were approved, while 27 applications (16%) were disapproved, and 16 (9%) were withdrawn, or filed only. In another 27 (16%) of the submissions, program review staff could not determine what final action had been taken.

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Figure III-3. Life and Health Division Processing Times:  
A National Comparison

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- 1 - Individual Life
- 2 - Universal Life
- 3 - Annuity Products
- 4 - Variable Life
- 5 - Accident & Health

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The Property/Casualty Division began keeping a log in April 1987 that tracks all policy and rate submissions. Program review examined all entries logged from April 23, 1987, through June 30, 1987.

As the table indicates, the vast majority (84%) of the submissions in the Property/Casualty Division are approved, with only 2 percent disapproved by the department, and another 5 percent deferred until more information could be received.

Table III-20. Disposition of Policy Forms Submissions.  
Property/Casualty Division.

	Number	Percent
Approved	434	84%
Deferred	26	5%
Disapproved	9	2%
Unknown	48	9%
Withdrew	1	.1%
Total	517	100%

Underwriting guidelines. Underwriting guidelines are the criteria a company uses to accept or deny risks such as an applicant for automobile insurance. These guidelines are based on a company's judgment of what is an acceptable risk, and need not be supported by data. Unlike policy forms, companies develop their own underwriting guidelines and do not rely on insurance service bureaus.

Since 1978, insurers of automobile liability policies are statutorily required to file their underwriting rules with the department, in addition to policy forms and this underwriting filing requirement was extended to homeowner insurers in 1983. In practice, insurers of other products also file underwriting guidelines with policy submissions, although it is not required.

While the department cannot approve or disapprove underwriting guidelines per se, the underwriting guidelines for automobile insurance must be on file at least 30 days before becoming effective. The department examines the guidelines to ensure that they do not violate Connecticut statutes, which prohibits denial of insurance based on certain factors such as religion, age, sex, marital status, occupation or profession. In addition, if the department receives a complaint concerning underwriting practices, the Casualty/Actuarial Division staff check a company's underwriting guidelines to verify whether the guidelines on file are those the company is actually using.

Program review examined the underwriting guidelines on file in the Casualty/Actuarial Division for each company writing private passenger automobile insurance. Of the 168 companies reported by NAIC writing this type of insurance, program review found that only 150 companies had direct premiums for private

passenger automobile in Connecticut in 1986. Although guidelines had been filed for all companies, program review found that 40 companies had not filed guidelines since 1985, 72 since 1986, and only 38 companies had filed guidelines in 1987. Each time guidelines are changed, or a revision is made to them, companies are required to file a current copy with the department.

## SECTION V

### THE DEPARTMENT'S ROLE IN CONSUMER PROTECTION

Another major responsibility of the Connecticut insurance department is to make certain that the consumer is adequately protected in the marketplace. The department performs the following functions aimed at protecting the consumer: 1) responding to individual complaints; 2) providing insurance information to consumers; 3) performing market conduct examinations; 4) licensing agents and brokers; and 5) disciplining violators. The department's efforts in each of these areas are described in this section.

#### Complaint and Inquiry Processing

The Department of Insurance responds to insurance complaints and inquiries from consumers, businesses, and others who have general or specific questions or problems with insurance. Complaints and questions focus on life, accident and health, automobile, and other property and liability insurance. Four divisions fulfill the department's complaint-handling function; the Life and Health Division, Casualty/Actuarial Division, Property/Casualty Division and Licensing and Investigations Division. The last division receives and responds to the majority of complaints. Generally, it appears that the nature of the complaint determines the division that is responsible for responding, although some overlap does exist between the Licensing and Investigations Division and other divisions.

For calendar year 1986, the program review committee identified 7,679 written complaints and inquiries received by the department and reviewed 1,651 of them. The committee examined written complaints and inquiries in the four divisions. The committee looked at both the content of the complaints and inquiries and the process used to resolve them. Data were compiled on the nature, origin, final disposition, and processing time of each. All complaints and inquiries located by program review staff were recorded except those in the Licensing and Investigation Division where a random sample of 553 of the 6,581 total complaints and inquiries was selected. Table III-21 shows the breakdown of written complaints and inquiries the committee reviewed by division. The results are analyzed below.

Each division also receives numerous phone inquiries although Licensing and Investigations receives the vast majority. Often the information can be relayed quickly over the phone, so no letter is required.

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Table III-21. Number of Written Complaints and Inquiries Examined by Division.

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<u>Division</u>	1986 <u>Number of Written Complaints/Inquiries Examined</u>
Licensing & Investigation	553*
Casualty/Actuarial	558
Property/Casualty	182
Life & Health	358
TOTAL	1,651

\* Random sample of 553 reviewed out of a total of 6,581 complaints identified in this division.

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#### Complaint/Inquiry-Handling Process

The only similarities that exist from division to division in the complaint/inquiry-handling process is that a date is stamped on each letter that arrives, and examiners check statutory and company underwriting guidelines to ensure compliance with both the laws of the state and guidelines the company has filed with the state. Otherwise, there appears to be no department-wide policy on complaint/inquiry processing. Summarized below are the processes each division uses to handle complaints and inquiries.

Life and Health Division. The Life and Health Division receives more inquiries than complaints. The number of inquiries in this division outnumbered complaints 277 to 81. Inquiries consist mainly of requests for regulatory information by businesses or insurance availability questions from consumers. Complaints received usually relate to rates, policy coverage, and insurance availability. Inquiries are maintained separately from complaints.

Complaints are filed by company name and by the product offered in folders also filled with general correspondence between the division and insurance companies. Complaints are difficult to locate and catalog because they are interspersed among unrelated pieces of correspondence in the company file.

Life and health examiners ask complainants to state their complaint in writing if the problem is complex, although, if

quickly resolvable, examiners handle a complaint over the phone. If written, the complaint is either referred to the insurance company with a request by the division for a written reply or an examiner may phone an insurance company representative and request information pertaining to the complaint.

Casualty/Actuarial Division. Written complaints received in this division generally concern automobile insurance including rates, policy cancellations, risk classifications, and refunds. Complaints are separated into two categories; one for the Assigned Risk Plan and the other for the auto "voluntary" market. Complaints are filed by month received. The Assigned Risk Plan makes auto insurance available to consumers who are considered high risks and unable to obtain insurance through the open or voluntary market.

If a complainant phones the department, examiners request that the person send a letter stating the nature of the problem and a copy of the automobile policy. As in the Life and Health Division, an examiner forwards a copy of the complaint to an insurance company representative requesting a written reply to the division or phones the company for further information. Information supplied by an insurance company is carefully reviewed. The examiner checks the company's filed underwriting guidelines and risk classifications as well as the department's bulletins and statutory guidelines for possible errors in computation or regulatory noncompliance.

If the examiner finds that an error has been made by the insurance company, the division informs the company and asks for a written reply outlining what corrective action will be taken. Once received, the examiner informs the complainant of the error made and the restitution that will follow. If no error has occurred, the complainant is provided with an explanation of why the complaint is invalid.

Property/Casualty Division. This division is responsible for complaints and inquiries concerned with rates, cancellations, availability and regulatory concerns involving commercial properties and liability insurance, workers' compensation, and homeowners insurance. Many complaints are initially handled by phone with no record of what transpired. Occasionally, the division may request a written letter, but usually does not. If written, a complaint is referred to the insurance company with a request by the division for the company to respond directly to the complainant. Unlike other divisions, the Property/Casualty Division in most cases does not request a copy of the company's response to the complainant.

Program review found it difficult to track complaints from the original letter through to final resolution in this division. Files often contained either the original complaint or only correspondence from a company. Furthermore, replies and final resolution of the complaints were filed in separate

folders with no cross-referencing to match initial letters. Thus, the program review committee frequently could not determine how complaints were finally handled.

Licensing and Investigations Division. The Licensing and Investigations Division receives the largest portion of the complaints. Established procedures exist for handling each complaint. During most of the study, complaints were handled manually, although a computerized system developed to process the department's complaints became operational in September 1987.

Written complaints are given a claim number, logged into a book, and assigned to an examiner. Complainants are sent an acknowledgement card with the file number and the examiner's name in charge of the investigation. An examiner may request additional information from the complainant in order to facilitate complaint resolution. Each complaint is kept in a folder with an index of pertinent information. A form letter and copy of the complaint is sent to the appropriate parties (company, agent, etc.) named in the complaint requesting a response within a specific time period. The examiner notes the date by which a response should be received from a company. A follow-up letter is sent if there is no reply restating the length of time allowed for a response to the division.

The Licensing and Investigations Division receives approximately 1,300 phone calls a week; the vast majority of them from persons with complaints rather than inquiries. To deal with this number of calls, the division recently installed a rollover phone system with a recorded message.

According to telephone personnel within the department, about 80 percent of the complaint calls are transferred to division examiners, while 20 percent of the calls can be handled by operators. Examiners, in turn, might either respond to the question on the spot, request the complaint be sent in writing, or, if urgent, begin an investigation immediately.

#### Analysis of Complaints and Inquiries

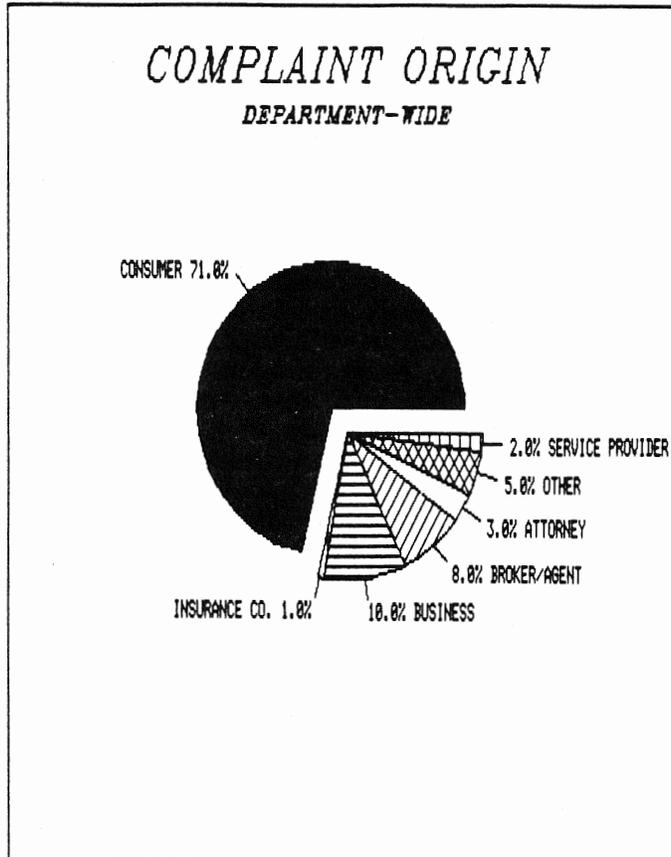
Program review reviewed 1,651 written complaints and inquiries in the four divisions. Of those, 1,207 were complaints and 434 were inquiries. The nature, origin, person or entity named in the complaint, and final disposition of each complaint was recorded and analyzed.

Complaint origin. As depicted in Figure III-4, the program review committee found that a consumer was by far the most frequent complainant to the department. Of all complaints reviewed, 839 or 71 percent were from individual consumers. Businesses other than insurance companies ranked a distant second

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Figure III-4. Complaint Origin: Department-Wide.

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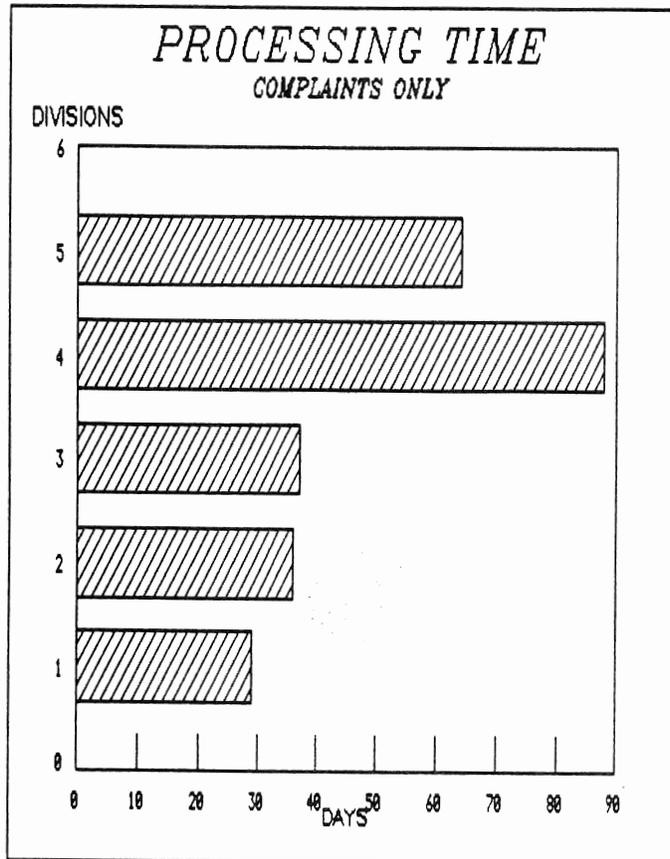
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in the complainant category, with only 10 percent or 120 complaints registered. The department received only 1 percent of all complaints from insurance companies.

Processing time. The program review committee also examined processing time -- the number of days from initial receipt to final disposition -- to handle complaints received by the department. There was variation among divisions regarding the processing time of complaints. Figure III-5 shows the processing times ranging from 29 days in the Life and Health

Division to 88 days in the Licensing and Investigations Division. Department-wide, the average length of time to process a complaint was 64 days.

Figure III-5. Processing Time: Complaints Only.



- 1 - Life and Health Division
- 2 - Casualty/Actuarial Division
- 3 - Property/Casualty Division
- 4 - Licensing and Investigation Division
- 5 - Department Average

It is important to note that the nature of the complaint affects the processing time. Some complaints, such as those involving rate increases, take much less time for the examiner to investigate and, therefore, the processing time reflects this. Claims settlement problems, however, will often take

months to resolve because the examiner must correspond with the insurer and the insured to obtain a resolution.

Processing time for inquiries received by the department was much shorter than that for complaints. The nature of inquiries are similar to those of complaints although many more deal with requests for regulatory information. The Life and Health Division received 277 inquiries and, on average, processed each information request within 8 days. The Casualty/Actuarial Division received 91 inquiries and processed them in an average of 25 days. There were 54 inquiries received by the Property/Casualty Division with a 37-day processing time. Finally, the Licensing and Investigations Division took an average of 72 days to process each of the 12 inquiries it received.

In most cases, complaints were handled promptly. Complainants were either provided with an explanation or corrective action was undertaken to remedy the situation in favor of the complainant.

Nature of complaint. The nature of the complaints varied depending on the division that received them. As shown in Figure III-6, in the Life and Health, Casualty/Actuarial, and Property/Casualty divisions, rates were the most frequent complaint. All divisions, except Life and Health, also received complaints about policy cancellations/nonrenewals. Two divisions handled complaints concerning policy coverage and insurance availability, and one division received complaints about risk classification systems used by insurance companies for underwriting or rates. The majority of complaints received by the Licensing and Investigations Division involved questions of claims settlement while the other divisions received few complaints of this nature.

Program review also found complaints registered against brokers, agents, companies, and adjusters. However, insurance companies elicited the most complaints. Table III-22 shows the breakdown of person or entity named in the complaint.

Final disposition. There are several ways in which the department can resolve a complaint, from explaining why a rate was increased to referral for legal advice. When a complaint is received in the department, an examiner requests the insurance company provide proof to the department that it acted properly. Once the department is satisfied that the company violated no statute or regulation, the department responds to the complainant with an explanation. If, on the other hand, the company's actions are not within the law or department regulations, the department can order the company to take corrective action. For example, if the company did not give proper notification of an

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Table III-22. Person/Entity Named in Complaints.

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<u>Person/Entity</u>	<u>% Named in Complaints*</u>
Insurance Company	90%
Other	9%
Agent/Broker	7%
CT Insurance Dept.	2%
Service Provider	1%

\* Percentages add up to more than 100 due to multiple responses.

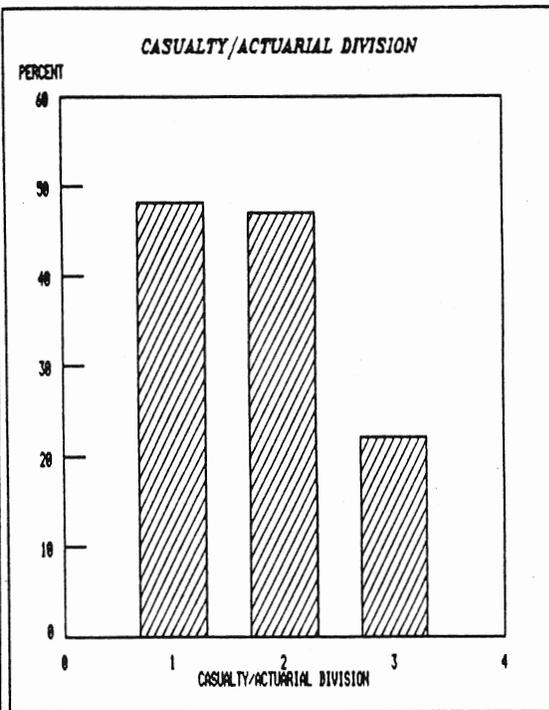
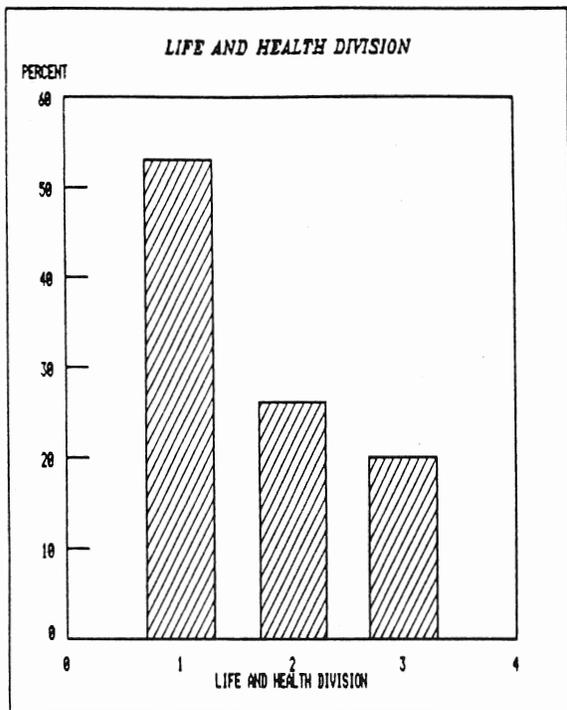
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insurance policy cancellation as required by law, then the department would order the policy reinstated. However, if notification was provided in the statutory time frame, the department would provide the complainant with an explanation and no further action would be taken.

The program review committee examined the final dispositions taken by the department and found they varied among divisions as well. As with the length of processing time, the nature of the complaint affects the final disposition. For example, the Licensing and Investigation Division receives almost all claims-settlement complaints, while Casualty/Actuarial receives many complaints about cancellations/nonrenewals. Since there are strict statutory provisions for cancellations/nonrenewals, corrective action is taken more often in the Casualty/Actuarial Division. However, the department does not have the authority to determine liability or to order a company to pay a claim. If the insurance company is disputing the payment of a claim, the Licensing and Investigations Division would likely suggest that the complainant seek legal advice or initiate action in small claims court.

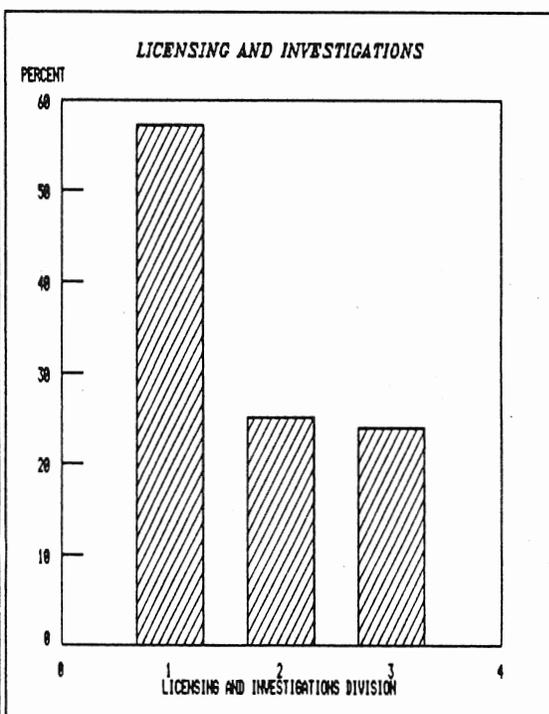
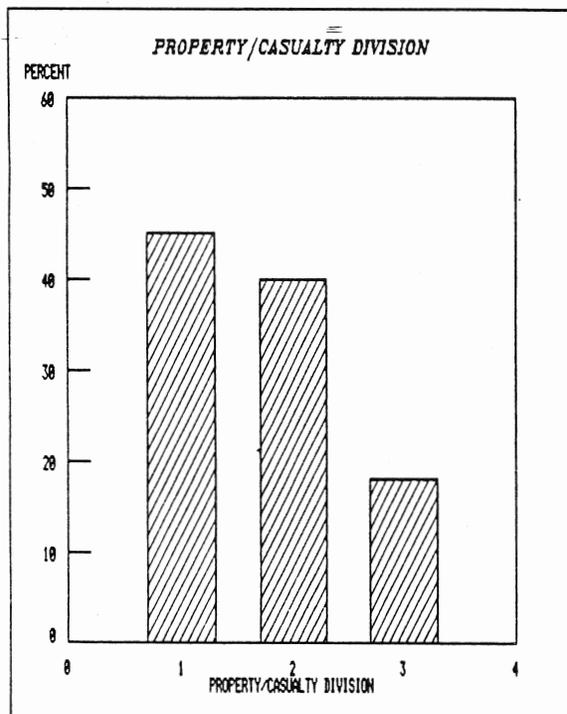
As Table III-23 shows, the Licensing and Investigations Division and the Casualty/Actuarial Division were able to take corrective action more often than other possible complaint dispositions. In the Life and Health Division, an explanation was given 62 percent of the time, while corrective action was taken only 5 percent of the time. Finally, in the Property/Casualty Division, complainants were provided with an explanation in 32 percent of the cases, corrective action was taken in 32 percent, and 35 percent were disposed of in some other

e III-6. Nature of Complaints by Division.



- 1 - Rates/Premiums
- 2 - Policy Coverage
- 3 - Insurance Availability

- 1 - Rates/Premiums
- 2 - Cancellation/Nonrenewal
- 3 - Risk Classifications



- 1 - Rates/Premiums
- 2 - Cancellation/Nonrenewal
- 3 - Insurance Availability

- 1 - Claims Settlement
- 2 - Policy Coverage
- 3 - Cancellation/Nonrenewal

Table VIII-3. Final Resolution of Complaints by Division.

Resolution Category	D I V I S I O N							
	Property/Casualty		Casualty/Actuarial		Licensing/Inv.		Life/Health	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Information Provided	--	--	3	1%	2	--	9	11%
Explanation Given	40	32%	186	40%	172	32%	50	62%
Corrective Action Taken	40	32%	215	46%	228	43%	4	5%
Dept. Unable to Resolve	1	1%	3	1%	49	9%	0	0
Case Pending	--	--	4	1%	34	6%	3	4%
Referred to Another Agency	1	1%	2	--	--	--	3	4%
Other	45	35%	50	11%	49	9%	12	15%

manner. The "other" category in the Property/Casualty Division is high because program review classified unknown final dispositions under this category.

### Consumer Information

The Department of Insurance is statutorily mandated to "provide price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets" (C.G.S. Section 38-201dd). The department receives daily inquiries from the public requesting both general and specific information about insurance.

One way in which the department informs the public about insurance is through telephone and written inquiries. Program review examined all written inquiries and found approximately one-quarter of correspondence received from the public are inquiries.

The department also distributes pamphlets answering frequently asked questions in response to telephone or written inquiries. Annually, a consumer information fair is held in New Haven, where questions are answered and written information is distributed. To date, the department has issued pamphlets covering automobile, health, and property/casualty insurance.

The Casualty/Actuarial Division distributes pamphlets on subjects ranging from general information about Connecticut's no-fault law to more specific price information on automobile insurance. Specifically, booklets on Connecticut's no-fault insurance law and Connecticut's Insurance Information and Privacy Protection Act, as well as a guide to purchasing auto insurance and a consumer guide for handicapped drivers, all contain general information that help make the public more knowledgeable when purchasing auto insurance. Two of these booklets were written in English and Spanish. To assist consumers in comparing automobile insurance prices, the department also developed seven examples of typical consumers, and then listed prices for 50 major companies by each territory within the state. However, these pricing pamphlets were issued in 1984 and have not been updated since.

The Life and Health Division distributes information published by the federal government about Medicare and medicare supplement insurance. This booklet describes the policy coverage available through Medicare. It also explains the applicable deductibles and services that are not covered by Medicare, and provides useful suggestions for purchasing a medicare supplement policy. This division also prints lists of insurance companies that offer medicare supplement insurance, long-term nursing home policies, and individual major medical insurance with addresses and telephone numbers.

In 1986, the Property/Casualty Division offered a rate comparison by company for homeowners insurance, similar to the one published for automobile insurance. The division, in response to concerns about daycare insurance availability, also developed a pamphlet concerning daycare liability insurance. The Governor's Task Force on Insurance Availability also instituted a hotline in late 1985 for consumers with liability insurance problems and the calls were handled by the Property-/Casualty Division. The hotline was discontinued in March 1987.

### Market Conduct

The behavior of a company in the marketplace in pricing its product, its advertising, its claims handling, and its underwriting are all facets of a company's market conduct. The practice of reviewing companies' market conduct is relatively new to the insurance regulation area. According to guidelines published by the National Association of Insurance Commissioners, a market conduct division should examine general business practices and procedures of insurance companies. The Market Conduct Division in the Connecticut Department of Insurance was created in 1986; however, the division was not fully staffed until 1987. The division is responsible for detecting violations of unfair trade practice laws and protecting policyholders and claimants against companies operating contrary to insurance statutes or regulations.

Connecticut's Market Conduct Division conducts examinations in the areas of: 1) sales and advertising; 2) underwriting; 3) rates; and 4) claims. Market conduct is particularly concerned with examining a company's procedures regarding cancellations and nonrenewals, claims settlement, and pricing practices. A division examination is prompted when the department finds a pattern of improper business conduct rather than an isolated incident.

The NAIC guidelines suggest that, to be effective, divisions overseeing market conduct should be guided by five principles in carrying out its functions. They include: 1) developing procedures for scheduling examinations; 2) defining the scope of the examination in relation to the size and lines offered by the company; 3) having qualified examiners conduct examinations; 4) reporting results in a timely manner; and 5) fostering interstate cooperation and coordination.

According to NAIC guidelines, market conduct staff should rely heavily on other divisions within the insurance department to provide them with notification if those divisions detect any patterns that indicate a company may be disregarding statutes or regulations. Market conduct might receive information on companies from several sources, any of which may trigger an examination. These sources could include: financial examiners, staff who are involved in responding to complaints, staff reviewing policy forms and rates, and staff who regulate agents

and brokers. In addition, market conduct staff might analyze the company's complaint data or use information from other states to detect possible violators.

In Connecticut, the Market Conduct Division began concentrating its efforts on examinations of commercial liability lines; however, reviews now include personal lines as well. Since becoming operational, the division has conducted and issued reports on four market conduct reviews, which focused mainly on the cancellation and nonrenewal of policies. Another full market conduct review is currently in process. One of the examinations has led to disciplinary proceedings against the company.

### Licensing of Brokers and Agents

Ensuring that only competent persons are licensed to sell insurance is another method of protecting consumers in the insurance marketplace. In Connecticut, all insurance agencies, agents, brokers, adjusters, partnerships, or corporations must be licensed to conduct business in the state. The department's Licensing and Investigations Division is responsible for this function. Insurance companies are licensed by the Examination Division.

Requirements. Each individual applicant must apply to the department on a department application form stating that the applicant is of good moral character and is financially responsible. A first-time applicant must show proof he or she meets the educational requirements necessary to sit for an insurance exam. The commissioner may waive the exam requirements if the applicant has other experience as outlined in statute. In addition to the educational and exam requirements, candidates must also provide documentation from a company indicating the person will represent that company when licensed.

Exams for agents and brokers are currently administered by the Insurance Testing Institute, a private organization under contract with the department. The exams developed by the department, are given daily at two locations in Connecticut. The division administers exams for adjusters, appraisers, and consultants, which are given once a week. During FY 86, the department examined 8,465 applicants.

All licenses are issued for two years and due for renewal in May of each even-numbered year. However, each time an agent wishes to represent an additional company, he or she must apply for an additional license. Thus, the number of licenses far exceeds the number of individuals licensed to sell insurance. For example, in FY 86, 127,146 licenses were issued to 42,382 individual insurance agents. Table III-24 below shows the number of individuals licensed to sell insurance for FY 86.

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Table III-24. Number of Insurance Licensees -- FY 86.

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	<u>1986</u>
Agents	42,382
Brokers	4,023
Casualty Adjusters	3,239
M.V. Physical Damage App.	2,604
Fraternal Insurance Agents	198
Excess Lines Brokers	111
Certified Insurance Consultants	505
Public Fire Adjusters	82
Insurance Premium Finance Comp.	24

Source: Department of Insurance Annual Report.

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#### Disciplinary Sanctions

The Connecticut Department of Insurance oversees agents, brokers, adjusters, and companies for compliance with the state's insurance laws, and imposes disciplinary sanctions against violators.

Licensed persons and companies are statutorily prohibited from conducting business in any unfair or deceptive manner, or engaging in any unfair methods of competition. Connecticut statutes specify 15 actions that are violations of fair insurance practices. These include:

- misrepresentation and false advertising;
- defamation;
- false financial statements;
- unfair claims settlement practices, including failure to pay accident and health claims within 45 days;
- failure to maintain complaint handling procedures;
- misrepresentation on insurance applications;
- offering rebates, inducements, favored agents or insurers, coercion of debtors, or other unlawful business practices; or

- refusal to insure based on physical or mental handicap (unless based on actuarial principles), blindness, or exposure to diethylstilbestrol (DES).

Other specific laws, such as cancellation and non-renewal notification, must also be complied with.

Process. No action can be taken against any person without an administrative hearing. A hearing notice citing the alleged violations must be provided to the agent, broker, or company at least 30 days prior to the scheduled hearing. According to rules of practice developed by the department, the alleged violator must provide a written answer to the charges within 20 days of the notice; if he or she does not answer, a decision can be made in default.

Hearings are held at the department offices, usually by one of the two attorneys within the legal office. After the hearing, the commissioner must issue written findings based on the hearing, and may order any one or more of the following actions, depending on the type, circumstances, and willfulness of the violation:

- payment of a monetary penalty of not more than \$1,000 per violation or \$10,000 total;
- payment of a monetary penalty of \$5,000 for each violation or \$50,000 total in any 6-month period; and/or
- suspension or revocation of license.

Any person aggrieved by the commissioner's decision may appeal the order to Superior Court.

Analysis. Program review staff analyzed all 53 enforcement hearings that were scheduled during calendar years 1985 and 1986. (The department also holds hearings on other matters such as company mergers; the 53 examined here include only enforcement cases).

The following information was reviewed in each of the 53 cases: 1) the division where the case originated; 2) the alleged violator including agents, brokers, or companies; 3) the type of violation; 4) the disposition of the hearing; and 5) the disciplinary action taken. The results of the analysis are shown in Table III-25.

As the table indicates, cases can originate in any division, although the most likely to initiate proceedings was Licensing and Investigations. Often, the cases result from individual complaints to the department. The Market Conduct

Table III-25. Analysis of Enforcement Hearings -- 1985 and 1986.

	1985	1986
A) <u>Total Enforcement Hearings</u>	24	29
B) <u>Originating Division(s):</u>		
Examination	1	4
Licensing and Investigation	13	23
Casualty/Actuarial	-	2
Life and Health	10	2
C) <u>Violators</u>		
Agents	6	4
Brokers	-	2
Combination	6	7
Companies	12	15
Other	-	1
D) <u>Violation</u>		
Selling without license	3	13
Selling products not approved	9	-
Cancellation/nonrenewal violation	-	4
Failure to remit funds	7	4
Forgery	3	2
Overcharging insureds	1	1
Financial statement violation	1	3
Advertising/solicitation/ misrepresentation violation	1	5
E) <u>Disposition</u>		
Hearing held	1	1
Hearing/default	4	4
Stipulation	18	19
Pending	-	2
Not determined	1	2
F) <u>Action</u>		
<u>Fine:</u>		
\$1,000 or less	3	5
\$1,001 to \$5,000	4	6
\$5,000 to \$10,000	4	1
\$10,001 to \$25,000	1	2
\$25,000 or over	4	4
Revocation/Surrender of License	6	5
Refunds/restitution ordered	3	2
Cease and desist order	-	2
Pending/unknown	1	3

\* Numbers in each category may total more than hearing total due to duplication of factors within each category.

Division is another likely source for identifying violators, once it is fully operational.

The most likely violators in both 1985 and 1986 were insurance companies, and the two most frequent violations were selling insurance without a license or selling products not previously approved by the department.

While all the cases reviewed had hearings scheduled, in practice, few enforcement hearings are actually held. The vast majority of cases are stipulated to, while a few hearings are held by default, with the violator not making an appearance.

Finally, program review's examination of the cases showed that the disciplinary sanctions taken varied as indicated in the table. The department records show that for FY 85 fines totaled \$80,380 and for FY 86 fines and costs collected equaled \$297,642. In addition, 11 revocations and 5 orders of restitution to the consumer were issued in the past 2 years.



## SECTION IX

### INFORMATION SYSTEMS

The data processing function is currently under the jurisdiction of the Casualty/Actuarial Division. The Casualty/Actuarial director and one staff member are responsible for: preparing the long-range data processing plan; security and maintenance of the system; developing, operating, and training others to operate the systems used; and supervising personnel under contract to the department to develop and implement programs.

Currently, the department's use of data processing systems is limited to:

- providing licenses and renewals to individuals;
- processing complaints in the Licensing and Investigations Division;
- preparing department annual reports;
- analyzing automobile territorial rating systems;
- preparing consumer information;
- determining the cost of insurance company examinations; and
- providing word processing capabilities.

The department computerized the complaint system in the Licensing and Investigations Division in September 1987. The program is designed to track specific complaints and prepare reports based on several factors such as origin and nature of the complaint. The system was obtained from the Utah Department of Insurance and was adapted to meet Connecticut's needs. In addition, form letters commonly used by examiners have been entered into the system.

The department developed a five-year data processing plan, in response to a legislative mandate, outlining its long-term data processing needs. This plan prioritizes the department's objectives and the benefits that will result from implementation, with its main goal to install computers in all the divisions. The department has several objectives that it plans to implement by 1992. First, it intends to expand the licensing system to include insurance companies. Second, it plans to make the word and data processing system uniform to provide a cross reference for various forms and endorsements identifying the companies, the form numbers, and approval dates. The department

also plans to create a program that will aid in the financial analysis of individual insurance companies (i.e. financial solvency tests) and test insurance markets to determine the degree of competition. When accomplished, the department believes that it will be better able to detect solvency problems and perform checks and audits not previously done.

Staffing. The department has very limited staffing resources in the data processing area. Recently, it upgraded one employee to a computer operator. However, other functions continue to be performed by existing personnel, including major system responsibilities which fall to the Casualty/Actuarial director. Appropriate staff have been requested, but according to the department, disagreements with Department of Administrative Services over the type of personnel needed have resulted in no hirings.

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CHAPTER IV

FINDINGS AND RECOMMENDATIONS

SECTION I Introduction

SECTION II Insurance Department Reorganization

SECTION III Information Systems

SECTION IV Department Funding

SECTION V Market Competition, Financial Solvency, and  
Rate Regulation

SECTION VI Policy Forms Review

SECTION VII Consumer Affairs

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## SECTION I

### INTRODUCTION

The following Legislative Program Review and Investigations Committee recommendations are intended to strengthen the Connecticut insurance department's role in providing assistance and protection for the insurance consumer. The recommendations and areas affected address the reorganization of the department along functional lines, the regulation of rates and policy forms, the handling of consumer complaints, consumer education, market competition, and the licensing of insurance companies. The reorganization will reduce the number of staff reporting directly to the commissioner and consolidate similar functions under five divisions and the office of legal counsel. This will lead to better coordination among department activities resulting in better delivery of services and regulatory oversight.

The insurance department endorsed the idea and plan the committee proposed for reorganizing the insurance department. However, the department did voice strong concerns that the reorganization, and other staffing and information systems changes, could not be implemented unless adequate space is found to house the staff and equipment.

The Legislative Program Review and Investigations Committee's recommendations place emphasis on maintaining the department's excellent record of detecting financially troubled insurance companies, while strengthening its ability to provide a competitive marketplace that allows for the broadest range of choices for Connecticut's citizens. Streamlining the rate regulation and policy review processes, eliminating anti-competitive practices, providing the consumer with expanded information on rates and complaints against insurance companies, and making access to the insurance department easy for the consumer will help achieve this balance.

The findings and recommendations are presented in the following six sections: Section II describes the department reorganization and functions related to each proposed division. Section III outlines the data processing and information-gathering needs of the department. Section IV discusses restructuring the department's current funding mechanism. Section V deals with rate regulation and the competitive market, and Section VI describes the simplification of policy forms review. The last section outlines the findings related to consumer complaints and recommendations affecting the handling of complaints, the dissemination of consumer information, and the establishment of an arbitration procedure for the settlement of claims disputes.



## SECTION II

### INSURANCE DEPARTMENT REORGANIZATION

The insurance department is currently organized into seven divisions, including the office of the legal counsel, all reporting directly to the commissioner. As a result of recent legislative and executive branch action, the 7 divisions may be further expanded to 11 divisions. The department has not developed a formal implementation plan for achieving the reorganization, or outlining the functions the divisions would be required to carry out. The department's proposed organization chart is included in its current data processing plan. This chart is reproduced as Figure IV-1 and shows the creation of the 11 separate divisions.

The program review committee found the current span of control within the department too broad, negatively impacting management and policy formulation. The large number of divisions results in a fragmentation of planning, coordination, and oversight of insurance rates and policy forms review, as well as the handling of consumer complaints. These problems will worsen if the department expands the number of divisions.

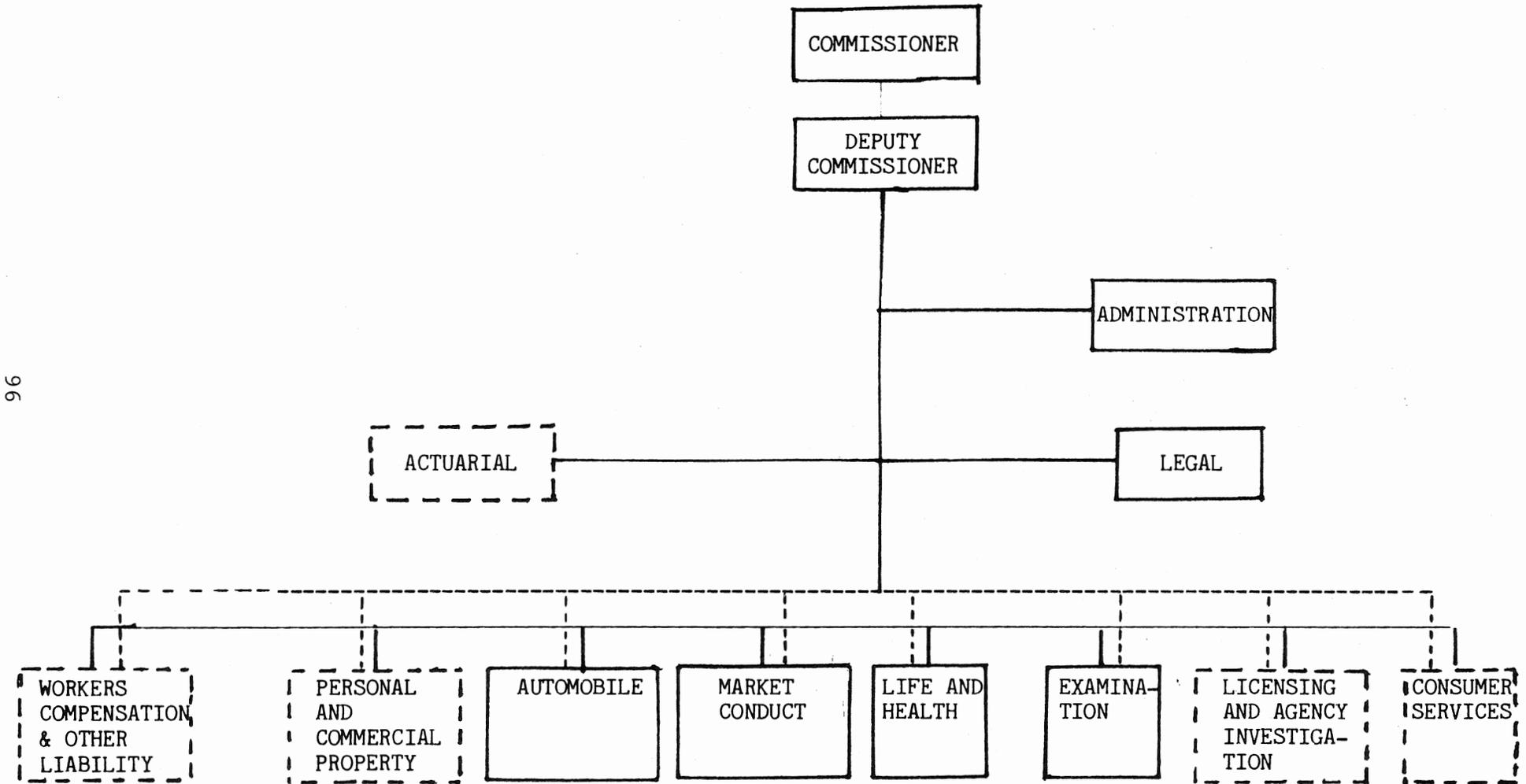
There is no clear organizational theme to the department, with some divisions organized along narrow product lines, while others serve many functions. Further, there is no clear department policy on how these various divisions will carry out their duties. For example, one division may conduct policy reviews and rate reviews, or handle consumer complaints in a different manner than another, even though the insurance products they review are similar. This fragmentation also results in small operating divisions, some with less than five people. With so many divisions handling overlapping functions it is not clear how new functions will be carried out. In addition, key functions, like data processing, are not the responsibility of any one division, making accountability for the coordination of these activities unclear.

To correct these deficiencies, program review recommends the following reorganization.

#### Recommendation

The Legislative Program Review and Investigations Committee proposes a streamlining of the department into five major divisions that are organized along distinct functions. One division, information systems, would coordinate all the department's business administration and information systems. Another division, Consumer Affairs, would handle all consumer

Figure IV-I. Department's Proposed Reorganization Chart.



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Source: Department of Insurance, Data Processing Plan 1988-1993.

protection matters for the department, including consumer information, public inquiries, and complaints. It would also be responsible for examining and investigating the business practices of licensed agents and insurance companies. A third major unit, the Examination Division, would be responsible for all regulatory activities relating to the licensing of new companies and insurance lines, and the maintenance of financial solvency of companies doing business in Connecticut. Finally, two divisions, organized along product lines, would be responsible for all activities relating to the regulation of rates and review of insurance policy forms. The two product lines are life and health insurance, and property and casualty insurance.

The office of legal counsel would remain separate and report directly to the commissioner.

The Legislative Program Review and Investigations Committee recommends that the insurance department be organized into five divisions based upon the following organizational structure. This structure should be adopted by the insurance department by regulation.

#### Division Functions

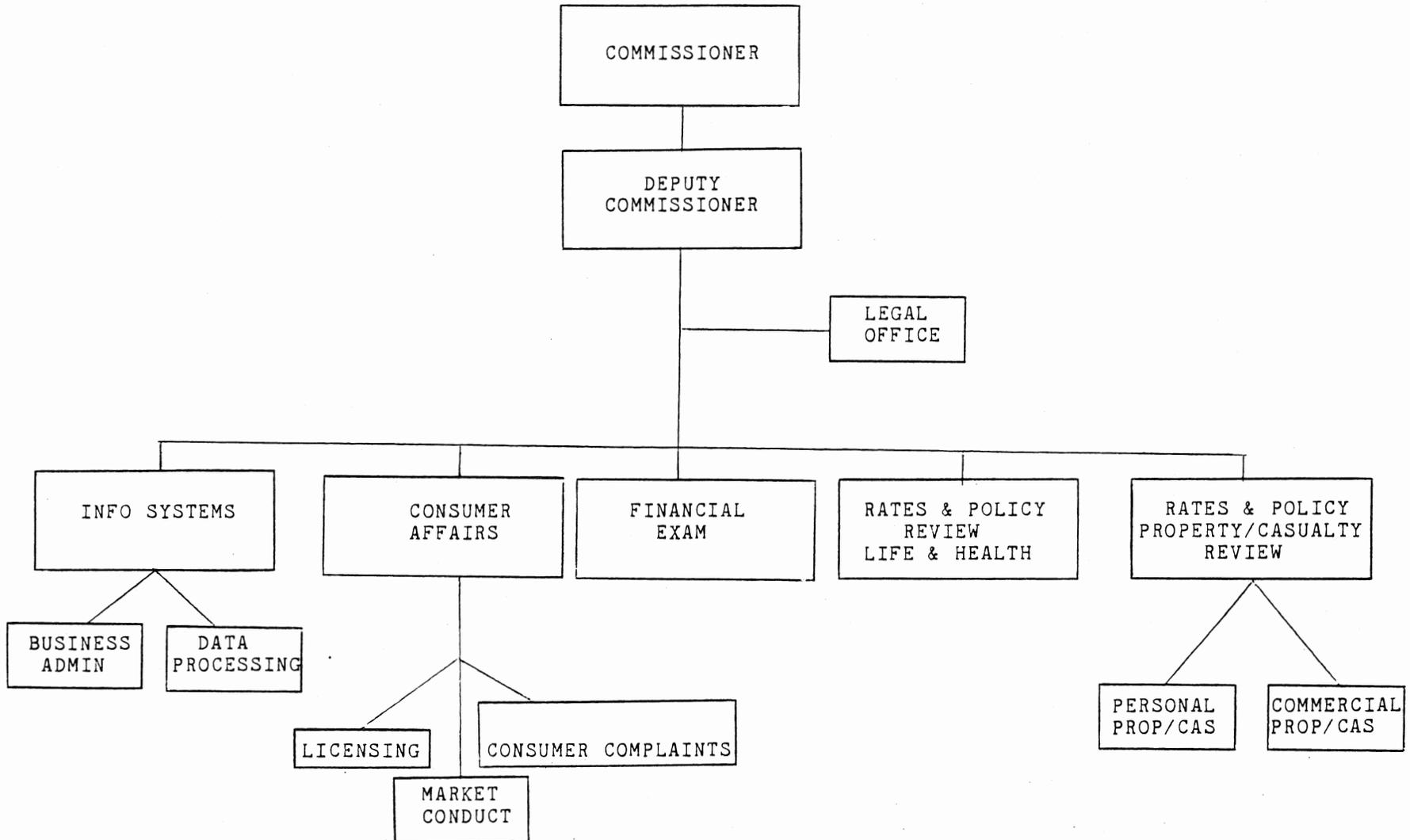
This proposed organizational structure, presented in Figure IV-2, places like functions under a single division and will lead to better coordination of policy formulation, regulation, consumer protection, and the delivery of services. The following details the committee's functional plan for each division and its responsibilities.

Information Systems Division. This division would be responsible for providing the department with data processing and business administration services. The division director should have experience in developing and implementing computer and business systems.

An area the program review committee found in need of additional resources and emphasis is that of information systems and data processing. While the department has a thorough plan for data processing, it has not made substantial progress in implementing its objectives. For example, the department only recently computerized agent licenses and consumer complaints. There has not been much additional progress in automating the department.

The current plan outlines significant goals to be met in the next five years in the areas of analyzing financial solvency, determining market competition, and developing a cross-reference system for the review of policy forms. These objectives found in the department's plan will enhance its

Figure IV-2. LPR&IC Proposed Reorganization -- Department of Insurance.



ability to provide increased consumer protection but the plan cannot be met without adequate resources or a vehicle to implement the plan.

The program review committee envisions this division as the vehicle for meeting the plan's goals. The legislature has made increasing demands upon the insurance department to collect and analyze insurance data. This division will have to be critically involved in compiling the information and developing systems that allow the appropriate divisions to adequately analyze the required information.

Consumer Affairs Division. This division, recently created by the legislature, will coordinate all activities relating to the investigation, processing, and resolution of complaints. The division would be divided into three units, licensing and investigations, consumer complaints, and market conduct reviews. By having all complaints handled within this division, two key sections, licensing and investigations and market conduct, will be aware of the trends in complaints and use the information in planning their review and enforcement responsibilities.

In addition, this division will be responsible for providing assistance to consumers concerning inquiries and complaints. Further recommendations affecting this division will be made in Section V of this chapter.

Financial Examination Division. Financial examinations are viewed as a separate regulatory function and would remain within a separate division. The division would continue to be responsible for licensing all companies seeking to do business in Connecticut as well as conducting financial examinations of licensed companies.

Property and Casualty Rates and Policy Review Division. This division is based upon the rating division that was recently created by the legislature. Four of the divisions proposed by the department -- workers compensation and other liability, automobile, personal and commercial property, and actuarial -- would be combined into this division. The new division would be able to coordinate the oversight of policy forms review with that of rates and provide a consistent review methodology. The sections under this division would be organized into the two major property/casualty lines, commercial and personal insurance.

Life and Health Rates and Policy Review Division. This division would be responsible for all matters relating to the regulation of life and health insurance products. Rate reviews and policy forms approvals will be conducted within the division. In addition, the division will be responsible for all activities relating to health maintenance organizations.

This consolidation will foster a closer connection between changes in policies and their effects on rates, to better assess the impact of rates and rate changes. These two divisions will more effectively carry out analyses of the insurance market as it relates to all products. The methodology for reviewing market structures would be developed by each of these two divisions and could be applied to all product lines. These two divisions will be best positioned to develop the appropriate analytical framework to inform the legislature on the insurance market.

## SECTION III

### INFORMATION SYSTEMS

The insurance industry is highly dependent on automated systems to generate financial, statistical, and forecasting information. Thus, it is essential that the department be equipped with modern computer equipment and qualified staff if it is to effectively regulate the industry. Despite this, the program review committee found that the department has developed limited computer information systems.

As mentioned previously in this report, the data processing function is currently under the jurisdiction of the Casualty-/Actuarial Division. Other than one full-time computer operator, there are no other EDP classified personnel. The establishment of an Information Systems Division, as recommended in the previous section of this report, would allow resources to be focused on this function so that computer systems could be upgraded throughout the department and ensure that their implementation becomes a priority.

The data processing plan developed by the department outlines clear and appropriate objectives, and includes rudimentary implementation plans. However, there is at present no separate data processing unit within the department to implement those plans. Furthermore, there is no one person or division that is accountable to the commissioner for achieving the department's objectives. Thus, it is highly unlikely the department will accomplish its goals within the time-frame specified by the plan without qualified personnel with computer expertise.

The committee also found that lack of adequate databases in the department inhibit the gathering and analysis of financial and statistical data. Currently, when information is compiled it is done so manually.

The commissioner is specifically authorized by statute to assemble information to analyze market competitiveness for personal risk insurance through a variety of tests. These tests include: size and number of firms operating in the market; market share based on premium volume; ease of entry and exit from a given market; underwriting restrictions; earned investment income; and availability of consumer information. However, analysis to date has been severely limited, partly due to the department's lack of automated systems.

Program review found that policy submissions and applications for licensure had significant backlogs in the department. Submissions for approval of policies, rates, licensure of new insurance companies, and guidelines by insurance companies are

processed manually. Underwriting guidelines were difficult to locate and several were not current, but dated back to 1985. Financial examination information is also compiled manually, making the analysis of company solvency a slow and tedious process.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the department establish and develop various systems in order to integrate financial and statistical information by company, both in Connecticut and country-wide. The system should be capable of:

- conducting the financial tests on companies for solvency;
- determining competitiveness of the market through analysis of market share, pricing information, and other relevant data;
- developing a tracking system for policy submissions, rate submissions, underwriting guidelines and licensure of companies; and
- compiling and analyzing the financial data for selected commercial lines that the legislature has required.

The five-year plan has targeted appropriate objectives but implementation strategies are not well-defined. For example, too many objectives are scheduled for three to four years in the future. Considering the prominence placed on computer data by insurance companies, the department is at a severe disadvantage in regulating the industry if it lags far behind in computer technology. Expanding automation will strengthen the department's regulatory role in monitoring and determining competition in the marketplace, and aid in the detection of insolvency. In addition, if deregulation is extended to commercial risk insurance as is being proposed below, it will be imperative for the department to collect, analyze, and develop market information to ensure adequate competition.

Computerization of all pertinent information relating to policy submissions, rate submissions, and licensure of insurance companies will contribute to the reduction of backlogs, by making better use of staff resources in performing regulatory functions such as policy or rate review or examining the financial solvency of companies. Rate and policy submissions, as well as licensure applications can be checked more easily to verify if they have been received and where they are in the processing system. For example, reports on numbers of documents received, numbers incomplete, numbers approved/disapproved would all be readily available if the system were computerized. In addition,

division heads will be able to ascertain easily whether a backlog exists, and the points in the process contributing to the wait.

The increase in financial insolvencies country-wide, as well as the Examination Division's audits of quarterly statements, in addition to annual statements, necessitates a system that will be able to quickly monitor companies for solvency. Furthermore, computerization will provide easy access to information, and will also allow for information to be easily updated. This will facilitate tracking documents and will provide each division with a valuable management tool.



## SECTION IV

### DEPARTMENT FUNDING

The Legislative Program Review and Investigations Committee, in approving the scope of the study on the insurance department and insurance regulation, determined that the current method of funding the department ought to be examined.

At present, the Connecticut Department of Insurance is funded totally by the Connecticut-chartered insurance companies. As discussed earlier in this report, each of the 74 Connecticut companies is assessed a fee based on premiums written and taxes paid in Connecticut. Until June 30, 1987, the statute provided that companies pay the lower cost of two formulas: either the department's actual expenses including fringe benefit costs; or the percentage increase or decrease of the state's net general fund applied to the previous year's assessment.

During the 1987 legislative session, the General Assembly passed Public Act 87-515, which removed the cap on the assessments. The program review committee believes that this is a necessary action, if the department is to be adequately funded and staffed to regulate the industry effectively. The committee examined the department's budget growth compared with that of the regulated industry, measured by the increase in direct premiums written. The department's budget, adjusted for inflation, increased by 52 percent from 1980 to 1987 while the insurance industry's premiums grew by 84 percent.

Therefore, the program review committee believes that the removal of the statutory cap was a positive measure. However, the committee believes that this remedies only one problem with the department's funding mechanism. There are other flaws that the committee sought to address.

The department's expenses are funded dollar for dollar by the regulated industry, thus raising questions of conflict, and influence on the department by the industry. The current assessment system is unfair in that only domestic companies are levied a fee for the department's expenses, while all companies doing business in Connecticut are overseen, to some extent, by the department.

At present, the assessment is linked totally to the taxes paid on premiums written in Connecticut. Consequently, one company -- Blue Cross & Blue Shield of Connecticut -- currently pays 40 percent of the department's expenses. Thus, there is at least the appearance of potential for undue influence by that company on either the department, or on the legislative appropriations process, which could directly affect the department's funding.

To lessen the unfairness in the current system, and remove the potential for conflict and undue influence, the program review committee recommends that one of the following two funding options be implemented. The committee did not vote in favor of one option over the other, but instead elected to present both proposals in this report to the General Assembly.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the current system of assessing insurance companies to the department's operating expenses should be abolished. The department would be funded from General Fund revenues.

This funding system option would eliminate the notion that the regulated industry is directly paying for the regulators. Instead, it would provide funds for the department in the same manner as the vast majority of state agencies are funded, the General Fund. This mechanism would also terminate the disproportionate amount currently paid by a single company.

Additionally, the funds could be raised to compensate for the increase in appropriations from the General Fund by increasing the premium tax. However, if that option is implemented, it is likely that other states will retaliate by increasing their premium tax. According to data obtained from the Connecticut Department of Revenue Services, this would mean that 22 states, whose premium tax is currently at 2 percent or below, might increase their tax on Connecticut companies to a comparable level.

The program review committee proposes, as a second option, the following system, which would also alter the way the department is currently funded.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that a cap of 20 percent should be placed on the amount any one company, or group of companies under a parent company, could be assessed, if the current system is continued.

While this recommendation would maintain the current assessment system, which is levied against only in-state companies, it would remove the imbalance of having 40 percent of the department's budget paid by one company.

Currently, the assessment system statutorily provides that 20 percent of the department's expenses shall be paid by hospital and medical service corporations, incorporated under chapters 592 and 593 of C.G.S., while 80 percent is paid by other insurance companies. The 20 percent cap was put in place when Blue Cross and Blue Shield of Connecticut was incorporated

under the hospital service corporation statutes. When Blue Cross and Blue Shield changed the way in which it is incorporated, the cap no longer took effect.

The program review committee believes that if the cap of 20 percent was initially put in statute to prevent any one company from paying a disproportionate amount of the department's expenses, that concern should hold true no matter how the insurance company is incorporated.



## SECTION V

### MARKET COMPETITION, FINANCIAL SOLVENCY, AND RATE REGULATION

The Legislative Program Review and Investigations Committee examined the insurance industry for market competition, financial solvency, and the rate regulation system and presents findings and recommendations in each of these areas. While the recommendations affecting each area are interrelated they are presented separately for clarity. The market competition section discusses the status of the insurance marketplace in Connecticut and offers recommendations aimed at ensuring competition. The next section discusses the importance of maintaining financially solvent companies and the department's responsibilities in meeting that objective. The final section on rate regulation deals with systems currently in place for conducting rate analysis, the role of rating bureaus in establishing rates, and expansion of the competitive rating system in Connecticut.

The recommendations in this section are intended to encourage a healthy competitive market, remove anti-competitive business practices, maintain Connecticut's high standards for ensuring financial solvency, and provide for a rational rate regulation process.

#### Market Competition

The program review committee analyzed the competitiveness of the Connecticut insurance marketplace and presented detailed market information in Chapter II, Section II of this report. It is the committee's finding that most markets are highly competitive, based upon the information presented.

As Table IV-1 shows, there are many companies writing insurance, none having a significant market share. For the four lines of insurance analyzed, the table gives a breakdown of the number of companies falling either above or below the two percent level of market share. For example, the table indicates that in the homeowners insurance market each of the top 12 or 13 writers had between only 2 and 10 percent of the market, while the vast majority of companies writing that product had less than 2 percent during the 5-year period reviewed. For these product lines there clearly is a substantial number of companies operating in Connecticut, none having a large market share.

By contrast, the marketplace for medical malpractice presents a different picture in terms of market competition. In 1982, 2 companies had a large portion of the marketshare at 69 percent. By 1984, the market became somewhat more competitive with 4 companies writing 69 percent of the medical malpractice business. However, one company still had 36 percent of the

market. In 1986, the market became less competitive when compared to 1984, with 3 companies writing 76 percent of the business.

Table IV-1. Number of Companies Over/Under 2 Percent of Market Share.

Year	Homeowners		General Liability		Commercial Multi-peril		Personal Auto	
	Over/Under	2 Percent	Over/Under	Market share	Over/Under	Market share	Over/Under	Market share
'82	13	98	10	119	12	117	10	104
'83	12	102	10	118	9	119	11	111
'84	13	102	10	122	12	120	11	118
'85	12	103	9	140	8	141	13	119
'86	13	101	10	150	9	151	12	12

Source: NAIC Computer Files.

Given the changing nature of the insurance market, the department needs to continually monitor each product line to determine whether companies are writing for all risks or are limiting their writing to certain types of business, leaving the majority of consumers without a wide range of choices. The program review committee recommends that the insurance department take a more active role in assessing market competition. Further recommendations will be made in the consumer protection area that provide individuals with better information so that they can adequately evaluate the insurance marketplace.

#### Recommendation

The Legislative Program Review and Investigations Committee recommends that the department be required to review and determine every three years whether markets are or are not competitive.

To implement this system the department must publish guidelines that define a market and set standards for determining market competitiveness.

This recommendation, coupled with a program review committee recommendation on the extension of competitive rating to commercial property/casualty insurance, will allow the department to conduct prior approval of rates if a particular market is found to be non-competitive. However, in competitive markets, rates could be disapproved if they were found to be discriminatory or inadequate, but could not be deemed excessive.

#### Barriers to Market Entry

Allowing ease of market entry is a fundamental principle underlying a competitive market. However, this principle must be balanced with ensuring that companies doing business in Connecticut have the financial resources to pay future policyholder claims. The Connecticut Department of Insurance has an impressive record in protecting the consumer against insolvent companies. A comparison of Connecticut's record with that of other states will be presented later in this section.

The program review committee researched the requirements for doing business in Connecticut and found that most could not be considered restrictive. For example, meeting certain financial requirements to do business in the state was not considered to be a restrictive barrier to entry, but instead necessary for ensuring financial solvency. However, two areas were detected to be overly restrictive and need to be addressed. One area involves the length of time it takes the insurance department to review an application to write business in Connecticut, and the other deals with the regulatory requirement that a company must be writing insurance in a contiguous state before it is allowed to write in Connecticut.

Licensing new companies. Program review found a lengthy waiting period for companies seeking licensure. A wait of two to three years to be reviewed for licensure is not uncommon. In a telephone survey of several states, program review found that waiting times do vary -- from a mandatory 120 days in Virginia to waits of two to three years in other states. All states reported that they receive approximately 40 applications each year, slightly fewer than that received by Connecticut. Program review believes several factors contribute to the lengthy waiting period in Connecticut.

First, the Financial Examination Division has only one person assigned to this function. Currently, only the assistant division chief reviews applications for companies wishing to do business in Connecticut. Secondly, the department has had an ongoing backlog of at least 100 applications at the beginning of each year -- 128 in 1985, 135 in 1986, and 107 in 1987. The

department also receives between 45-55 new applications per year. Thus, the division's workload clearly exceeds the personnel currently assigned to handle it.

In addition to the department backlog, it appears that companies, aware of the long waiting time, are applying for a license before they are actually ready to write insurance. Some companies file incomplete applications and leave them pending. The companies project that by the time their applications come up for review, they will supply complete and current financial information. The department has indicated that one of the reasons companies have to wait so long is because of their slow response in supplying the information needed to make the application complete.

Because of the lengthy waits, ease of entry into the market is hampered. However, program review believes that the current high standards of review and the resulting low rates of insolvencies should not be compromised. Instead, the process should be expedited to allow for quicker decisions to be made on applications, while maintaining current thoroughness of reviews.

### Recommendations

The Legislative Program Review and Investigations Committee recommends that the following action be taken to improve the application process and reduce barriers to market entry.

First, the Examinations Division should hire a senior examiner to assist the assistant division chief in reviewing the applications for new companies requesting a license. Secondly, the current regulations should be revised to establish time guidelines for the review procedure similar to the following:

The department should determine if the application is complete within 60 days. If the application is incomplete then it should be returned to the company indicating why it is not being placed on the wait list. No application shall be kept pending unless it is complete. Upon determining that the application is complete, the department shall have 12 months to approve or reject the application. If an application is rejected, the company may request a hearing. Any company whose application is rejected may resubmit the application without prejudice at any time.

Program review believes these two changes will not compromise the standards by which companies are reviewed, but will provide the necessary and regulatory guidelines to allow applications to be reviewed on a timely basis. The revised procedures will promote ease of entry and will place reasonable limits on the amount of time a decision can be made. It will also put companies on notice, that, to be placed on the waiting list an application must be complete and contain current information.

Geographic restrictions. In addition to the timeliness of the review procedures, program review examined the standards by which new companies are evaluated. One regulatory prerequisite for licensure in Connecticut requires companies first to be licensed in a state contiguous to Connecticut. The program review committee finds this regulatory requirement to be overly restrictive by narrowing the field of those companies who can be licensed in Connecticut.

Currently, Connecticut statutes require that any company wishing to do business in Connecticut must demonstrate "an orderly pattern of growth in its marketing territories in th[is] geographic region" (C.G.S. Sec. 38-20). Department regulations defined the "orderly pattern of growth" requirement as being licensed in one or more contiguous states. Therefore, before a license can be granted to an out-of-state company, the company must first be licensed in Massachusetts, Rhode Island, or New York. In a sense, Connecticut is abdicating its regulatory responsibilities to these states.

Program review examined the department's files of rejected applications. The results, discussed in Chapter III, Section II showed that, while the contiguous-state rule was not the most frequent reason for rejection, it was cited in 2 of the 20 companies rejected in 1985, and 4 of the 20 companies rejected in 1986.

The program review committee believes that to limit the introduction of new companies into Connecticut to these states is too narrow a definition of orderly geographic growth. It also restricts entry significantly and at least gives the appearance of inhibiting competition.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the regulatory requirement that a company be licensed in a state contiguous to Connecticut be deleted.

### Financial Solvency

The major regulatory role of the Department of Insurance is to maintain the financial integrity of insurance companies operating in Connecticut. Program review studied the operations of the Financial Examination Division and found the results in identifying financially troubled companies and taking early action to limit the impact of insolvencies on Connecticut consumers to be impressive.

The program review committee examined the analysis the Financial Examination Division conducts, and found it to be thorough. The comprehensiveness of the analysis is borne out by the favorable comparison of Connecticut's payments to its guar-

anty fund, a statutorily established mechanism for paying off claims for insolvent companies, as presented in Chapter III, Section II of this report. All insurance companies are assessed payments into the funds, based on the amount of premiums written in each of the states. The table in that section ranks Connecticut as sixth from the top in terms of the ratio of assessment payments to premiums written for the three-year period. The lower the ratio the less a state has paid into the guaranty fund, weighted by the premiums written in the state.

Computerization. The program review committee found that the analysis of the financial statements, the computations of ratios, quarter to quarter comparisons, and the resulting analysis for company solvency, was being done without the aid of computers. To date this has not seemed to have a severe detrimental effect on the department's ability to detect financially troubled companies. However there are several important factors that make a computerized system for analyzing financial data imperative.

First, the number of licensed companies the Financial Examination Division must oversee continues to grow, thereby increasing the demands on the division's staff time. Secondly, in addition to the annual statements, quarterly statements are also filed and reviewed, requiring the financial examiners to increase their workload. Most importantly, there has been a dramatic increase in the number of insurance company insolvencies nationwide, as reported by the Government Accounting Office and the National Association of Insurance Commissioners. Figure IV-3 graphically portrays this increase.

Even though no Connecticut-chartered company has appeared on the list of insolvent companies, these findings show that state regulators will have to be more diligent in their oversight of companies to ensure that they remain financially solvent so that policyholders' future claims can be settled.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the department introduce a computerized system using NAIC data in conducting its financial examinations of companies writing insurance in Connecticut.

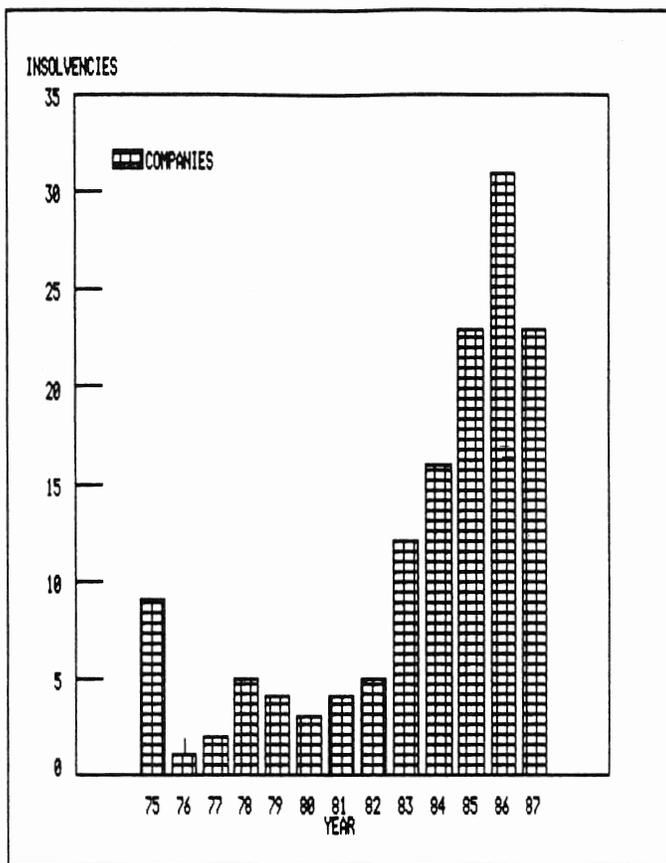
The new Information Systems Division will have the responsibility for developing a computerized system that would best suit the needs of the Examination Division. The goal of having financial tests for solvency computerized is listed in the department's data processing plan. However, the implementation of the goal is projected for 1989-90. Program review believes that the implementation should be made a higher priority. Because of the increasing number of insolvencies nationally, it is likely that more companies in Connecticut will have to be targeted for increased oversight. This recommenda-

tion, in combination with other methods used by the division will enhance the department's ability of ensuring that only financially solvent companies continue to write business in Connecticut.

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Figure IV-3. Number of Insolvencies Nationwide by Year -- 1975 to 1987 (June).

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Source: NAIC Report on Insolvencies, June 1987.

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Quarterly and annual reports. The department indicated to program review that there is a problem with companies filing their quarterly and annual financial statements after the required deadline. These reports, and the timeliness of their

submission, are vital to the department in detecting financial instability as early as possible.

The department currently has limited enforcement power to deal with such violations. It must either not renew or revoke the company's license, or fine the company not more than \$10,000, after holding an administrative hearing. Both of these penalties are inappropriate for the violation, and are too cumbersome to impose.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the Financial Examination Division have statutory authority to impose a late filing fee of \$100 for each day a quarterly or annual report is not filed on time.

### Rate Regulation

The program review committee examined rate-making in detail and concluded that due to the complex nature of the insurance pricing process, competitive market forces are the best regulator of insurance rates. In arriving at this conclusion, the committee analyzed both market competition and various rate regulation systems. The results of the market analysis were presented earlier in this report, along with the various systems of rate regulation.

Determining the increase in the cost of insurance to consumers is difficult because of the nature of insurance products. Insurance premiums are the result of the rate for insurance multiplied by the quantity of insurance purchased. Most insurance rate regulation systems rely on controlling only the rate, with little attention paid to other factors that affect the premium, such as underwriting guidelines or the impact of insuring increasing property values.

For instance, consumers have faced rising premiums for homeowners insurance even though the rate for coverage has remained steady. The increased premium is due to the increasing quantity of insurance being purchased as a result of rising property values. Controlling rates by regulation in this area would have little impact because increased premiums are the result of homeowners buying more units of insurance to cover an appreciating property value rather than an increase in the rate.

The program review committee found similar results in automobile insurance. The increasing value of vehicles, resulting from owners replacing older cars with newer ones has affected the premiums charged. Insurance coverage for a new car is more expensive than that for older vehicles. For example, the average premium for an automobile policy with collision (\$100 comprehensive deductible and \$200 collision deductible) rose 14.1 percent from 1983 to 1984, and 14.7 percent from 1984

to 1985. The rate increases that were filed with the department indicated that there was an average increase of 7.7 percent for 1984 and 8 percent for 1985. The difference between the average rate increase and average premium can largely be accounted for in the increase in the value of the automobiles. The average value of an automobile on the state's property tax grand list (for motor vehicles) rose 12.5 and 6.3 percent for 1984 and 1985 respectively. Obviously, consumers were paying more for insurance, in part, because they were insuring vehicles of greater value.

Regulating rates is even more difficult in the commercial property/casualty industry. Of those risks that can be classified, one insurance rating bureau has over 60 categories of businesses and 7,100 risk classifications. To set rates in this area would require the regulator to determine prices for 7,100 types of risks. Again, this would affect only the rate and not the actual premium charged, which is dependent on the amount of insurance purchased and the value of the property being insured.

Due to the complex nature of insurance rate-making and the fact that insurance premiums are customized to the risk being insured, the program review committee concluded that the most effective way to regulate insurance rates is to actively promote a healthy competitive market. Competitive pressures will force producers to sell their products at their lowest costs to maintain or improve their market share. The previous recommendations concerning competition should ensure that the insurance department takes an active role in analyzing the market.

As noted earlier, the committee found four systems of rate regulation used by the insurance department. Generally, in the health lines of insurance, rates are filed and can be used if not disapproved by the department in 30 days. Life insurance rates are not subject to any filing requirements, with the exception of credit life insurance. In private passenger and commercial automobile insurance for the voluntary market, rates can be filed and used without any waiting period. A similar system is in place for reviewing property/casualty rates. In the non-voluntary or assigned risk markets, rates are subject to review and prior approval by the insurance department.

In addition to these four systems of rate regulation, the committee found differences in the methodology used to evaluate rates. These differences are due to several reasons. One is the result of the statutory provisions that affect criteria used for reviewing property/casualty personal rates versus commercial rates. As indicated in Chapter III, Section III, personal insurance has been largely deregulated in the sense that rates cannot be disapproved for excessiveness if the market place is

determined to be competitive. Commercial rates are subject to the same file and use system, but can be disapproved if they are deemed excessive.

Another major difference between the two systems is that rating bureaus are not allowed to develop and publish rates for personal insurance, but can only supply insurance companies with industry-wide loss costs, loss development, and loss trend information. However, in commercial lines of insurance, bureaus are allowed to establish and file on behalf of the companies the full rate for each line of insurance. Those rates include not only the loss costs, loss development, and loss trend data, but also industry-wide expense information that is used to establish a benchmark rate.

The committee found several problems with the current rate review process. First, the department does not have guidelines for reviewing rates that apply department-wide. The committee found that rate review methodology differs from division to division. This is due in part to the different systems being used, as required by statute. However, it is also due to the lack of coordination among divisions as to which methodology would be most appropriate for reviewing rates.

A second problem exists with the requirement that rates be reviewed in more detail if the market is deemed to be non-competitive. By statute, the market is presumed to be competitive unless the department "determines that a reasonable degree of competition does not exist in a market and issues a ruling to that effect" (C.G.S. sec. 38-201w). The department, as noted earlier, has not taken an active role in reviewing the insurance market. The previous recommendation requiring an ongoing review of market competition will resolve this shortcoming.

A third problem surrounds the use of underwriting guidelines used in the personal insurance lines. Underwriting guidelines are the rules that an insurance company uses to decide whether or not to insure an individual. Guidelines must be filed with the department for private passenger automobile and homeowners insurance 30 days before becoming effective. If changes are made to guidelines, new guidelines must be filed. The department has no disapproval authority unless guidelines violate statutes. Guidelines differ by company and indicate how selective a company is in the risks it will underwrite. Furthermore, most companies have different classes of risk ranging from a preferred program to a substandard program. The company will place an insured in a particular program depending on the probability of loss.

Changes in underwriting guidelines can affect both the rates companies charge and the relative competitiveness of the market. For example, while a company may receive a minor rate increase, it may simultaneously tighten its underwriting

guidelines, limiting selection to its preferred program, thereby forcing more policyholders into the company's standard program. Because companies expect greater losses in the standard program, the rate charged is higher, in effect, raising policyholders' premiums.

The program review committee also found that the department does little in terms of linking underwriting guidelines to rates in order to determine the overall effect on the consumer. The department has no system for ensuring that guidelines are current. After a review of the files, program review found that several companies' guidelines had not been updated since 1985. The Policy Review and Rating Division for property-/casualty insurance should examine and review underwriting guidelines in conjunction with rating information and market competition.

Finally, the setting of rates in the commercial property-/casualty lines of insurance by rating organizations is considered by program review to be an anti-competitive practice. This would not be allowed by federal law if the industry was not exempted from certain aspects of the anti-trust legislation under the McCarran-Ferguson Act.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that several changes be made to the current rate regulatory system as follows.

The department shall establish two systems of rate review: a system of file and use; and a prior approval system. The file and use system shall be used for all lines of insurance for which a competitive market has been determined to exist by the insurance department. A prior approval system shall be used for insurance products sold in a non-competitive market and for those products sold in the assigned risk markets.

Under the file and use system, the department would have the authority to disapprove rates within a 30-day period, if it determined that the rates were discriminatory or inadequate. The department would have no authority to review rates for excessiveness if the market has been determined to be competitive. To implement this system the department must publish guidelines that define the criteria used to determine discriminatory or inadequate rates.

Rating organizations shall only be allowed to compile and distribute rating information relating to loss costs, loss development, and loss trends.

The department should also maintain a computerized system for tracking and maintaining personal lines insurance guidelines. Notices should be sent to companies annually reminding

them to update guidelines. If guidelines remain in effect from a previous year, a company should send a letter attesting to that, otherwise, new guidelines should be filed. A check should be made by the department after 30 days to ensure compliance.

These recommendations will put into effect a rational system of rate regulation. They will remove anti-competitive practices and allow the competitive market to produce the lowest possible prices. Insurance companies in the commercial lines will have to apply their own expenses to the bureau-established loss costs and will not be able to rely upon an industry benchmark from which to price their products. However, the recommendation will continue to allow insurance companies to use rating bureaus to pool their loss information and develop estimates of future loss trends.

## SECTION VI

### POLICY FORMS REVIEW

Policy forms review is an important regulatory function since it protects consumers against ambiguous or misleading insurance contracts and ensures that required statutory or regulatory provisions are included in the policy. The program review committee examined the procedures used in reviewing policy forms in three divisions -- Life and Health, Property/-Casualty and Casualty/Actuarial (auto). The committee recommends improving the department's policy forms review process by establishing the review procedure in regulation, developing criteria for review and approval, and by authorizing the department to hire additional staff to conduct the policy review function.

Review procedures. There are almost identical types of systems used in the review and approval of policy forms as the rate review systems described earlier. For example, the "file and use" system is employed for property and casualty and automobile insurance products, while life and health products are subject to prior approval. The complicated policy review system is compounded by the fact some life and health products are subject to prior approval with no deadline, while others must be approved within a 30-day period, after which the policy would be deemed to be approved.

There seems to be no rationale for why some products are approved in some ways and with differing time periods. For example, it is unclear if there are implications that one type of policy poses more risk to the consumer if deemed approved than another product that requires prior approval.

The current system also contributes to significant backlogs. At the beginning of calendar year 1987, there was a backlog of 2,599 submissions in the Life and Health Division. The vast majority of these (2,569) were for policy forms. One of the deficiencies of the system, and the resulting backlog, is that division examiners will review policy forms that must be approved within 30 days first, even though other policies might have been received weeks before, raising a fairness issue.

The program review committee also believes that the current approval system could place consumers and companies at a disadvantage in terms of choosing or offering new products in the market. As pointed out in the briefing package, Connecticut's approval time was double the national average for most life and health products. When products take this long to be introduced in the market, then consumers are limited in their choice to already existing products.

Similarly, some companies may be temporarily handicapped competitively if a competitor's product is approved, and other companies must wait several months for an identical or similar product to be approved.

In addition, program review found that there are no department-wide guidelines that state the methods or criteria for how policies will be assigned, reviewed, approved, or denied. Neither does the department have a mechanism for ensuring that new policy provisions are treated similarly in all divisions. For example, it is possible that one of the property/casualty divisions might approve a policy that allows a new provision (e.g., legal defense costs to be subtracted from the overall liability limits), while the other division dealing with property/casualty policies might disapprove it.

The program review committee believes this system allows for too much flexibility, gives a good deal of discretion to individual examiners, and does not ensure regulatory consistency. To provide for increased regulatory uniformity, streamline the policy review system, and provide for timely uniform procedures, the following system should be implemented.

#### Recommendation

The Legislative Program Review and Investigations Committee recommends that the Policy and Rating Divisions, for both property/casualty and life and health products should establish a timely review procedure in regulation, as follows:

Any submission for policy approval should be on file with the department not less than 30 calendar days prior to the policy's stated effective date. The department shall have 15 calendar days to determine whether the application is complete or not. If the submission is determined to be incomplete, the submission shall be returned to the company.

If the application is determined to be complete, the department shall have 75 calendar days from the date it was deemed to be complete to make a determination on the application. If no decision has been made at the end of 90 calendar days from the time the policy was initially submitted, the submission will be deemed to be approved.

If the application is disapproved for any reason during the 90-day period, the submission will be returned to the company with a letter of transmittal stating the reason(s) for denial.

The company may resubmit the policy, without prejudice, for approval at any time.

The department should also develop guidelines on methods and criteria for policy review, and division directors should meet monthly to establish the department's position on all new policy provisions and products.

The committee believes that this policy review system would provide for regulatory consistency, requiring that all policies be reviewed within the same time frames. In addition, it would introduce greater fairness into the system, since all policies would be taken in chronological order. The recommendation also provides a mechanism for the department to meet and reach consensus on new products and provisions. Finally, consumers would benefit by having products introduced more quickly into the market.

Staffing. The Life and Health Division receives by far the most policy submissions of any division in the department. Department statistics show that during 1986 the division received 8,561 new submissions, approximately 2 1/2 times as many as the Property/Casualty Division and 10 times as many submissions as the Casualty/Actuarial Division. Furthermore, there is added importance to policy review in the life and health area because competition in this field revolves largely around the policy contract and its coverage, rather than price as is the case with property casualty products. Despite these facts, the Life and Health Division has the same number of examiners as the other two divisions that conduct policy reviews. The Life and Health Division was authorized three new positions during the 1987 legislative session, but that staff are to be assigned to reviewing health maintenance organizations.

The Life and Health Division, at the beginning of 1987, had a backlog of over 2,500 submissions. It is unlikely, with the number of new policy applications the division receives, that this backlog can be diminished unless new staff is added to review policy and rate submissions.

Finally, as pointed out in Chapter III of this report, the Life and Health Division has much slower processing times than other states do for similar products. For example, in four of five product categories -- individual life, universal life, annuity products, and variable life -- Connecticut had double the national average processing times. These slower processing times may have the effect of inhibiting competition by failing to introduce new products quickly.

## Recommendation

The Legislative Program Review and Investigations Committee recommends that the Department of Insurance be authorized to hire three additional examiners in the Life and Health Division to conduct policy and rate reviews.

Currently, the Life and Health Division has four examiners and the division director who work on policy and rate submissions. At this staffing level, the division is able to complete 5,700 submissions a year, or about two-thirds of its workload. Based on these calculations, the program review committee estimates that the additional three examiners will allow the division to fully meet its workload demands.

The adoption of the recommendation would also lessen the unevenness in the workloads between life and health products examiners and those in the auto and property casualty areas. Second, the addition of new personnel will lessen the backlog in the Life and Health Division. Thirdly, the recommendation would promote competition in Connecticut with the expedited introduction of new products, yet ensure that those products approved receive adequate regulatory attention.

## SECTION VII

### CONSUMER AFFAIRS

A major regulatory responsibility of the Connecticut Department of Insurance is to ensure that the consumer is adequately protected in the insurance marketplace. The Consumer Affairs Division, as discussed in Section II of this chapter, will protect the consumer in a number of ways. First, this division will respond to and investigate individual insurance complaints. Second, the division will attempt to prevent complaints from occurring by providing adequate information which will enable consumers to find the insurance best suited to their needs. Third, trends in complaints can be referred to either the Market Conduct Section, if they're against a particular company, or the Licensing and Investigation Section if a pattern develops against an agent, for further examination and investigation. Finally, the division is authorized to establish an arbitration process for the settlement of claims disputes.

#### Complaint Processing

As noted previously in this report, there is no department-wide policy on complaint processing. Complaints are handled in four divisions and are processed and recorded differently in each. Some complaints are handled by telephone, others are in writing. For instance, program review found that in some divisions, an examiner may request that the company reply in writing directly to the complainant. In other divisions, the department acts as a liaison between the complainant and company, handling all correspondence between the two. The program review committee found this variation in complaint handling made it difficult to determine how the complaint was finally resolved.

During the program review committee's study, complaints were handled and processed by hand. Further, to date no compilation of complaints, their nature or how they were resolved has been conducted by the department. Computerization of complaints is now occurring only in the Licensing and Investigations Division.

The committee found that processing times of complaints also varied from 29 days in the Life and Health Division to 88 days in the Licensing & Investigations Division. The average time to process a complaint from receipt to final resolution was 64 days.

The current fragmentation of complaint handling, due to the lack of cross-referencing complaints between the Licensing and Investigations and Market Conduct divisions makes it difficult

to identify complaint trends. The identification of trends will allow the newly created Market Conduct Section within the Consumer Affairs Division to target examinations of insurance company business practices on the basis of complaint patterns.

#### RECOMMENDATION

The Legislative Program Review and Investigations Committee recommends that the department:

Consolidate all complaints within the newly created Consumer Affairs Division and process and computerize complaints uniformly.

Establish guidelines and procedures for processing and investigating complaints. Specifically, require insurance companies to respond directly to the department within a certain time. The department should establish performance standards for examiners to meet in processing complaints.

Consolidating complaints under one division will increase the efficiency of the department and make better use of current resources. The division will be able to compile complaint statistics which, in turn, may be used by other divisions within the department to improve the regulatory function in protecting the consumer.

Established procedures will ensure that all consumers are equitably treated. In addition, by consolidating complaints in one division, consumers will be less confused and frustrated when telephoning the department for assistance. It is much easier for the public to deal with one division rather than four. To facilitate complaint handling, examiners in the Consumer Affairs Division unfamiliar with specific product areas may request assistance from the appropriate division on how the complaint should be handled.

The wide variation in processing times should also be controlled. Although the nature of the complaint can affect the amount of time necessary to process it, department guidelines should include an average acceptable processing time to resolve a complaint. This will ensure that complaints do not go unattended for an inordinate length of time, that consumers obtain a response to their complaint quickly, and that insurance companies respond promptly to a request from the department.

If complaints are consolidated in the Consumer Affairs Division, computerized, and statistically compiled, the division will be able to analyze the information to serve the consumer, the legislature, and the internal operations of the department. For example, the new Market Conduct Section will be able to investigate possible insurance practice violations by focusing on complaint trends that identify specific companies that might be operating contrary to statute or regulation.

## Market Conduct Examinations

The Market Conduct Division, within the Connecticut Insurance Department, is charged with detecting violations of unfair trade practice laws and protecting policyholders and claimants against insurance companies operating contrary to insurance statutes or regulations. The division originally focused on commercial lines insurance but has recently expanded its scope of operation into personal lines. Four examinations have been completed to date.

The program review committee found no consistent procedures for initiating market conduct exams. The division began operations by examining specific complaints in the commercial liability area. Other market conduct exams were chosen on the basis of a company's market share, linking market conduct exams with financial examination, and direct referrals from other divisions.

## Recommendation

The Legislative Program Review and Investigations Committee recommends that the Market Conduct Section, within the newly created Consumer Affairs Division, use the computerized complaint system to analyze complaints by company's volume of business, and use the results to target companies for market conduct reviews.

Market conduct examinations serve an important regulatory function. Through the computerization of complaints, and by working within the Consumer Affairs Division, the Market Conduct Section will be able to obtain valuable information in identifying and examining companies that may be operating in violation of insurance statutes and regulations. Further, procedures should be established to target companies for exams, rather than random selection.

## Complaint Information

The program review committee found that currently there is no compilation of complaint data by company in the department. Consumers are uninformed as to which insurance companies have the most complaints registered against them, and hence have scant information as to the record of the service provided by a certain company.

The Licensing and Investigations Division does collect complaint data by company manually, however, this information is not compiled and analyzed. Each complaint received is recorded on a card by company name and cross-referenced by complainant name. However, as of September 1987, the department has begun to computerize its complaints which will allow for the compilation of statistical data on complaints.

## Recommendation

To provide the consumer with information that will assist them in choosing an insurance company, the Legislative Program Review and Investigations Committee recommends the following:

The department should compile and publish quarterly the number and type of complaints received against insurance companies. Complaint statistics should be weighted to adjust for the premium volume of an insurance company.

Deregulation of personal risk insurance occurred in Connecticut in 1982. The basis of competitive rating laws is to promote price competition among insurers and create a favorable market for consumers to shop. However, for competition to exist consumers must have available pricing and product information in order to choose the most appropriate insurance.

Publishing complaint data will provide consumers with the necessary knowledge (in conjunction with pricing information) to make an educated decision when purchasing insurance. Armed with this information, consumers may choose an insurance company that is best suited to their needs.

In addition, the publication of this information will provide the companies with an incentive to prevent complaints from occurring. The desired effect may be to improve their quality of service if they are aware that complaints by company will be published.

Both department regulators and the legislature would also benefit from the information. The legislature could determine if there were complaint areas that might require legislative remedies, while department staff could focus more regulatory attention on areas of concern. The Market Conduct Section will also be able to utilize this information for investigatory purposes.

## Consumer Information

By statute, the commissioner is authorized to develop consumer information, including pricing and other relevant information, on a "readily available basis" for personal risk insurance. The program review committee found that the department is not adequately meeting that requirement. The department provides limited information to help the consumer make insurance decisions. Further, most available information is outdated.

As mentioned earlier in this report, the department developed an auto rating guide by territory in 1984 which provided pricing information by company for seven different examples of drivers. In 1986, the department also published a pamphlet on homeowners, however, this also has not been updated.

The department receives numerous complaints and inquiries concerning all types of personal risk insurance. For calendar year 1986, program review staff identified 7,679 complaints. Given the number of complaints and inquiries the department receives, the consumer would certainly benefit from this information.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the department:

- publish an annual pamphlet containing pricing information for personal lines insurance;
- distribute brochures, pamphlets, and information guides according to the distribution plan previously developed by the department, including procedures for disseminating information through public service announcements, news releases, brochures, libraries, the motor vehicle department, consumer groups, and local government offices;
- publish a consumer guide regarding more specific complaint areas such as nonrenewals and cancellations, claims settlement practices, and mandated coverages listing statutory provisions insurance companies and agents must comply with;
- make consumers aware of the governor's toll-free telephone number which refers insurance complaints to the insurance department; and
- develop a computerized system to update rates, so they would always be current and easily accessible.

One of the major roles of the insurance department is to protect the consumer in the insurance marketplace. The newly created Consumer Affairs Division should provide the department with an ideal mechanism to fulfill that responsibility. However, the consumer needs to be aware of the division's existence, and the assistance it can provide, if it is to function well. Program review believes the above recommendations will promote such awareness.

The department is reactive in resolving complaints rather than proactive. Complaints commonly involve pricing, claims settlement, and policy cancellations or nonrenewals. If consumer education was undertaken by the department through information dissemination, the department may be able to prevent some complaints from occurring. By making consumers aware of the laws governing the insurance companies and legislation designed

to protect them against unfair business practices, consumers could contact the company directly when their rights have been violated.

Competitive rating laws in the personal lines of insurance in Connecticut assume that consumers will have the knowledge to find insurance best suited to their needs through a competitive marketplace. The department has a responsibility to ensure that consumers are provided with that.

When an insurance company increases rates, that increase is reflected in their policyholders' premiums. However, the company only states the premium owed on the bill, not the increase in premium since the last bill. Therefore, many consumers do not know by what percent their premium has increased, nor what portion of that is due to a rate increase the company has received.

### Recommendation

The Legislative Program Review and Investigations Committee recommends that the department require insurance companies to state, for renewal policies, the prior year's premium on a consumer's bill.

The committee believes that this recommendation, in concert with the previous ones in this section, will furnish the consumer with additional information needed to operate effectively in a competitive rating environment. A consumer should be aware of an increase in premium so that he or she will be able to compare the new price with the old, and if dissatisfied, search for a better price; the basis of a competitive rating system.

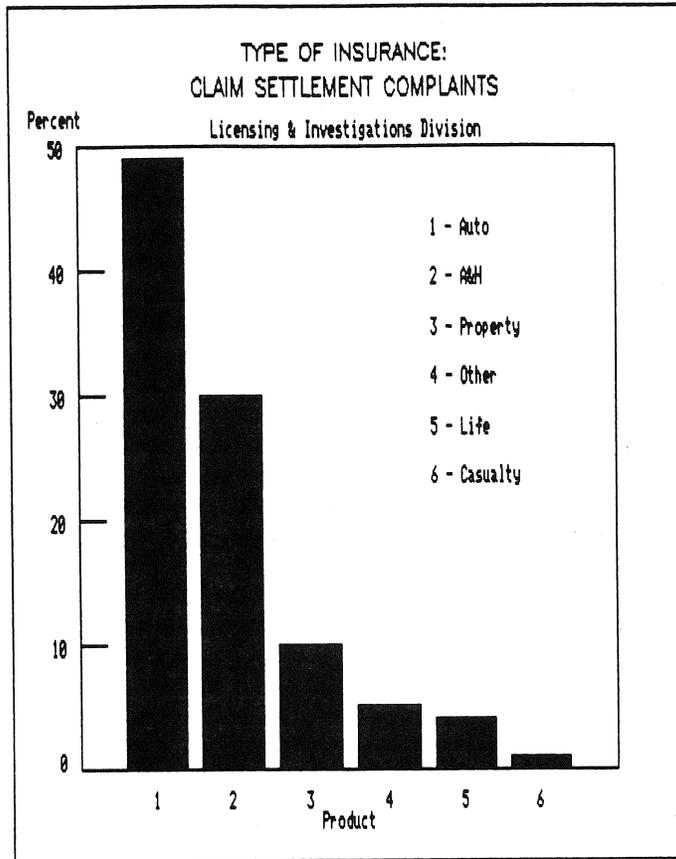
### Consumer Claims Settlement and Arbitration

The program review committee examined the authority of the insurance department to resolve complaints. The committee found the department has no jurisdiction to determine liability in a claims settlement dispute, or to order an insurance company to pay a claim. If a claim is contested between an insurance company and a complainant, the department's Licensing and Investigations Division will attempt to mediate a settlement between the two parties, but has no arbitration power. If mediation is unsuccessful, the division is likely to suggest that the complainant seek legal advice or initiate action in small claims court.

The majority of claim settlement complaints are handled in the Licensing and Investigations Division. Program review staff reviewed the policy type, origin, nature and final disposition of each complaint found in that division. The committee identified 303 claim settlement complaints, 57% of the 535 complaints reviewed. As shown in Figure IV-4, by far the most common of these claim settlement complaints involved private

passenger automobile insurance. Program review found that of a total of 303 claim settlement complaints examined, 148 (or 49 percent) concerned automobile claims.

Figure IV-4. Claims Settlement by Product Area.



Program review examined the final disposition of the claim settlement complaints and found that the Licensing and Investigations Division was able to take corrective action, defined by the committee as a resolution for the complainant resulting in some type of restitution, in 46 percent of the complaints. However, 28 percent of the complainants received only an explanation, with no further action taken by the department on their behalf. In 13 percent of the complaints, the department was unable to resolve the complaint and suggested to the complainants that they consult an attorney or take their dispute to small claims court. Thus, if determination of liability was

necessary in order to resolve a claim, or if the policy coverage or amounts of settlement were disputed, the department was unable to take any action other than a referral.

In addition to the written complaints examined, the program review committee also received testimony at its public hearings from consumers who expressed concern about the difficulty in getting their claims settled. Consumers stated that they feel settlement of claims takes too long, that their choices are limited because litigation is too time-consuming and expensive, and that the department should have greater authority to resolve claim disputes. To address these issues, the Legislative Program Review and Investigations Committee recommends the following:

### Recommendation

The Department of Insurance shall establish an arbitration procedure for the settlement of disputes between consumers and insurance companies. The arbitration procedure shall apply to automobile physical damage claims only. Any company licensed to write private passenger automobile physical damage (collision, comprehensive and theft) insurance in Connecticut shall participate in the arbitration process.

The arbitration procedure shall be operated within the Consumer Affairs Division, within the Department of Insurance. The department shall be authorized to hire one additional person to oversee and administer the arbitration process.

The commissioner shall prepare a list of at least 10 attorneys, who have not been, for at least one year, employees of the department or of insurance companies, to serve as arbitrators in the settlement of such disputes. The arbitrators shall be members of the American Arbitration Association. The arbitrators shall be paid on a per diem basis as established by the insurance commissioner. One arbitrator shall be appointed to hear and decide each complaint. Appointment shall be based solely on the order of the list. If an arbitrator is unable to serve on a given day, or if either party objects to the arbitrator, then the next arbitrator on the list will be selected. The department shall schedule arbitration hearings as often as, and in the locations, it deems necessary.

Procedure. The commissioner of insurance shall adopt regulations, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, to carry out the arbitration process including provisions for the following. Only those disputes that have first been referred to the department's Consumer Affairs Division, and where attempts at mediation have failed, will be accepted as arbitrable. The referral of the complaint to arbitration shall be made by the department examiner who investigated the complaint.

Parties to the dispute shall be notified of the hearing, at least 10 days prior to the hearing date. The commissioner may issue subpoenas on behalf of the arbitrator to compel the attendance of witnesses and the production of documents, paper and records relevant to the dispute.

Decisions shall be made on the basis of the hearing testimony and materials presented at the arbitration hearing. Where the arbitrator believes that technical expertise is necessary to decide a case, she/he may consult with such experts.

The arbitrator shall, as expeditiously as possible, but not later than 15 days after the arbitration hearing, render a fair decision based on the information gathered and disclose the findings and the reasons to the parties involved. If the decision favors the consumer the decision shall provide specific and appropriate remedies.

The decision shall specify a date for performance and completion of all awarded remedies. Notwithstanding any provisions of the general statutes or any regulation to the contrary, the Department of Insurance shall not amend, reverse, rescind, or revoke any decision or action of any arbitrator.

The department shall contact the consumer within 10 working days after the date for performance, to determine whether performance has occurred.

Either party may appeal the arbitrator's decision. However, if it is determined by the court that the insurance company or consumer has acted without good cause in bringing the appeal, the court, in its discretion, may grant to the consumer, or the company, their costs and reasonable attorney's fees.

The department shall maintain records of the disputes, including names of parties to the arbitration, decisions, compliance, appeals and appeal outcomes. Annually, the department shall compile these statistics and send a copy to the Insurance and Real Estate Committee of the General Assembly. This report shall be considered a public document.

The committee believes that this recommendation will greatly enhance the consumer's ability to resolve a dispute with an insurance company. As discussed above, it is sometimes difficult for consumers to have their claims settled, and they seek department assistance with their problem. Since the department has no authority, other than attempts at mediation, to decide a dispute, the consumer must often be referred to an attorney or small claims court in order for a resolution to occur. However, small claims court has an upper limit of \$1,500, and often the consumer's claim is above that limit. In order to pursue civil action, the consumer is likely to need an attorney which can be costly. Further, the wait for a case to be heard in civil court

can be years. Thus, the remedies available to the consumer at present are far from ideal.

If the department's new Consumer Affairs Division is to adequately protect the consumer, it must be given appropriate authority to resolve the consumers' problems. The program review committee believes that this recommendation does provide that authority. The recommendation makes participation in the program mandatory for all companies writing private passenger automobile insurance. Thus, if after the department's attempts to mediate a claim are unsuccessful, a consumer wishes to have the complaint go to arbitration, the company must comply, as a provision of its being licensed in the state.

The above recommendation also will allow the courts to grant the consumer his/her costs and attorney's fees if the decision is appealed by either party without good cause. Further, the recommendation will provide the legislature and the public with the results of the arbitration process to gauge how well the system is working, and to make modifications or expansions to the program where it deems necessary.

At this time, the program review committee proposes that the recommendation apply only to automobile physical or property damage claims involving private passenger automobiles for both first- and third-party claimants. However, the department should examine other complaint areas to determine if the arbitration procedure needs to be extended, and if so, the department should propose to expand the procedure legislatively.

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APPENDICES

APPENDIX A      Bibliography

APPENDIX B      Glossary

APPENDIX C      Public Hearing/Interview List

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APPENDIX A  
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## APPENDIX B

### GLOSSARY

actuary - individual (usually holding a professional degree) who computes statistics related to insurance; estimates loss reserves and premiums.

admitted assets - assets permitted under state regulations to be included in insurers' financial reports.

agent - individual or organization who solicits and writes insurance on behalf of under contract to an insurer or insurers.

allied lines - forms of insurance sold in conjunction with fire insurance, covering such perils as sprinkler leakage, water damage, and earthquake.

automobile insurance - (a) liability: protection for insured against financial loss due to legal liability for car-related injuries to others or damage to other's property; (b) physical damage: coverage to pay for damage to or loss of insured's automobile due to collision, fire, theft, or other perils.

bodily injury liability insurance - protection against loss due to liability for injury, sickness, or disease sustained by any person or persons other than employee.

boiler & machinery insurance - protection against damage sustained from and liability arising due to explosion and other accidents caused by boilers, tanks, and related machinery.

broker - individual or organization who solicits and places business; the broker does not represent a set of companies as does an agent, but instead acts as a representative of the insured.

burglary and theft insurance - covers property losses due to burglary, theft, and larceny.

capacity - the amount of insurance or reinsurance available from a single company or from the market as a whole.

captive - a subsidiary of another firm, usually insuring risks and exposures of its parent or affiliates, but frequently writing outside business as well.

casualty insurance - insurance primarily covering losses due to legal liability for injuries to others or damage to other's property; also includes forms such as burglary, robbery, and workers' compensation.

claim - formal request for reimbursement for loss under terms of an insurance contract.

Source: Introduction to the Analysis of the Property-Casualty and Insurance Brokerage Industries, Langen McAlenny, December 1986.

coinsurance - provision in an insurance policy under which the insured agrees to carry a certain amount of insurance expressed as a percentage of the value of the property; provides for full payment up to amount of policy if individual actually carries specified percentage. If insured fails to carry specified percentage, he or she must pay a proportionate share of any losses.

combined ratio - a measure of underwriting profitability, equal to the sum of (a) the rates of losses incurred to premiums earned, and (b) the rates of expenses incurred to premiums written.

commercial multiple peril - a package of insurance coverages providing for losses due to a wide range of liabilities and property damages.

comprehensive coverage - in automobile insurance, covers protection against loss or damage to an automobile except by collusion or "upset." Under other types of policies, comprehensive coverage includes all hazards under the general scope of the contract except those specifically excluded.

deductible - amount which policyholder agrees to pay, per claim or accident toward the total amount of an insured loss.

earned premium - that part of an insurance premium which has been recorded as revenue by a carrier in return for protection provided. Earned premiums may be calculated from financial statements as the difference of premiums written and the change in unearned premium reserve.

employers' liability coverage - provided under the basic workers' compensation policy, employers' liability provides coverage against losses due to bodily injury, accident or disease sustained by workers arising out of or during the course of an employee's employment with the insured.

excess and surplus insurance - coverage for risks which do not fit normal underwriting patterns or involve a degree of risk which is not commensurate with standard rates.

excess of loss reinsurance - a form of reinsurance which covers losses incurred by ceding firm in excess of a stipulated sum, known as the "primary retention".

expense ratio - under statutory accounting, the rates of expenses incurred to premiums written; under GAAP accounting, the ratio of expenses incurred to premiums earned.

facultative reinsurance - reinsurance of individual risks by offer and acceptance.

fidelity insurance - coverage for employers to protect against losses due to dishonest acts by employees.

farmowners' insurance - package coverage for farms and ranches, providing property-liability coverage against personal and business losses.

fire insurance - coverage for losses caused by fire and lightning, plus associated damage caused by smoke and water.

foreign company - in regulatory parlance, a company organized under the laws of another state or territory of the U.S. A company incorporated in Vermont doing business in Connecticut is a foreign company in Connecticut. A company incorporated in another country, on the other hand, would be referred to as an alien company.

glass insurance - coverage against breakage of glass.

gross premium - premiums written before deduction for reinsurance ceded.

guaranty fund - a fund set up through assessments against solvent insurers to absorb claims made by insureds against insolvent insurers.

homeowners' insurance - a package coverage including fire and allied lines, theft insurance and comprehensive personal liability.

impairment of capital - condition under which, as a result of losses, the surplus account is exhausted and the capital account must be drawn down to meet the firm's liabilities. Typically, when capital becomes impaired, the right to do business is suspended by regulatory authorities.

incurred expenses - expenses which occur in a given period. Generally, expenses incurred approximates expenses paid.

incurred losses - losses incurred during a fixed period whether paid or not. Incurred losses are equal to the sum of losses paid during a given period and the change in the loss reserve during the period. The incurred loss ratio is the ratio of incurred losses to premiums earned.

inland marine insurance - covers property in transit against loss or damage; as not restricted to water transport, but does not cover ocean transport. Inland marine also covers various "instrumentalities" of transportation and communication such as bridges, roads, tunnels, and signs.

Insurance Services Office (ISO) - a voluntary association of property-casualty insurers providing rating, statistical, and actuarial services. Functions both as a rating bureau and as an advisory service.

investment income - that part of an insurer's revenues generated by its asset holdings. Consists principally of bond interest and stock dividend income.

liability limits - maximum sum payable under a liability contract, beyond which the carrier does not protect the insured.

Lloyd's association - a group of individual underwriters who share in writing and provision of insurance coverage, making contributions to a common fund. Individual members, however, are responsible only for their share of the risk (s) assumed.

Lloyd's broker - a broker that can place business with Lloyd's of London underwriters.

loss ratio - the ratio of losses incurred to premiums earned, expressed as a percentage.

loss reserve - liabilities of an insurance company set up to provide for the payment of claims.

marine insurance - includes inland and ocean marine lines, both of which provide coverage for property in transit.

medical malpractice insurance - coverage against liability arising from misconduct or lack of ordinary skill by health care professionals.

moral hazard - risk arising from morals or personal habits of the insured which increase the probability of loss from a given peril.

multiple peril - personal (homeowners') or commercial insurance which combines property and casualty coverages.

National Association of Insurance Commissioners (NAIC) - an association of state insurance commissioners formed for the purpose of developing uniform regulatory procedures across the states through the drafting of model bills and regulations. The organization itself has no enforcement authority.

net premiums written - gross premiums less net reinsurance premiums ceded.

no-fault automobile coverage - coverage designed to compensate the insured for medical and hospital expenses due to auto accidents without proving fault or responsibility on anyone's part.

non-admitted assets - assets which, under state regulations, may not be shown or included in submitted financial reports.

ocean marine insurance - insurance coverage to protect against loss of a ship or its cargo; also covers liabilities arising out of loss of life to any person, or illness of or injury to any members.

officers and directors' liability insurance - coverage for officers and directors of firms to protect against liabilities arising from negligence or wrongful conduct.

paid-in surplus - surplus paid in by shareholders (as opposed to earned surplus, or retained earnings).

policyholders' surplus - all unassigned surplus and capital of an insurer; the insurer's net assets.

pro rata reinsurance - generic term for surplus and quota share reinsurance contracts, under which the reinsurer assumes a proportion of the premiums of the ceding insurer and pays the same proportion of associated losses.

product liability insurance - coverage to protect against losses arising from use of a product sold or manufactured by the insured.

quota share reinsurance - a form of pro rata reinsurance in which reinsurer reimburses ceding company for a fixed percentage of losses associated with a) a given contract, or b) a defined class of business.

reciprocal exchange - an unincorporated association of insurers, known as subscribers, who agree to share each other's losses. Each member is liable for a proportionate share of total liabilities. A reciprocal essentially functions as an unincorporated mutual insurer, where the member/policyholders are themselves insurers.

retention - the amount of liability exposure retained on a given risk, the remainder of which is reinsured.

riot and civil commotion insurance - insurance coverage to protect against losses done by rioters and individuals engaged in civil uprisings.

self-insurance - retention of risk by an individual or organization.

stop-loss reinsurance - excess reinsurance.

surplus reinsurance - a form of pro-rata reinsurance under which the reinsurer pays a fixed percentage of losses in excess of a specified amount.

underwriting profit or loss - net income or loss associated with a carrier's insurance operations (as opposed to earnings from its investment).

unearned premium reserve - a liability set up by an insurer representing the portion of coverage not yet provided but for which payment has been recorded.

workers' compensation insurance - insurance coverage which protects against liabilities arising from injury, disabilities or death to an employee while on the job; workers' compensation benefits generally are payable whether the employer has been negligent or not.



APPENDIX C

Persons Who Provided Testimony  
or Were Interviewed For  
The Insurance Regulation Study

Anghoff, Jay	Counsel, National Insurance Consumers Organization, Washington, D.C.
Arsenault, Jon	Executive Assistant and Counsel, Connecticut Department of Insurance
Anderson, Berst	Consumer
Bartolini, Jim	Vice President, Connecticut Trial Lawyer's Association, Hartford CT
Biafore, Gabriel	Representative, 125th District, Connecticut General Assembly
Blair, John	President, Insurance Association of Connecticut
Boucher, Henry	Touche-Ross & Co., Hartford, CT
Carey, Carolyn	Administrative Services Division, Connecticut Department of Insurance
Carter, William Jr.,	Regional Manager, Insurance Services Office, New England Region, Quincy, MA
Carlton, Cyrus	Consumer
Coburn, Ray	Vice President and Senior Counsel, Phoenix Mutual Life Insurance Co., Hartford, CT
Cosme, Tony	Assistant Director, Financial and Regulated Activities, Connecticut Department of Insurance
Day, John	Chief Legal Officer, CIGNA Corp., Bloomfield, CT
DiSanto, Waldo	Director, Property/Casualty Division, Connecticut Department of Insurance
Donohue, Juliet	Consumer
Doyle, Toby	Attorney, Connecticut Department of Insurance

Etkind, Jerry	Connecticut Citizen's Action Group
Farley, John	Director, Market Conduct Division, Connecticut Department of Insurance
Garlock, Bonnie	Consumer
Gillies, Peter	Commissioner, Connecticut Department of Insurance
Gilligan, William	Deputy Commissioner, Connecticut Department of Insurance
Gorski, Walter	Vice President, Connecticut Mutual Insurance Company
Griest, Richard	Consumer
Hudson, Janet	Connecticut Citizen's Action Group
Ide, Lynn	Connecticut Citizen's Action Group
Ives, Alden	President, Patron's Mutual Insurance Company, Glastonbury, CT
Jovenetti, Paul	Senior Representative, Insurance Services Office, New England Region, Quincy, MA
Katz, Henry	Vice President, The Hartford Insurance Co., Hartford, CT
Kelly, Peter	Director, Financial and Regulated Activities, Connecticut Department of Insurance
Kennedy, Malcolm	Consumer
Linden, John	Director, Casualty/Actuarial Division, Connecticut Department of Insurance
Lohr, Wally	Director of Government Relations, Blue Cross and Blue Shield of CT
Low, Stuart	Consumer
Markowitz, Israel	Consumer
Melley, Maura	Director, Government Relations, The Hartford Insurance Group, Hartford, CT

Mervine, Lewis	Secretary, Employee Benefits Division, Aetna Life and Casualty Co., Middletown, CT
Noonan, Michael	Connecticut AFL-CIO
O'Sullivan, Lee	President, Professional Insurance Agents of Connecticut
Papandrea, Patsy	Director, Licensing and Investi- gations Division, Connecticut Department of Insurance
Powers, Mark	Senator, 20th District, Connecticut General Assembly
Reeves, Dick	Secretary, Regulatory and Legal Division, The Travelers Insurance Co., Hartford, CT
Sansone, John	Director, Life and Health Division, Connecticut Department of Insurance
Shea, Jean	Assistant Director, Licensing and Investigations Committee, Connecticut Department of Insurance
Siclari, William	Vice President of Administration, Patron's Mutual Insurance Co., Glastonbury, CT
Sterlin, Maryann	Independent Insurance Agent, Norwalk, CT
Storms, Peter	Chief Financial Officer, Travelers Insurance Corp., Hartford, CT
Strode, Tammy	Connecticut Citizen's Action Group
Twigg, Theresa	Counsel, Insurance Association of Connecticut, Hartford, CT
Woodcock, John	Representative, 14th District, Connecticut General Assembly
Zitser, Barry	Connecticut Alliance for Insurance Reform



# State of Connecticut

Peter W. Gillies  
INSURANCE COMMISSIONER  
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January 28, 1988

Michael L. Nauer, Director  
Legislative Program Review &  
Investigations Committee  
Legislative Office Building  
18 Trinity Street  
Hartford, Connecticut 06106

Dear Mr. Nauer:

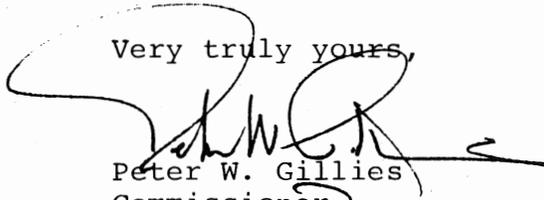
I wish to commend the Committee and staff which conducted the inquiry into the operations of the Insurance Department. The recommendations were thoughtful and constructive, and in general, have my full support and endorsement. Where there are areas of disagreement with the recommendations, they center about the method of implementation, rather than the result sought to be accomplished.

It is my understanding that there will be an opportunity to address more specifically any particular concerns the department may have with the report. What follows, therefore, are simply general observations made to apprise the Legislature as to broad areas of concern.

The structural reorganization is, to a large extent, being implemented. I would, however, urge the Legislature to avoid adopting an organization structure through statute. It is certainly appropriate for the Legislature to provide guidelines of expected performance and goals of regulatory oversight. To freeze those recommendations into a statutorily mandated office format invites problems for future development. A commissioner should be charged with the responsibility to execute a statutory mandate, but implicit in that authority should be the ability to form the organizational units best suited to the task.

While there are other areas of general concern, the report was submitted in the spirit of constructive criticism. It has been received in the same spirit, and with the thanks of this commissioner and his staff.

Very truly yours,

  
Peter W. Gillies  
Commissioner

PWG:g





