Chapter 2

Who Provides Insurance and How Is It Regulated?

Educational Objectives

After studying this chapter, you should be able to:

1. Describe and compare the various types of private insurers that provide property and liability insurance. (pp. 2-3 to 2-10)
2. Describe common federal government insurance programs. (pp. 2-10 to 2-11)
3. Describe common state government insurance programs. (pp. 2-11 to 2-13)
4. Describe the purpose and activities of the National Association of Insurance Commissioners (NAIC). (pp. 2-14 to 2-15)
5. Explain how insurance rates are developed. (pp. 2-15 to 2-16)
6. Explain why and how insurance rates are regulated. (pp. 2-16 to 2-19)
7. Explain: (pp. 2-19 to 2-22)
   a. How insurance regulators monitor insurance company finances
   b. What else insurance regulators do to protect consumers

8. Explain how the excess and surplus lines market meets the needs of various classes of business that are often unable to find insurance in the standard market. (pp. 2-22 to 2-24)
9. Define or describe each of the Key Words and Phrases for this assignment. (All Key Words and Phrases appear in bold print in the text and in boxes in the margins throughout this chapter.)

Chapter 2

Who Provides Insurance and How Is It Regulated?

Insurance, as introduced in Chapter 1, is a transfer system, a business, and a contract, and it is provided by several types of insurance companies. This chapter continues the exploration of these different types of insurers and of how state governments regulate them.

Types of Insurers

Private (nongovernment) insurers provide most of the property and liability insurance in the United States. Private insurers also provide some insurance through government-sponsored insurance programs, and the federal government and the various state governments act as insurers for some types of loss exposures.

Educational Objective 1

Describe and compare the various types of private insurers that provide property and liability insurance.

Private Insurers

Numerous kinds of private insurers provide property and liability coverages for individuals, families, and businesses. Private

insurers differ from one another in several ways. Some of the differences among insurers developed through historical circumstances. Other differences, however, result from legislative action or the interests of the parties that formed the insurer.

All insurers provide a means to indemnify insureds if a covered loss occurs and to spread the costs of losses among insureds. Although all insurers perform these basic functions, the underlying motives of the parties forming different types of insurers are not the same. Some types of insurers are formed in the expectation that the insurer's operations will make a profit or provide some other direct financial benefit for its owners. Other insurers are formed by or on behalf of groups of insureds with the motive of making insurance more readily available or making insurance available at a cost lower than if it were purchased through the general insurance market.

This section discusses various types of private insurers, primarily in terms of:

- The purpose for which they were formed
- Their legal form of organization
- Their ownership
- Their method of operation

Exhibit 2-1 outlines these differences for the major kinds of private insurers discussed in this chapter. In addition to these differences, insurers differ according to their licensing status, the marketing systems they use, and the types of insurance coverage they provide. Licensing of insurers is covered later in this chapter. Chapter 4 examines the different types of marketing systems used by private insurers. Various types of insurance coverage provided by insurers are the subject of the last segment of this textbook.

Stock Insurance Companies

A **stock insurance company** is an insurer that is owned by its stockholders and formed as a corporation for the purpose of earning a profit for these stockholders.

Insurers formed for the purpose of making a profit for their owners are typically organized as for-profit (stock) corporations. For-profit corporations are owned by their stockholders. By purchasing stock in a for-profit insurer, stockholders supply the capital the insurer needs when it is formed or the additional capital needed by the insurer to expand its operations. These stockholders expect to receive a return on their investment in the form of stock dividends, increased stock value, or both. Therefore, one of the primary objectives of a **stock insurance company** is returning a profit to its stockholders. Many of the largest property and liability insurance companies in the United States are stock insurance companies. Such companies include The Hartford and the SAFECO Insurance Companies. These companies have been able to attract and retain stockholders by providing sufficient investment returns.

Exhibit 2-1
Differences Among Major Types of Private Insurers (and Lloyd's of London)

Type	Purpose for which formed	Legal form	Ownership	Method of operation
Stock insurer	To earn profit for its stockholders	Corporation	Stockholders	The board of directors, elected by stockholders, appoints officers to manage the company.
Mutual insurer	To provide insurance for its owners (policyholders)	Corporation	Policyholders	The board of directors, elected by policyholders, appoints officers to manage the company.
Reciprocal insurance exchange (interinsurance exchange)	To provide reciprocity for subscribers (to cover each other's losses)	Unincorporated association	Subscribers (members)	Subscribers choose an attorney-in-fact to operate the reciprocal.
Lloyd's of London	To earn profit for its individual investors ("Names") and its corporate investors	Unincorporated association	Investors	The Committee of Lloyd's is the governing body and must approve all investors for membership.

Stockholders have the right to elect the board of directors, which has the authority to control the activities of the insurer. The board of directors creates and oversees corporate goals and objectives and appoints a chief executive officer (CEO) to carry out the insurer's operations. The chief executive officer and a team of top-level management personnel are given authority by the board of directors to implement the programs necessary to operate the company.

The stock form of ownership also provides financial flexibility for the insurer. For example, the management of a stock insurance company may decide to expand its operations by purchasing another insurance company, by developing new territories or product lines, or by purchasing a noninsurance company in order to diversify its operations. One way that a stock insurance company can finance such expansion is by selling additional shares of common stock. The ability to raise additional funds by selling common stock is an important aspect of the stock form of organization.

Mutual Insurance Companies

A **mutual insurance company** is a corporation owned by its

A **mutual insurance company** is an insurer that is owned by its policyholders and formed as a corporation for the purpose of providing insurance to its policyholder-owners.

policyholders. The corporation of a traditional mutual insurer issues no common stock, so it has no stockholders. The policyholders of a mutual company have voting rights similar to those of the stockholders of a stock company. They elect a board of directors that performs the same functions as the board of directors of a stock company. Large mutual companies include the State Farm Insurance Companies and Liberty Mutual Insurance Company.

Although initially formed to provide insurance for their owners, mutual insurers today have approximately the same incentive to earn profits in their ongoing operations as stock companies. A mutual insurer needs profits to assure the future financial health of the organization.

Several types of mutual insurance companies exist. One traditional difference among mutual insurers involves the insurer's right to charge its insureds an assessment, or additional premium, after the policy has gone into effect. Known as an assessment mutual insurance company, this type of mutual insurer is less common today than in the past.

From the perspective of the insured, differences between stock and mutual insurance companies are becoming less significant. Such things as potential assessments, which were a disadvantage, and dividends, which could be a competitive advantage, are not prevalent features of mutual insurers today. In fact, the structure of mutual companies is gradually changing, making them more similar to stock companies. Some state laws now allow mutual insurers to sell stock to the public by creating a mutual holding company, and other states are considering the adoption of similar regulations. In recent years, some mutual companies have converted to stock companies through a process called **demutualization**. Some mutuals have made these structural changes because they wanted to raise additional capital through the sale of stock to compete with stock companies, which have benefited from favorable stock market conditions.

Demutualization is the process by which a mutual insurer, which is owned by its policyholders, becomes a stock company, which is then owned by its stockholders.

Reciprocal Insurance Exchanges

A **reciprocal insurance exchange** (or an **interinsurance exchange**), also simply called a reciprocal, consists of a series of private contracts among the **subscribers**, or members, of the group, with subscribers agreeing to insure each other. The name "reciprocal" comes from the reciprocity of responsibility of all subscribers to each other. Each member of the reciprocal is both an insured and an insurer. Because the subscribers are not experts in running an insurance operation, they contract with an individual or organization to operate the reciprocal; this manager is called an **attorney-in-fact**. The subscribers empower the attorney-in-fact to handle all the duties necessary to manage the reciprocal. Typically, the function of the attorney-in-

A **reciprocal insurance exchange** (or an **interinsurance exchange**) is an unincorporated association formed to provide insurance coverage to its members. One of the distinguishing features of a reciprocal is that the *subscribers* empower an *attorney-in-fact* to manage it.

Subscribers (also known as members) are the policyholders of a reciprocal insurance exchange who agree to insure each other.

The **attorney-in-fact** of a reciprocal insurance exchange is the contractually authorized manager of the reciprocal who administers its affairs and carries out its insurance transactions.

fact is to administer the affairs of the reciprocal and to carry out its insurance transactions. An agreement (known as a subscription agreement) authorizes the attorney-in-fact to act on behalf of the subscribers to market and underwrite insurance coverage, collect premiums, invest funds, and handle claims. The existence of an attorney-in-fact, empowered by the subscribers, is one of the main features that distinguishes a reciprocal from other types of insurers.

Today, reciprocals make up a small percentage of the total number of insurance companies in the United States; however, they include some major companies such as Farmers Insurance Exchange, which is part of Farmers Group and United States Automobile Association (USAA), which markets insurance to military persons and their families. Small regional reciprocals also operate on a state-by-state basis.

Lloyds Associations

Among the providers of insurance is a unique type known as Lloyds. Two types of Lloyds associations exist: Lloyd's of London and American Lloyds.

Lloyd's of London

Although not technically an insurance company, Lloyd's of London is an association that provides the physical and procedural facilities for its members to write insurance. In other words, it is a marketplace, similar to a stock exchange. Members of Lloyd's of London do not take an active part in the day-to-day operation of Lloyd's. They are investors who hope to earn a profit from the insurance operations that occur at Lloyd's.

Each individual investor (called a "Name") of Lloyd's belongs to one or more groups called *syndicates*. A syndicate's underwriter or group of underwriters conducts its insurance operations and analyzes applications for insurance coverage. Depending on the nature and amount of insurance requested, the underwriters for a particular syndicate might accept only a portion of the total amount of insurance. The application is then taken to other syndicates for their evaluations.

The insurance written by each individual Name is backed by his or her entire personal fortune. However, each individual member is liable only for the insurance he or she agrees to write, not for the obligations assumed by any other member. In 1993, Lloyd's began admitting corporations as members. Unlike its individual members, corporate members of Lloyd's have limited liability.

Lloyd's of London has earned a reputation for accepting applications for very unusual types of insurance, such as insuring the legs of a famous football player against injury. These applications may be the subject of newspaper articles, but the bulk of

Lloyd's business does not involve such unusual coverages. In fact, most of the insurance written through Lloyd's is commercial property and liability insurance.

Lloyd's has operated continuously for more than three hundred years, and Lloyd's underwriters are considered to be some of the world's leaders in their fields. The integrity of Lloyd's stems from the influence of the Committee of Lloyd's, which is the governing body of the association. The Committee of Lloyd's accepts only members who meet rigorous financial standards. Over the years, despite serious natural disasters and occasional mistakes in underwriting judgment, Lloyd's members have had the financial resources to survive catastrophes, pay claims, and move forward to more profitable times. Until recently, many members have received an excellent return on their investments, and Lloyd's has had little trouble attracting new members. Recent large losses over several years have created a strain on some of Lloyd's syndicate members. Nevertheless, Lloyd's remains one of the world's most important sources of insurance.

American Lloyds Associations

American Lloyds associations are much smaller than Lloyd's of London, and most are domiciled in Texas, with a few in other states. Most of the Texas Lloyds associations were formed or have been acquired by insurance companies. Unlike the individual Names of Lloyd's of London, members (called underwriters) of American Lloyds have limited liability. The liability of underwriters at American Lloyds is limited to their investment in the Lloyds association. State laws require a minimum number of underwriters (ten in Texas) for each Lloyds association. American Lloyds are usually small and operate as a single syndicate under the management of an attorney-in-fact.

Other Private Insurers

In addition to stock insurers, mutual insurers, reciprocals, and Lloyds associations, several other types of private insurers or groups provide insurance, including captive insurance companies and reinsurance companies.

Captive Insurance Companies

When a business organization or a group of affiliated organizations forms a subsidiary company for the purpose of having the subsidiary provide all or part of the insurance on the parent company or companies, the subsidiary is known as a **captive insurance company**, or simply a **captive**. Although captive insurance companies have been in existence since the early part of the twentieth century, the widespread use of captives is more recent, with the major growth occurring since the late 1970s.

A **captive insurance company** (or simply a **captive**) is an insurer that is formed as a subsidiary of its parent company, organization, or group, for the purpose of writing all or part of the insurance on the parent company or companies.

Three factors have contributed to the growth of captives in recent years: low insurance cost, insurance availability, and improved cash flow. First, captives might be able to provide

insurance coverage at a lower cost than other private insurers because acquisition costs are eliminated. For example, captives might not have to pay agents' commissions or advertising expenses because they provide insurance primarily to the parent company. Second, a captive helps eliminate the problems some corporations might face because necessary or desired insurance coverage is unavailable or costs more than the corporation is willing or able to pay. Forming a captive insurance company eases the problems of availability and affordability for a parent company that has loss exposures that are difficult to insure. The third and most important factor is cash flow. A premium paid to a captive remains within the corporate structure until it is used to pay claims. Instead of paying premiums to an unrelated insurer, the corporation is able to invest its funds until the time they are needed for claims. Thus, the corporation can receive a significant cash flow advantage by creating a captive. This advantage becomes even greater when interest rates are high, as was the case during the late 1970s and early 1980s, when the number of captives increased dramatically.

Captives have become an important alternative in the insurance-buying decisions of corporations. The relative importance of the factors affecting the growth of captives changes over time, but it appears that captives will remain an important source of insurance.

Reinsurance Companies

Some private insurers provide **reinsurance**, which is a contractual arrangement that transfers some or all of the potential costs of insured losses from policies written by one insurer to another insurer. The insurer that transfers the loss exposures is the **primary insurer**, and the insurer that accepts the loss exposures is the **reinsurer**. Some reinsurers are companies or organizations that specialize in the reinsurance business. Other reinsurers are also primary insurers that enter into reinsurance arrangements with other insurers.

Reinsurance is a type of insurance in which one insurer transfers some or all of the loss exposures from policies written for its insureds to another insurer.

In reinsurance, the **primary insurer** is the insurance company that transfers its loss exposures to another insurer in a contractual arrangement.

A **reinsurer** is the insurance company that accepts the loss exposures of the primary insurer.

A primary insurer might buy reinsurance for a variety of reasons. One of the most important reasons is that reinsurance permits the primary insurer to share its exposures with the reinsurer. For example, an insurer that writes a large amount of property insurance in an area where tornadoes commonly occur can use reinsurance to reduce its exposure to claims from its insureds arising from windstorm damage to their property.

Reinsurance also enables a small insurer to provide insurance for large accounts (such as large national or multinational corporations) whose insurance needs would otherwise exceed the insurer's capacity. For example, suppose a primary insurer writes a commercial liability policy for a large company that manufactures sports helmets. Since the potential for heavy liability losses resulting from injuries caused by defective

helmets is great, the primary insurer might arrange with a reinsurer to cover all of its liability losses for this insured over a certain amount, such as $1,000,000. Therefore, the primary insurer and the reinsurer are sharing the liability loss exposures for this insured.

Government Insurance Programs

Reminder

Characteristics of Ideally Insurable Loss Exposures

- Large number of similar exposure units
- Losses that are accidental
- Losses that are definite and measurable
- Losses that are not catastrophic
- Losses that are economically feasible to insure

Despite the size and diversity of private insurers in the United States, private insurers do not provide some types of insurance. As discussed in Chapter 1, some loss exposures do not possess the characteristics that make them ideally insurable, but a significant need for protection against the potential costs of losses resulting from these loss exposures still exists. Both the federal government and state governments have developed certain insurance programs to meet specific insurance needs of the public.

Educational Objective 2

Describe common federal government insurance programs.

Federal Government Insurance Programs

Some federal government insurance programs serve the public in a manner that only the government can. For example, only the government has the ability to tax in order to provide the financial resources needed to insure some loss exposures and the power to make the system viable by requiring mandatory participation. One federal government insurance program that requires mandatory participation is the Social Security program.

The Social Security Program

The Social Security program, formally known as the Old Age, Survivors, Disability, and Health Insurance program (OASDHI), is a comprehensive program that provides benefits to millions of Americans. The Social Security Administration, a federal governmental agency, operates the program and provides four types of benefits to eligible citizens:

- Retirement benefits for the elderly
- Survivorship benefits for dependents of deceased workers
- Disability payments for disabled workers
- Medical benefits for the elderly (under the Medicare program)

Mandatory participation in the Social Security program for those eligible for coverage eliminates the need for individual underwriting and helps to generate premium revenues to operate the system. Private insurers provide similar benefits (retirement benefits, life insurance, disability insurance, and health insurance) to some insureds, but they cannot approach

the scope of the Social Security program. Some private insurers provide protection to supplement specific Social Security benefits.

Other Federal Insurance Programs

Other federal government insurance programs provide coverage for loss exposures that private insurers have avoided largely because of the potential for catastrophic losses. Some of the insurance plans operated by the federal government were created to overcome availability problems. Examples of such plans are the National Flood Insurance Program and the Federal Crop Insurance Program. The need for each of these programs is highly concentrated. Only a specific portion of the population needs the coverage: those who have property in areas exposed to flooding need flood protection, and farmers in areas subject to hailstorms need crop insurance. This concentration of exposure units generally makes private insurers reluctant to provide coverage for flood and crop losses. In other words, the exposure units are not independent and thus are subject to catastrophic losses that private insurers cannot insure economically.

Educational Objective 3

Describe common state government insurance programs.

State Government Insurance Programs

State governments are actively involved in insuring certain loss exposures of their citizens. Among the most common types of insurance programs provided or operated by state governments are:

- Workers compensation insurance funds
- Unemployment insurance programs
- Automobile insurance plans
- FAIR plans
- Beachfront and windstorm pools

In addition, all states have some type of insurance guaranty fund designed to pay for covered losses in the event that an insurer is financially unable to meet its obligations to its insureds.

State Workers Compensation Insurance Funds

Many states offer workers compensation insurance. North Dakota, Ohio, Washington, West Virginia, and Wyoming operate **monopolistic state funds**, which means that the state fund is the only source of workers compensation insurance in the state. All employers in the state who need workers compensation insurance must obtain it from the monopolistic state fund. (Until 1999, Nevada also had a monopolistic state fund,

A **monopolistic state fund** is a state workers compensation insurance plan that is the only source of workers compensation insurance allowed in that state.

but Nevada now allows private insurance, making its fund a *competitive state fund.* Puerto Rico and the U.S. Virgin Islands operate territorial funds, similar to monopolistic state funds.)

A **competitive state fund** is a state workers compensation insurance plan that competes with private insurers to provide workers compensation insurance.

A **residual market plan** (or **shared market plan**) is a program that makes insurance available to those who cannot obtain coverage because private insurers will not voluntarily provide such coverage for various reasons.

Some states have a **competitive state fund**, which means that employers may choose between the state fund or some other means of meeting their obligations under workers compensation statutes. Still other states provide workers compensation through residual market plans. A **residual market plan** (also known as a **shared market plan**) is an insurance source of last resort. When an applicant is unable to obtain insurance from a private insurer, the applicant applies to the state fund to obtain coverage. In this way, the state is performing the function of satisfying a demand for coverage that private insurers are unwilling or unable to meet.

Other State Insurance Programs

All state governments operate unemployment insurance programs, and the benefits provided vary by state. Minimum federal standards, however, as well as some federal financing, ensure that eligible workers have some unemployment insurance protection. Private insurance covering the loss of income due to unemployment is not available because of the catastrophic potential of widespread unemployment.

Most states now require that owners of motor vehicles have auto liability insurance before registering an automobile. However, applicants with poor driving records or persons with little or no driving experience might have difficulty obtaining automobile insurance. As a result, all fifty states and the District of Columbia have implemented automobile insurance plans through a residual market system to make auto liability insurance available to nearly every licensed driver. The form and operation of these plans vary by state, but all of the plans spread the cost of operating the plan among all private insurance companies writing business in the state. In most cases, the state has mandated the creation of automobile insurance plans but has left the administration of the plans to private insurers, which then share the costs.

In most states, FAIR (Fair Access to Insurance Requirements) plans make property insurance available where it would otherwise be unavailable. These state-run plans spread the cost of operating the plan among all private insurers selling property insurance in the state. FAIR plans were originally created in response to the urban riots of the 1960s so that property owners in urban areas could have access to property insurance. These plans now make property insurance more readily available to property owners who have exposures to loss over which they have no control. Therefore, eligible property includes property in urban areas as well as property exposed to brush fires, for example.

Beachfront and windstorm insurance pools are residual market plans similar to FAIR plans. These plans exist in states along the Atlantic and Gulf Coasts, and they provide insurance to property owners against wind damage from hurricanes and other windstorms. Since these states have been severely affected by hurricanes in recent years, some property owners along the coasts have had difficulty obtaining windstorm coverage from private insurers.

Insurance Guaranty Funds

Each state (as well as the District of Columbia) has a property and liability insurance **guaranty fund** that covers the unpaid claims of insolvent insurers licensed in the state. The money to pay the claims of insolvent insurers comes from assessments made against private insurers doing business in the state. In most states, the claims that must be paid after an insurer becomes insolvent are estimated, and then other licensed insurers operating in that state are assessed for their proportionate share of the obligation.

A **guaranty fund** is a state fund that provides a system to pay the claims of insolvent insurers. Generally, the money in guaranty funds comes from assessments collected from all insurers licensed in the state.

Insurance Regulation

The possibility that an insurance company might not be able to pay legitimate claims to or for its policyholders is the primary concern of insurance regulators, who monitor the financial condition and operations of insurance companies. This scrutiny helps to protect the public from irresponsible, unwise, or dishonest activities that could leave consumers with worthless insurance policies.

Historically, state governments have regulated the insurance business. State regulation of insurance began when state legislatures granted charters to new insurance companies and specified certain conditions regarding their minimum capital requirements, their investments, and their financial reports. During the latter part of the nineteenth century, states established insurance departments to monitor the operations of insurance companies and to investigate complaints from insureds. State insurance departments generally have broad powers to regulate the insurance business in the public interest.

Insurance regulations vary by state. Although many insurance professionals believe that state regulation of insurance has advantages over federal regulation, inefficiency can result when over fifty different insurance departments separately perform similar tasks and address the same issues and problems.

Educational Objective 4

Describe the purpose and activities of the National Association of Insurance Commissioners (NAIC).

National Association of Insurance Commissioners

The **National Association of Insurance Commissioners (NAIC)** is an association consisting of the commissioners of the insurance departments of each state, the District of Columbia, and U.S. territories and possessions. The NAIC coordinates insurance regulation activities among the various insurance departments.

The **National Association of Insurance Commissioners (NAIC)** was established to encourage coordination and cooperation among state insurance departments. The members of the NAIC are the heads (usually called commissioners) of the insurance departments of each of the fifty states and the District of Columbia. (The commissioners of Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands also belong to the NAIC.) The NAIC facilitates cooperation, coordination, and uniformity in insurance regulation among the states.

The NAIC meets quarterly, but it functions throughout the year with the assistance of its staff. NAIC standing committees meet periodically during the year and report to the NAIC at its regularly scheduled meetings.

A **model law** is a document drafted by the NAIC, in a style similar to a state statute, that reflects the NAIC's proposed solution to a given problem and provides a common basis to the states for drafting laws that affect the insurance industry.

When a new problem or issue arises, the NAIC studies the matter and issues a statement describing its position. In many cases, the NAIC develops a **model law**, written in a style similar to that of a state statute, that reflects the NAIC's proposed solution to a given problem or issue. Each state legislature then considers the model law for possible enactment. A model law might not be passed in its exact form by every state legislature, but it provides a common basis for drafting state laws. In this way, certain aspects of insurance regulation have a degree of uniformity among states.

The NAIC has also created a uniform financial statement for property and liability insurance companies. Each insurance company completes an annual financial statement in the prescribed manner and submits it to the insurance department in each state in which the company is licensed in order to satisfy the financial reporting requirements of that state. This uniformity not only lessens the reporting burden for insurance companies but also simplifies the insurance department's task of comparing the financial reports of many different insurers.

In a further effort to help states monitor the financial condition of insurers, the NAIC has implemented an accreditation program to increase uniformity and improve state regulation of insurance. The program's purpose is to ensure that states have the appropriate legislation and authority to regulate the solvency of the insurance industry. It also attempts to ensure that states apply the required legislation consistently. Under this program, states that have been accredited by the NAIC cannot

accept the results of insurance company examinations performed by states that have not been accredited.

Through its various programs and committees, the NAIC enables state regulators to pool their resources while preserving state regulation of insurance. The NAIC encourages uniformity, but each state can tailor its regulatory approach to meet the state's unique needs. Despite the differences among the states, the primary objectives of insurance regulation are:

- Rate regulation
- Solvency surveillance
- Consumer protection

Rate Regulation

Because insurers develop insurance rates that affect most people, the laws of nearly all states give the state insurance commissioner the power to enforce regulation of insurance rates.

Educational Objective 5

Explain how insurance rates are developed.

Ratemaking

An insurer must collect sufficient premiums to pay for the insured losses that occur, cover the costs of operating the insurance company, and allow a reasonable profit. Determining the proper rate to charge each insured for coverage involves the process of ratemaking.

Ratemaking is the process by which insurers calculate rates that determine the premium to charge for an insurance policy. The **rate** is the cost of a given unit of insurance (for example, $100 worth of coverage). The **premium** is the price of the coverage provided for a specified period. To arrive at the premium, the rate is multiplied by the number of insurance units purchased. For example, if an insurer charges a rate of $1.20 per $100 of coverage on jewelry, the premium for a ring insured for $1,000 would be $12.00, according to the following formula:

Rate x Number of exposure units = Premium

$1.20 x 10 units = $12.00

Developing rates that accurately reflect each insured's share of predicted losses is one of the most important operations performed by insurance companies. Since a given rate is the basis of an insured's premium, it is important to both the insured and the insurer that the rate, and therefore the premium, be a fair measure of the insured's exposure to loss.

Ratemaking is the process insurers use to calculate the *rates* that determine the *premium* for insurance coverage.

A **rate** is the price of insurance for each unit of exposure. The *rate* is multiplied by the number of exposure units to arrive at a *premium*.

A **premium** is a periodic payment by an insured to an insurance company in exchange for insurance coverage.

To determine the premiums to charge, insurance companies predict, as accurately as possible, the expenses they will incur to pay for losses, recognizing that this prediction is uncertain. Insurers add an amount sufficient to cover the expected administrative costs of company operations to the predicted claim expenses. In addition, the premium includes a charge to cover a margin for error and a charge for profits and contingencies, such as possible catastrophic losses. This amount is generally modified to reflect the investment income that can be earned on the funds held for future claim payments.

Insurance companies use rate classification systems that differentiate among insureds based on each insured's loss potential. For example, insureds with frame houses are placed in one classification for fire insurance and insureds with brick houses are placed in another, because the probable severity of a fire loss is greater for a frame house. Similarly, insurers group drivers into separate classifications so that young, inexperienced drivers are charged more than experienced drivers, and insureds who use their cars for business are charged more than insureds who do not. Insureds with similar characteristics are placed in the same class and charged the same rate. Insurers use technology extensively in the rating process; computers can be programmed to develop rates according to rating specifications.

An **actuary** is a person who uses complex mathematical methods and technology to analyze loss data and other statistics and to develop systems for determining insurance rates.

An **actuary** analyzes data on past losses and the expenses associated with losses and, combining this with other information, develops insurance rates. Actuaries usually have an education in mathematics and statistics as well as other specialized training. Advances in information technology in recent years have enabled actuaries to perform their jobs more efficiently by using computers.

The goal of an insurer's actuarial staff is to develop a ratemaking system that generates fair, equitable rates and meets corporate objectives. Attaining this goal requires actuaries to constantly monitor and update loss data to develop rates that state regulatory authorities will approve.

Educational Objective 6

Explain why and how insurance rates are regulated.

Objectives of Rate Regulation

Although the objectives of rate regulation are generally the same for all states, the approaches used differ significantly. Rate regulation serves three general objectives:

- To ensure that rates are adequate
- To ensure that rates are not excessive
- To ensure that rates are not unfairly discriminatory

Ensuring That Rates Are Adequate

When rates are adequate, the price charged for a given type of insurance coverage should be high enough to meet all anticipated losses and expenses associated with that coverage while generating a reasonable profit for the insurer. Rate adequacy helps insurers remain solvent so they can meet obligations to policyholders. Therefore, rate regulation attempts to ensure that rates are adequate.

Adequacy is not always easy to achieve. It is virtually impossible to guarantee that premiums paid by insureds will be adequate to cover insured losses. Even when a large group of similar exposure units is covered, unexpected events—such as a natural disaster—might lead to losses significantly higher than those predicted when rates were originally set. For example, when Hurricane Andrew hit the eastern United States in 1992, the resulting unexpected losses exceeded the predictions that had been used to rate the policies that covered these losses.

The goal of rate adequacy conflicts with pressures to hold down insurance premiums. An insurer might have difficulty competing if its rates are substantially higher than those charged by other insurers providing similar coverage and service. Also, although insurance regulators desire rate adequacy to maintain insurer solvency, other pressures encourage regulators to keep rates low.

Ensuring That Rates Are Not Excessive

To protect consumers, states also require that insurance rates not be excessive. Excessive rates could cause insurers to earn unreasonable profits. Determining whether rates are either excessive or inadequate is difficult, especially since insurers must price insurance policies long before the results of the pricing decision are known. Nevertheless, when regulators determine that insurers have earned substantial profits in a particular type of insurance, they may require insurers to reduce rates retroactively or to return the "excess profit" to policyholders.

Ensuring That Rates Are Not Unfairly Discriminatory

Since insurance is a system of sharing the costs of losses, each insured should pay a fair share of the insurer's losses and expenses. Some disagreement exists as to how this fair share should be determined.

One concept involves **actuarial equity**—basing rates on actuarially calculated costs of losses. Actuaries define rate classifications and calculate rates based on the loss experience of each given class. Insureds with similar characteristics are placed in the same rating class and charged the same rate. Thus, the premium should accurately reflect each insured's expected contribution to the losses of a group of similar insureds.

Actuarial equity is a ratemaking concept through which actuaries base rates on actuarially calculated loss experience and place insureds with similar characteristics in the same rating class.

Social equity is a rating concept that considers rates to be *unfairly discriminatory* if they penalize an insured for characteristics (such as age or gender) that are beyond the insured's control.

Unfair discrimination would involve applying different standards or methods of treatment to insureds who have the same basic characteristics and loss potential. Insurers generally establish rates based on "fair discrimination," which is the grouping of individuals with similar characteristics who have similar loss exposures. Members of that group are then charged the same actuarially developed rate. *Unfair discrimination* in insurance rating would include charging higher-than-normal rates for an auto insurance applicant based solely on the applicant's race, religion, or ethnic background.

Types of Insurance Rating Laws

- **Prior-approval laws**—rates must be approved by the state insurance department before they can be used.
- **Flex rating laws**—prior approval is required only if the new rates are a specified percentage above or below previously filed rates.
- **File-and-use laws**—rates must be filed but do not have to be approved before use.
- **Use-and-file laws**—rates must be filed within a specified period after they are first used in the state.
- **Open competition (no-file laws)**—rates do not have to be filed with the state.
- **State-mandated rates**—state-specified rates must be used by all insurers of a particular type of insurance in the state.

On the other hand, **social equity** holds that rate structures discriminate unfairly if they penalize an insured (through higher rates) for factors, such as age or gender, that are beyond the insured's control. In certain states, age and gender are no longer allowed as factors in rating auto insurance on the grounds that they are unfairly discriminatory. Rate regulation attempts to balance the concepts of actuarial equity and social equity in determining whether a particular rating plan involves **unfair discrimination**.

Insurance Rating Laws

In attempts to balance conflicting objectives, states have developed a variety of laws to regulate insurance rates. Rate regulation varies by state. Moreover, within a state, different laws might apply to different types of insurance. Despite these differences, the various insurance rating laws fall into the following categories:

- **Prior-approval laws**—Under these laws, which are used in most states, insurers must file their proposed rates with the state insurance department. Insurers must also provide data that show that the rates are not excessive, inadequate, or unfairly discriminatory. The commissioner has a certain time period, typically thirty to ninety days, to approve or reject the filing. Some states have a deemer provision (or "delayed effect" clause) that causes the rates to be deemed approved if the commissioner does not respond to a rate filing within the specified time period.
- **Flex rating laws**—Under this type of law, prior approval is required only if the new rates are a specified percentage above or below previously filed rates. Insurers are permitted to increase or reduce their rates within the specified range without prior approval. Percentage ranges vary by state and by type of insurance, but they are generally between 10 and 25 percent.
- **File-and-use laws**—Some states require insurers to file rates with the state insurance department before the rates become effective. However, insurers are not required to wait for approval from the commissioner but rather may begin using the rates as soon as they are filed.
- **Use-and-file laws**—These laws require that rates be filed within a specified period of time, often fifteen or thirty days, after they are first used in the state.
- **Open competition (no-file laws)**—In some states, insurers are not required to file rates or rating plans with the state regulatory authorities. This approach is called open competition, because it permits insurers to compete with one another by quickly changing rates without review by state regulators. Market forces rather than administrative action determine rates under this approach.

- **State-mandated rates**—This system requires all insurers to adhere to rates established by the state insurance department for a particular type of insurance, such as private passenger automobile insurance. Rates for all other types of insurance are subject to another type of rating law.

Modified versions of these laws also exist. For instance, modified prior-approval laws permit an insurer to revise rates without prior approval if the revision is based solely on a change in the insurer's loss experience. Another example is a modified open competition law, which allows open competition as long as certain tests are met, such as evidence of competitive markets or rate increases of less than a certain percentage per year.

The insurance rating laws that do not require prior approval of rates do not relieve insurers of their obligation to use rates that are adequate, not excessive, and not unfairly discriminatory. State insurance departments can and do exercise their legal right to request, at a later date, the statistics that support the fairness of the new rate.

Educational Objective 7

Explain:

a. How insurance regulators monitor insurance company finances
b. What else insurance regulators do to protect consumers

Solvency Surveillance

In an effort to ensure insurer **solvency**, insurance regulators carefully monitor the financial condition of insurance companies. Two major aspects of **solvency surveillance** are insurance company examinations and the Insurance Regulatory Information System (IRIS).

Solvency is the ability of an insurance company to meet its financial obligations as they become due, even those resulting from insured losses that might be claimed several years in the future.

Solvency surveillance is the process, conducted by state insurance regulators, of verifying the solvency of insurance companies and determining whether the financial condition of insurers enables them to meet their obligations and to remain in business in the long term.

Insurance Company Examinations

Regulatory authorities periodically conduct examinations of insurance companies. An examination consists of a thorough analysis of an insurance company's operations and financial condition. This analysis usually occurs every few years under the direction of the insurance department of the state where the insurer's home office is located.

During an examination, a team of state examiners, working at the insurance company home office, reviews a wide range of activities, including claim, underwriting, marketing, and accounting procedures. Of particular interest to the examiners is the financial condition of the insurer. The financial records of the insurer are carefully analyzed to ensure that the company is meeting all state financial reporting requirements and to determine whether the insurer has the ability to meet its obligations. If the examination uncovers problems, the insur-

ance department usually has broad powers to take control of the situation in an attempt to correct whatever problems are identified.

The Insurance Regulatory Information System

The **Insurance Regulatory Information System (IRIS)**, begun in the early 1970s as the Early Warning System, is an analytical system designed by the NAIC to monitor an insurer's overall financial condition.

The NAIC designed the **Insurance Regulatory Information System (IRIS)** to help regulators identify insurance companies with potential financial problems. IRIS takes data from insurers' financial statements and develops eleven financial ratios to determine insurers' overall financial condition. If a particular insurer has ratios that are outside predetermined norms, IRIS identifies the company for regulatory attention.

IRIS provides all state insurance departments with a timely and objective method of identifying companies that might have financial problems. Although the system does not always identify a problem before a financial crisis occurs, it is an important tool for solvency surveillance.

Consumer Protection

In addition to rate regulation and solvency surveillance, the activities that regulators undertake to protect insurance consumers include:

- Licensing insurers
- Licensing insurance company representatives
- Approving policy forms
- Examining market conduct
- Investigating consumer complaints

Licensing Insurers

A **licensed insurer** (or an **admitted insurer**) is authorized by the state insurance department to transact business within that state.

A **domestic insurer** is incorporated in the same state in which it is transacting business.

A **foreign insurer** is licensed to operate in a state but is incorporated in another state.

An **alien insurer** is licensed in a U.S. state but incorporated in another country.

Most insurance companies must be licensed by the state insurance department before they are authorized to write insurance policies in that state. A **licensed insurer** (or an **admitted insurer**) is one that the state insurance department has authorized to sell insurance in that state. An insurance company that is incorporated in the same state in which it is writing insurance is known as a **domestic insurer**. If an insurance company is licensed to operate in a state but is incorporated under the laws of another state, that company is known as a **foreign insurer**. A licensed insurer that is incorporated in another country is known as an **alien insurer**.

For example, an insurer that is incorporated in Massachusetts is considered a *domestic* insurer in that state. However, if the same insurer is also licensed to operate in New Hampshire and Vermont, it is considered a *foreign* insurer in those two states. An insurer that is incorporated in London, England, is considered an *alien* insurer in the United States.

A primary requirement for obtaining an insurance license involves tests of financial strength. Each state has specific requirements concerning the minimum amount of surplus (assets minus liabilities) an insurance company must have to be licensed in the state. The required amount of surplus varies, depending on the state and the type of insurance for which the company wants to be licensed. If an insurer fails to meet financial standards or fails to operate in a manner consistent with state insurance laws, state regulators have the authority to revoke or suspend the company's license in order to protect consumers' interests.

Licensing Insurance Company Representatives

In addition to licensing insurance companies, all states have licensing requirements for certain representatives of insurance companies. All states require insurance agents to be licensed to transact insurance business in the state. A license is usually granted only after the applicant passes an examination on insurance laws and practices. Most states have similar requirements for insurance brokers. Claim representatives (also known as adjusters) are also required to be licensed in some states before they are allowed to handle claims. (Chapter 4 explains the roles of insurance agents and brokers, and Chapter 6 describes the duties of claim representatives.)

In most states, continuing education requirements specify that, before renewing a license, the agent, broker, or claim representative must complete a prescribed amount of continuing education during a specified period. Licensing and continuing education laws vary widely by state, but all attempt to ensure that these insurance company representatives have a prescribed minimum level of insurance knowledge.

Approving Policy Forms

Most states require insurance companies to file their policy forms with the state insurance department in a manner similar to the method used for rate filings. Whenever an insurer wants to change the language of a particular policy, it must submit the new form for approval.

By regulating policy language, the state insurance department prevents insurers from including unfair or unreasonable provisions in insurance policies. Although the possibility always exists that an insured might misinterpret the policy, regulatory approval of policy forms reduces the possibility of misleading wording. Having clear and readable insurance policies is a goal of most regulators. In many cases, states also prescribe specific wording that must be included in insurance policies, such as cancellation requirements and procedures.

Examining Market Conduct

Market conduct regulation consists of state laws that regulate the practices of insurers in regard to four areas of operation: sales and advertising, underwriting, ratemaking, and claim handling.

Regulators also scrutinize specific insurance company practices. **Market conduct regulation** focuses on the treatment by insurance companies of applicants for insurance, insureds, and others who present claims for coverage. Market conduct examinations involve four areas of insurance company operations: sales and advertising, underwriting, ratemaking, and claim handling.

Most states have statutes, usually called unfair trade practices laws, that identify certain practices that are considered unfair to the public. State regulators could suspend or revoke the licenses of insurance agents or brokers who engage in any of these unfair trade practices. Similarly, an insurance company guilty of unfair underwriting practices could be fined or have its operating license suspended or revoked in the state. Most states also have statutes that prohibit unfair claim practices and assess stiff penalties against claim representatives and insurance companies that engage in such practices.

Investigating Consumer Complaints

Regulatory examinations of insurance companies identify some of the abuses mentioned above, but other abuses are exposed only when an insured or a claimant lodges a complaint. Every state insurance department has a consumer complaints division to enforce the consumer protection objectives of the state insurance department and to help insureds deal with problems they have encountered with insurance companies and their representatives. The state insurance department investigates consumer complaints and often holds formal hearings as part of the investigation process.

Educational Objective 8

Explain how the excess and surplus lines market meets the needs of various classes of business that are often unable to find insurance in the standard market.

Excess and Surplus Lines Insurance[1]

The standard market refers collectively to insurers who voluntarily offer insurance coverages at rates designed for customers with average or better-than-average loss exposures.

Most property and liability insurance policies are standardized, and many insurers use essentially the same policy forms. Insurers who use these policy forms and others who write traditional types of insurance are known collectively as the **standard market** for property and liability insurance. Such insurers write the majority of commercial property and liability insurance in the United States.

In most cases, the standard market provides the policies necessary to meet the property and liability insurance needs of the public. But what about the unique or unusual exposures that the standard market is unwilling or unable to insure? In many

instances, the standard market does not adequately meet the public's needs. Poor loss experience or expected losses associated with certain classes of business might not meet the underwriting requirements of standard insurers. Changes in business practices or technology might create new loss exposures not contemplated in traditional insurance policies. These exposures require a creative, nontraditional insurance market. The term **excess and surplus lines (E&S) insurance** is often used to identify this nontraditional insurance market. The term "excess and surplus lines" (or simply "surplus lines") refers to the types of insurance written in this market.

Excess and surplus lines (E&S) insurance consists of insurance coverages, usually unavailable in the standard market, that are written by unlicensed insurers.

Classes of E&S Business

The following classes of business are often insured in the excess and surplus lines market:

- Unusual or unique exposures
- Nonstandard business
- Insureds needing high limits
- Insureds needing unusually broad coverage
- Exposures that require new forms

Unusual or Unique Exposures

One of the requirements of a commercially insurable loss exposure is that a large number of similar exposure units should exist. If a exposure does not meet this requirement, standard insurers are often unwilling to provide coverage. For example, suppose a singer does not show up for a performance. The sponsors of the program can suffer a financial loss if they have to refund money to ticket holders. A coverage known as "nonappearance insurance," written by E&S insurers, covers the losses of the production or show sponsors if the performer named in the policy fails to appear because of a covered cause, such as injury, illness, or death.

Nonstandard Business

Sometimes loss exposures do not meet the underwriting requirements of the standard insurance market. There might be evidence of poor loss experience that cannot be adequately controlled. Perhaps the premiums that standard insurers normally charge are not adequate to cover these exposures. For example, suppose a particular restaurant has a history of grease fires in its kitchen, and its standard insurance company has nonrenewed its policy because of poor loss experience. An E&S insurer might be willing to write this restaurant with a premium substantially higher than a standard insurer would charge.

Insureds Needing High Limits

Some businesses demand very high limits of coverage, especially for liability insurance. A standard insurance company might not be willing to offer limits as high as an insured needs. The E&S

market often provides the needed limits in excess of the limits written by a standard insurer.

Insureds Needing Unusually Broad Coverage

The traditional insurance market uses standard coverage forms developed through advisory organizations, such as Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS). When broader coverage is necessary, however, producers and insureds often seek such coverage from the E&S market.

Exposures That Require New Forms

Creativity has long been a distinguishing characteristic of the E&S market. As new insurance needs arise, the E&S market is usually quick to respond. Producers and consumers often turn to the E&S market when they have an immediate need for a new type of coverage.

Excess and Surplus Lines Regulation

Nonadmitted (or **unlicensed**) **insurers** are insurers that are not licensed in many of the states in which they operate and that write E&S insurance coverages.

E&S insurance is usually written by **nonadmitted** (or **unlicensed**) **insurers**, which are insurers that are not licensed in many of the states in which they operate. Nonadmitted insurers are not required to file their rates and policy forms with state insurance departments, which gives them more flexibility than standard insurers.

Although nonadmitted insurers are generally exempt from laws and regulations applicable to licensed insurers, the E&S market is subject to regulation. Some states maintain lists of E&S insurers that are approved to do business in the state; others keep lists of those E&S insurers that are not approved. Most states have surplus lines laws that require that all E&S business be placed through an excess and surplus lines broker, also known as an E&S broker. The E&S broker is licensed by the state to transact business through nonadmitted insurers. When an insurance producer seeks to insure a customer with a nonadmitted insurer, he or she must arrange for an E&S broker to handle the transaction.

E&S insurers and brokers provide a valuable service to the insurance industry and to the public. They provide insurance to many insureds who might otherwise be unable to obtain coverage. They also find solutions to many problems created by unusual or unique loss exposures.

Educational Objective 9

Define or describe each of the Key Words and Phrases for this assignment. (All Key Words and Phrases appear in bold print in the text and in boxes in the margins throughout this chapter.)

Summary

In the United States, private insurers provide most property and liability insurance, but both federal and state governments also provide some types of insurance. Most private insurers are either stock or mutual companies. Other types of private companies or groups that provide insurance include reciprocal insurance exchanges, Lloyds associations, captive insurance companies, and reinsurance companies.

Private insurers are generally reluctant to insure loss exposures that do not possess most of the characteristics of an ideally insurable loss exposure. In some instances, state and federal governments have intervened to make certain types of insurance available to the public. Government insurance programs have arisen when needs for insurance coverage existed that were not satisfied by private insurers and when society benefitted from the programs. Examples of federal government insurance programs include the Social Security program, the National Flood Insurance Program, and the Federal Crop Insurance Program. State governments also provide various insurance programs, including state workers compensation funds, unemployment insurance programs, automobile insurance plans, FAIR plans, and beachfront and windstorm pools. In addition, all states have insurance guaranty funds that cover unpaid claims of insolvent insurers.

Because insurance is a business that affects the public, state governments are heavily involved in the regulation of the insurance industry. State insurance departments, with the assistance of the National Association of Insurance Commissioners (NAIC), are responsible for most insurance regulation. Insurance departments regulate insurance rates to ensure they are adequate, not excessive, and not unfairly discriminatory. Insurers and their actuaries develop insurance rates in a process called ratemaking. However, these rates are subject to various state insurance rating laws.

Solvency is another major concern of insurance regulators. Through periodic examinations of insurers' financial condition and the Insurance Regulatory Information System (IRIS), regulators conduct solvency surveillance to monitor the solvency of insurance companies.

Regulators also try to protect consumers by licensing qualified insurance companies and their representatives, approving policy forms, examining market conduct, and investigating consumer complaints. Through the licensing of excess and surplus lines brokers, state insurance regulators also regulate the excess and surplus lines market, which provides insurance coverages that are unavailable in the standard market.

Chapter Note

1. The section on excess and surplus lines insurance is adapted from material originally written for the Insurance Institute of America by William R. Feldhaus, Ph.D., CPCU, CLU, Georgia State University.