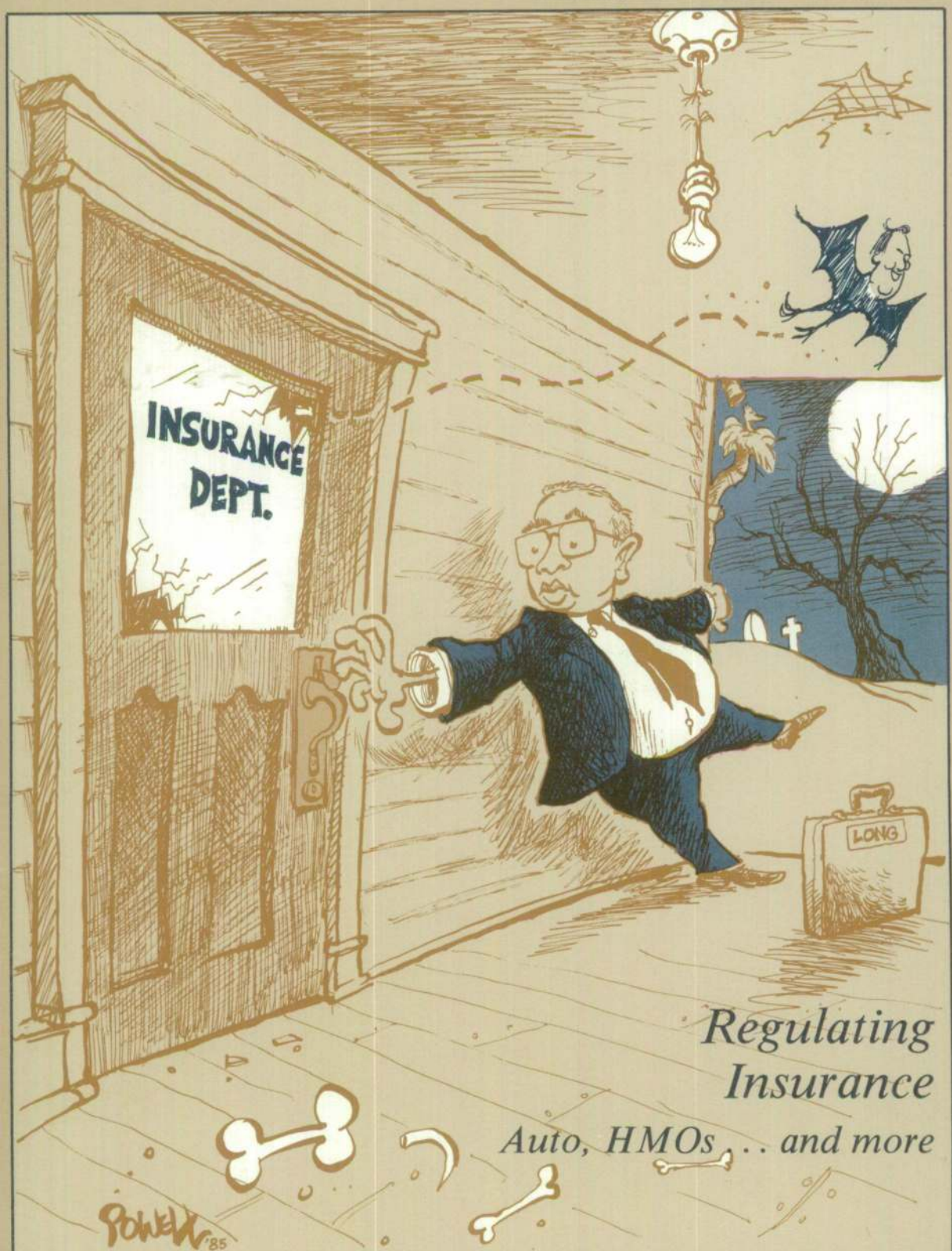
North Carolina **Insight**

February 1985 Vol. 7, No. 3



Regulating Insurance

Auto, HMOs . . . and more

N.C. Center for Public Policy Research

The North Carolina Center for Public Policy Research is an independent research and educational institution formed to study state government policies and practices without partisan bias or political intent. Its purpose is to enrich the dialogue between private citizens and public officials, and its constituency is the people of this state. The Center's broad institutional goal is the stimulation of greater interest in public affairs and a better understanding of the profound impact state government has each day on everyone in North Carolina.

A non-profit, non-partisan organization, the Center was formed in 1977 by a diverse group of private citizens "for the purpose of gathering, analyzing and disseminating information concerning North Carolina's institutions of government." It is guided by a self-electing Board of Directors and has individual and corporate members across the state.

Center projects include the issuance of special reports on major policy questions; the publication of a quarterly magazine called *North Carolina Insight*; the production of a symposium or seminar each year; and the regular participation of members of the staff and the Board in public affairs programs around the state. An attempt is made in the various projects undertaken by the Center to synthesize the integrity of scholarly research with the readability of good journalism. Each Center publication represents an effort to amplify conflicting views on the subject under study and to reach conclusions based on a sound rationalization of these competing ideas. Whenever possible, Center publications advance recommendations for changes in governmental policies and practices that would seem, based on our research, to hold promise for the improvement of government service to the people of North Carolina.

NORTH CAROLINA INSIGHT is a quarterly magazine published by the North Carolina Center for Public Policy Research, Inc. (a non-profit, tax-exempt corporation), P.O. Box 430, Raleigh, N.C. 27602. Telephone (919) 832-2839. Annual membership rates: Individual, $24; Organizational, $30; Supporting, $50; Corporate, $100; Supporting Corporate, $250; Patron, $500. Third class postage paid at Raleigh, N.C.

Printed by Theo. Davis Sons, Inc., Zebulon, N.C. The Center is supported in part by grants from the Mary Reynolds Babcock Foundation and the Z. Smith Reynolds Foundation, as well as by corporate contributions and 700 corporate and individual members across the state. The views expressed in this publication are those of the authors and are not necessarily those of the Center's Board of Directors or staff. Published February 1985.

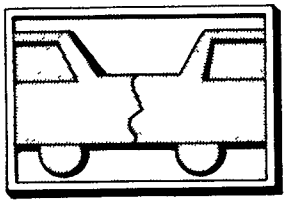
Cover by Dwane Powell.

North Carolina **Insight**

Vol. 7, No. 3

AUTO INSURANCE REGULATION: A SYSTEM OUT OF KILTER?

—*Steve Adams*



Editor
Bill Finger

Production Director
Carol Majors

Assistant Editor
Jody George

Production
Theo. Davis Sons, Inc.

The insurance company

This bookie always hates to pay off

Art Buchwald

I'm not a betting man but I have this bookmaker. He works for the Reluctant Insurance Company of America. This is how we bet. Every month I give him a certain amount of money, and he takes a gamble that my house won't burn down or be broken into or damaged by a falling tree.

Another bet I place with him is that my car won't hit someone in an accident, or I won't be hit by somebody else. Still a third one is that my family will not be stricken with an illness that would require hospitalization.

Funny, but I was never anxious to win one of these bets. I didn't want to collect from the bookie on any of them. He seemed to feel the same way I did. So much so that, if for some reason, I forgot to send him my check for one of our bets, he would mail me a nasty letter, wanting to know where the money was. He was not, he told me, in the bookmaking business for his health.

Well, recently, due to an illness in my family, my bookie lost one of the bets. Since this was the first time I had won I thought he would be happy to pay off. After all, even in Las Vegas the house expects to lose once in a while.

So I wrote him a nice letter telling him that I had won the bet with him that no one in the family would ever have to go to the hospital for surgery.

But instead of congratulating me, I got a very terse letter back telling me he refused to accept my word until I produced the facts that he had lost. What hurt was he didn't even sign the letter "Sincerely."

I sent him all the hospital and doctor bills and pointed out I wasn't making a dime on the wager. As a matter of fact, since he only covered 80 percent of costs I was still a loser.

His next letter arrived with 15 green forms and 20 red forms. Each body in the hospital, I was told, had to fill out either the green or red, or both, depending on what they had done.

A month later, when I didn't receive a check, I called the bookie at Reluctant's offices in Des Moines. He said he had received all the forms but couldn't pay off on the bet. He had to send it to his chief bookie in Chicago.

I protested I had made the bet with him and asked him why he couldn't send me my money. He told me that it wasn't his job to pay off bets for the Reluctant Insurance Company, but just to collect the money from me.

"Are you mad because I finally won a bet?"

"I'm not mad at you. But they are."

"Who's they?"

"The guys in Chicago. They don't like to lose, because then they can't gamble on another skyscraper, or loan a billion dollars to the Chrysler Corporation."

"That's tough," I said. "But when a bookie loses he has to pay off or he won't stay in business very long."

"We'll probably pay you, but your wager has to be reviewed by our in-house betting commission."

"How long will that take?"

"As long as they can keep making 15 percent interest on your money."

Two months went by and I still received no word on my bet. So I decided to take action, as any professional gambler would do under the circumstances. I grabbed a hammer from the tool box.

"Where are you going?" my wife asked.

"To Chicago and break the legs of the chief bookie if he won't pay off my bet."

She wept as my plane took off from Washington.

I returned the next day.

"Did he pay you?" my wife asked.

"No," I said.

"So did you break his legs?"

"I couldn't because he didn't have legs. The chief bookie in Chicago is a computer."

Carol Majors

Introducing Insurance

. . . Considering the Alternative . . .

by William K. Hale

To many people, paying insurance premiums is about as much fun as paying income taxes. We are required by the state to carry liability insurance in order to register and drive our cars. When we finance our cars, we must agree to carry physical damage insurance on the cars in order to secure our loans. When we buy our houses, mortgage lenders require us to carry homeowners insurance. In many cases when we borrow money, the lender will require credit life or credit health insurance to guarantee repayment of the loan if we die or become disabled.

These requirements are understandable. The state is simply trying to guarantee that people injured on the highways will be compensated by those responsible. A lender needs to protect the property financed; otherwise, there might not be any property of any value remaining if a borrower defaults on a loan.

Most people who have dependents feel compelled to purchase life insurance in the event of an untimely demise. We also feel more secure when we know that we are adequately covered by accident or health insurance. The key word here is *security*. Although we may begrudge having to pay out money for something we may never use or see—like the cheapskate who refused to pay his utility bill because he could not actually see the electricity coming into his house—the alternative, no insurance at all, is frightening.

How many of us would take our cars out on the road if we knew that we would have to pay out of our own pockets, for a long time, to com-

---

William K. Hale is a deputy commissioner in the N.C. Department of Insurance, heading the Administrative Law Division and serving as legislative liaison for the new Long Administration. For ten years, until January 1985, Hale worked for the Research Division of the Legislative Services Office, specializing in insurance regulation since 1977.

Landmark Dates in Insurance Regulation in North Carolina

by William K. Hale

(Ed. Note: Landmark dates concerning automobile insurance are grouped separately; see page 31.)

1899 Legislature established the Department of Insurance and gave it responsibility to admit, license, and generally regulate insurance companies. First commissioner elected by General Assembly, then to be appointed by the governor.

1907 Legislature made Commissioner of Insurance an elected position, for a four-year term, beginning in 1908.

1911 Standard policy provisions for accident and health insurance put into general statutes.

1913 Legislature prohibited unfair discrimination in rates, required the licensing of insurance agents, and required ratemaking organizations to file information and rates with the Insurance Commissioner. The commissioner may examine rates and hold hearings upon policyholder complaints.

1915 Insurance adjusters must be licensed;
Fire insurance companies must file rates with the commissioner, who may hold a hearing if a policyholder complains about these rates;
Standard policy provisions for fire insurance put into the general statutes.

1929 Rates for workers' compensation began to be regulated.

1931 Compensation Rating and Inspection Bureau established to collect data and file worker's compensation insurance rates and classifications with the commissioner.

1935 Assigned risk plan for workers' compensation insurance established.

1939 The Automobile Rate Administrative Office established to collect data and file automobile insurance rates and classifications with the commissioner.

1941 Nonprofit hospital and medical service corporations (Blue Cross and Blue Shield plans) began to be regulated.

1944 Commissioner of Insurance became a constitutional office and member of the Council of State.

1945 Federal McCarran-Ferguson Act exempted insurance ratemaking from federal antitrust laws to extent insurance is regulated by the states;
Fire Insurance Rating Bureau established to collect data and file fire insurance rates with the commissioner.

1947 New laws govern merger, rehabilitation, and liquidation of insurance companies.

1949 Unfair trade practices law enacted.

1951 For-profit accident and health insurance policies and rates began to be regulated.

1969 Coastal and urban property insurance made available through "beach" and "FAIR" plans.

1971 Property and Casualty Insurance Guaranty Association established to cover obligations of insolvent insurance companies;
New laws govern holding company registration and disclosure.

1974 Life and Accident and Health Insurance Guaranty Association established to cover obligations of insolvent life and accident and health companies.

1975 Rates and other regulatory provisions for credit life and credit health insurance written into the general statutes;
Reinsurance facility for medical malpractice established.

1976 Malpractice legislation enacted;
N.C. Supreme Court declared the malpractice reinsurance facility law unconstitutional.

1977 "File-and-use" system of rate regulation replaced "prior approval";
Rating bureaus for automobile, fire, and workers' compensation insurance consolidated into the N.C. Rate Bureau. Commercial insurers file their rates and classifications individually;
Health Maintenance Organizations (HMOs) began to be regulated;
Six percent annual limit on rate increases put into effect for automobile, homeowners, and workers' compensation insurance.

1979 Readable Insurance Policies Act passed for automobile, homeowners, life, accident and health, and health maintenance organization policies;
Product liability legislation enacted;
Six percent annual limit on rate increase taken off workers' compensation rates.

1981 Insurance Information and Privacy Protection Act passed;
Medicare Supplement Insurance (Medigap) Policies Minimum Standards Act passed;
Health Insurance Continuation and Conversion Privileges Act passed;
Six percent annual limit on rate increases taken off homeowners insurance.

1983 Rate deviations allowed in workers' compensation insurance.

1984 Coverage for treatment of chemical dependency (alcohol and drug abuse) must be offered in group health policies and health maintenance organization plans, effective January 1, 1985.

pensate someone we injured because of one moment of inattentiveness? Many of us would have trouble borrowing money or financing a car or home if property or credit insurance was not available to us. Without life or health insurance, none of us would be able to guarantee financial security for our dependents in the event of death or serious illness. (Metaphorically speaking, I do not mind getting older, considering the alternative.)

On a less personal and larger scale, businesses could not develop or function without insurance. Business owners and operators must carry insurance to secure credit; to protect goods, buildings, and equipment; to compensate employees for job-related injuries (a state requirement); to attract employees by offering fringe benefits such as group life and health insurance, pensions, and annuities; and to compensate persons who might be injured by defective products or by the negligence of employees. By purchasing insurance, businesses can free their working capital from the possibility of paying for losses, thus allowing entrepreneurs to venture more freely and willingly.

Insurance—A Different Kind of Product

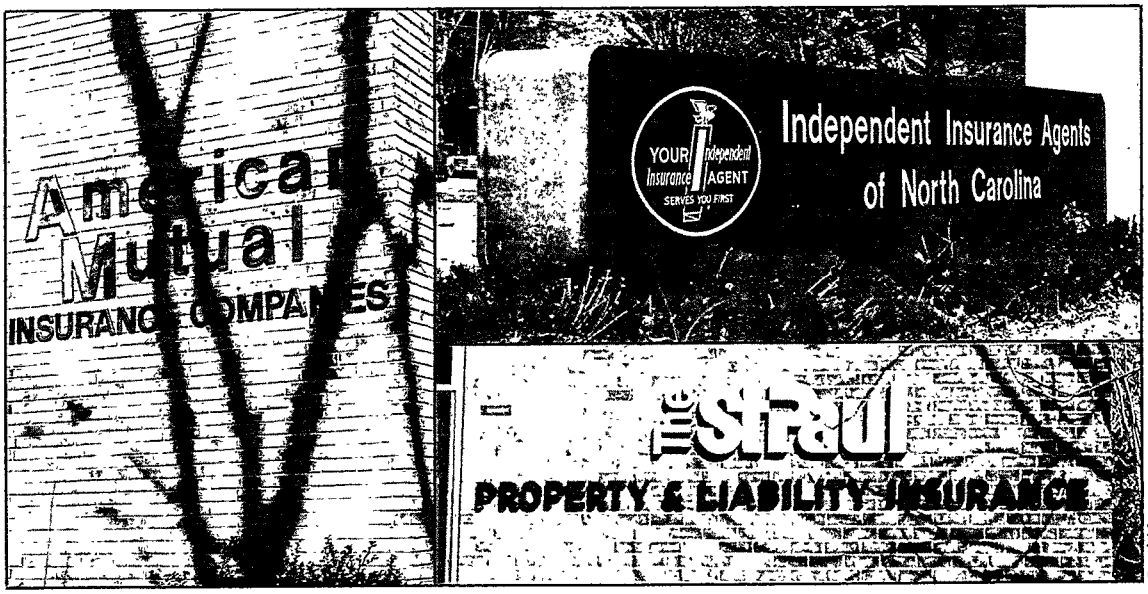
Insurance, unlike most commodities, is paid for in advance. The product or service is delivered, if at all, upon the occurrence of some unpredictable future event. Basically, insurance is: *first, the anticipation or expectation of a loss to be suffered by a portion of a group of people; and second, the redistribution of the cost of those losses to the entire group.* An insurer analyzes the loss experience for the types of risks insured, projects future losses based on this analysis, and sets the premium rates for each risk accordingly.

The concept of sharing the risk of anticipated losses is as old as commerce. The term "underwriter" originated in the most literal sense by the practices of wealthy men signing their names at the bottoms of insurance pooling agreements to cover maritime risks. The term has evolved to mean an employee or representative of an insurer who evaluates applicants for insurance and determines whether or not the insurer should provide coverage for the particular risk.

The Industrial Revolution changed the commercial world, including the natures of the risks to be insured. Developments in transportation and mass production of consumer goods meant more exposure to liability for personal injury and property damage. Over the years the concept of insurance has grown more and more complicated, leading today into such highly charged issues as the disposal of hazardous wastes and the operations of nuclear power plants. These ultrahazardous fields pervade the insurance concept and raise the big question: Who is to assume or share the risks of loss connected with these activities?

While insurance questions related to hazardous wastes still have to be answered, many insurance issues have been addressed. *People who buy this product must be assured that the insurer will be financially able to fulfill its obligations at all times.* The solvency of insurers must be carefully monitored by evaluating their assets, liabilities, investments, business structures (e.g., holding company systems), and the adequacy of their premium rates.

On the other hand, *the people who buy insurance must be protected from premium rates that are excessive* in relation to the value of the coverage, *from rates that are unfairly discrimi-*



Carol Mayors

natory in that they treat similar policyholders or risks differently, and *from unethical or unfair business practices,* either in underwriting or claims processing.

Because the general public does not know or understand actuarial principles, insurance concepts, and the technical language of this business, the public has vested in its state governments the power to regulate insurance. State regulation began with requiring insurance companies only to issue periodic reports on their finances to the public. In the middle of the 19th century, states began to establish regulatory agencies and vested them with the power to enforce insurance legislation.

In 1868, state regulation was challenged in *Paul v. Virginia*, but the U.S. Supreme Court reaffirmed state jurisdiction over insurance.[1] The Court held that insurance contracts were not interstate transactions (even though the insurer and insured might be domiciled in different states) and therefore were not subject to federal law under the Commerce Clause of the United States Constitution.[2]

In 1944, this doctrine was abandoned by the U.S. Supreme Court in *United States v. South-Eastern Underwriters Association:* "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance."[3]

Congress responded to this decision by passing the McCarran-Ferguson Act in 1945.[4] In this act, Congress, exercising its constitutional legislative power, redefined state regulatory authority. To the extent insurance is regulated by states, said McCarran-Ferguson, insurance was exempted from the federal antitrust laws (Sherman Act, Clayton Act, and Federal Trade Commission Act). Congress retained some jurisdiction over insurance, however, by providing that the intimidation, boycott, and coercion provisions of the Sherman Act still applied to insurance.

Carol Majors

The McCarran-Ferguson Act meant, in effect, that if a state enacted some form of insurance rate regulation, it would have jurisdiction over most insurance issues. Within a few years of the passage of McCarran-Ferguson, most states did exactly that, following in many cases a model state act prepared by the National Association of Insurance Commissioners.

Taking on the regulation of insurance was no simple matter for the states. Insurance can be purchased by several different methods and comes in different forms, as do the insurance companies themselves. A consumer can purchase insurance: 1) directly from the employees of the insurer (direct writers); 2) from persons who act as representatives of one or more insurers (agents); or 3) from persons who act as representatives of the buyer and who procure the coverage for that buyer (brokers).

Insurance companies come in three basic forms as well: stock companies, mutual companies, and nonprofit cooperatives. *Stock insurance companies* obtain operating capital by selling shares of stock. These companies declare and distribute dividends to their shareholders whenever they make a reasonable profit. *Mutual companies* result when persons participate in the insurance company by purchasing insurance policies; there is no stock per se. Mutuals declare dividends to their policyholders whenever they make a reasonable profit. A third form of insurer is the *nonprofit cooperative*, including Blue Cross and Blue Shield of N.C. and other similar medical or dental insurance plans.

The product of insurance has many forms. As regulation of the insurance industry evolved, the states generally grouped the different coverages into two broad types—*property and casualty coverage* and *life, accident, and health coverage.* This separation began with the New York General Insurance Act of 1849. Other states followed the lead of New York, apparently because of its status as a paragon of commerce and industry. Otherwise, there does not seem to be any compelling reason for segregating insurance coverages into these two categories. But such a division became a major factor in insurance regulation, affecting everything from who could write what type of coverage to the varying systems of rate regulations.

Property and Casualty Coverage. Property insurance is simply that—insurance on property. It can insure losses from physical damage to the property or loss of income and other expenses incurred because of damage to the property. Casualty insurance is a confusing term. If it really means any coverage for loss, due to any accident, it could describe virtually every insurance coverage in existence. By a process of

Table 1. N.C. State Government Departments with Insurance Responsibilities

Department/Division	Program/Responsibility
I. INSURANCE REGULATION	
Department of Insurance	
Consumer Information	Provides information on rates, policy language, etc.
Examination & Admissions	Inspects insurance companies' operations and licenses them to do business
Financial Analysis	Monitors companies for solvency and unfair trade practices. Assists other divisions with financial matters
Fire and Casualty	Analyzes rate filings
Licensing	Administers exams and regulates license renewals for agents, brokers, and adjusters
Life , Accident, and Health	Analyzes rate filings
Department of Justice	
Attorney General	Represents Dept. of Insurance in litigation
II. INSURANCE DELIVERY	
A. To the General Public	
Department of Commerce	
Employment Security Commission	Administers insurance and benefits system
Industrial Commission	Determines eligibility under Workers' Compensation Act and serves a quasi-judicial function in contested cases
Department of Human Resources	
Social Services	Determines eligibility for federal Social Security Disability
B. To State Employees	
Multiple Departments[1]	
Auto, liability, etc.	General coverage comparable to private sector coverage

FOOTNOTES

[1] All state-owned motor vehicles have liability insurance protection under a master policy. The state is a self-insurer for general workers' compensation. Specialized insurance varies. The Department of Human Resources, for example, carries malpractice insurance for eight physicians who perform electro-shock treatment.

Chart compiled by Jody George.

elimination of other definitions, however, casualty insurance could be said to comprise automobile, burglary and theft, credit, workers' compensation, and liability (products liability, malpractice, etc.). Even accident and health could be considered a form of casualty coverage, but it usually is grouped with life insurance instead.

Life, Accident, and Health. Accident and health insurance is simply that—coverage of costs for personal accidents or health problems. Unlike accident and health, life insurance and annuities could rationally be singled out and separated from the other types of insurance. *Annuities,* in effect, are life insurance without the uncertainty of when the payment is made. The insured (annuitant) makes one or more payments (over a brief period) to the insurer; the amount paid in accumulates interest; and at a specified later date (usually at retirement age) the insurer makes periodic payments to the annuitant.

Other Types. A few types of insurance are not usually put in either category. *Marine insurance,* for example, provides coverage for goods while they are in transit, either on land (inland marine) or at sea (ocean marine). *Surety bonds* guarantee the performances of the obligations of contractors, employees, executors,

public officials, and others; these bonds cover everything from negligence to outright dishonesty.

And all of this is regulated by the state, you ask? Yes, it is supposed to be. The state monitors the various forms of insurance and insurance companies, and the different ways of selling insurance. Primarily through the legislature and the Department of Insurance, the state:

- oversees the formation and operation of insurers;
- prescribes minimum financial standards for licensing and continued operations of insurers;
- regulates the premium rates insurers charge, the language in their insurance policies, and their risk classification systems;
- requires periodic financial disclosure by insurers;
- provides for audits of insurers at least every three years to monitor solvency;
- licenses and regulates agents, brokers, and claims adjusters;
- prescribes and defines what kinds of insurance may be written in the state;
- provides information to insurance consumers about their rights and responsibilities under their policies; and
- prohibits unfair and deceptive trade practices among or by insurers.

The Issues Ahead

For the past six months, two non-partisan efforts have been underway in North Carolina to identify the most pressing insurance issues ahead for the 1985 General Assembly and the new Commissioner of Insurance: the legislature's Insurance Study Committee and this issue of

Table 2. N.C. State Boards and Commissions with Insurance Responsibilities

Board, Commission or Council	Established by	Purpose	Membership Appointed by
A. Under Department of Insurance			
1. N.C. Health Insurance Advisory Board	NCGS 58-262.1	To review complaints about the health insurance industry, evaluate health insurance companies, and suspend licenses of companies not operating in the public interest.	9 - Governor[1] 1 - Ex-Officio Member (Commissioner of Insurance)
2. Insurance Advisory Board	NCGS 58-27.1	To set regulations for the holding of public hearings before the Insurance Commissioner on proposals to revise insurance rating schedules.	6 - Governor 1 - Ex-Officio Member (Commissioner of Insurance)
3. N.C. Manufactured Housing Board	NCGS 143-143.8	To provide a framework for regulations on licensing and bonding of the mobile home industry.	2 - Governor[2] 2 - Commissioner of Insurance[2] 4 - General Assembly [2,3] 1 - Ex-Officio Member (Commissioner of Insurance)
4. Building Code Council	NCGS 143-136	To adopt, amend, and interpret North Carolina State Building Code for all buildings in North Carolina.	12 - Governor[4]
5. N.C. Code Officials Qualifications Board	NCGS 143-151.9	To establish minimum standards for officials who enforce building, plumbing, mechanical, and electrical codes on behalf of cities, counties, and the state.	7 - Governor 4 - Lt. Governor 4 - House Speaker 1 - Commissioner of Insurance 4 - Others Making Appointments[5]

FOOTNOTES

[1]Five members from public-at-large and 4 members from insurance industry recommended by Commissioner of Insurance.

[2]No appointees may be legislators.

[3]Upon recommendation of President Pro Tempore of the Senate and Speaker of the House of Representatives.

North Carolina Insight. Both studies had to consider many aspects of state regulation of insurance and ultimately had to make choices of areas of concentration.

The Insurance Study Committee decided to focus on the issue of solvency of insurance companies. Many purchasers of insurance are aware that the Commissioner of Insurance regulates premium rates and policy provisions, and licenses insurance companies and agents. The commissioner also must evaluate, regulate, and monitor the financial conditions of insurance companies—those that apply to do business here and those already operating in North Carolina. The Insurance Department must assure that those companies can fulfill their promises to pay or indemnify their policyholders—a responsibility that often goes unnoticed.

New specters loom on the horizon that affect this monitoring of insurance company solvency. Policymakers must face the challenge of protecting the public from conditions gone awry. For example, the financial services industry—banking, securities, and insurance—are becoming more integrated. This blurring of functions affects the solvency of insurers. Changes in computer science, in the federal regulation of banks, thrift institutions, and securities, and in the nature of financial services could well make the task of monitoring insurance company solvency much more difficult for the state in future years.[5]

While the Insurance Study Committee was examining issues of solvency, the N.C. Center for Public Policy Research was working to produce this primer on insurance regulation in the state. What state agencies and what boards and commissions have insurance-related responsibilities?

Board, Commission or Council	Established by	Purpose	Membership Appointed by
B. Under Department of Administration			
6. Public Officers and Employees Liability Insurance Commission	NCGS 143B-422	To negotiate and acquire professional liability insurance for law enforcement officers, public officers and employees of any municipality. To act as a liaison between the company and public employees.	6 - Governor[2,6] 2 - General Assembly [2,7] 3 - Ex-Officio Members (Commissioner of Insurance, Attorney General, and Secretary of Crime Control and Public Safety)
7. Board of Trustees of the N.C. Public Employees Deferred Compensation Plan	NCGS 143B-426.24	To establish and maintain the Deferred Compensation Plan for state employees.	3 - Governor [2,8] 2 - General Assembly [2,7] 2 - Ex-Officio Members (Secretary of Administration, State Treasurer)
8. Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan	NCGS 135-39	To supervise and monitor the company that administers the plan and modify benefit levels when appropriate.	6 - General Assembly [2,7] 3 - Governor [2]

FOOTNOTES, *continued*

[4]Members are to be registered architects, licensing contractors, registered engineers, building inspectors, public-at-large, and fire safety experts.

[5]One appointment each by: Dean, NCSU School of Engineering; Dean, NCA&T School of Engineering; Director, Institute of Government; State President of Community Colleges.

[6]Governor appoints members nominated by Independent Insurance Agents of N.C., Carolinas Association of Professional Insurance Agents, N.C. Police Chiefs Assn., N.C. Police Executives Assn., N.C. Sheriffs' Assn., N.C. League of Municipalities, and N.C. Assn. of County Commissioners.

[7]Upon recommendation by Lieutenant Governor and Speaker of the House of Representatives.

[8]Members are to have experience in taxation, finance, and investments, and one is to be a state employee.

Chart compiled by Jim Bryan and Jody George.

From left, William K. Hale, Sen. Joseph E. Johnson (D-Wake), and Rep. Foyle R. Hightower Jr. (D-Anson) confer before the November 8, 1984 meeting of the legislature's Insurance Study Committee. Johnson and Hightower co-chaired the committee; Hale was staff attorney.

What are the landmark dates in insurance regulation? The tables accompanying this article provide policymakers, the press, and the public with a quick reference guide to answer these questions.

How does the rate regulation process work? What kinds of insurance are regulated and to what extent? The next article examines the state's overall system of rate regulation, including the role of the N.C. Rate Bureau. In simple terms, rates are now determined for the "essential" lines of insurance—homeowners, private passenger automobile, and workers' compensation—through industrywide rates (with downward deviations for individual companies), filed through the Rate Bureau. Is this better than a system of "open competition," where individual companies make separate filings? A chart comparing the systems in eight selected states provides a starting point for answering this question.

This issue of *Insight* then goes beyond the primer function.

By state constitutional law, the legislature is responsible for establishing the law and public policy for insurance regulation, the Commissioner of Insurance is responsible for administering and enforcing the insurance laws, and the courts must settle disputes over the meanings and applications of the laws. During the three terms of Commissioner John R. Ingram, the N.C. Court of Appeals and Supreme Court entertained an unprecedented number of ratemaking cases in which the orders of the Commissioner had been appealed. In all but one case, which was arguably insignificant, the courts overruled the Commissioner.

On January 5, 1985, James E. (Jim) Long became the ninth person to serve as the N.C. Commissioner of Insurance. How will he cope with the Ingram legacy? And how will he balance the legislative, administrative, and judicial roles within the insurance regulatory system? In a lengthy interview with the *Insight* editors, Long answered these questions and more.

Many innovations in insurance are taking place. There are new life insurance coverages that combine death benefits with investments, such as the universal life and variable life insurance products. New health care delivery systems, such as health maintenance organizations, preferred provider organizations, and continuing care or life care centers, pose conceptual challenges to the insurance regulator, because they have some of the characteristics of health insurance yet differ in many respects. Robert Conn, a reporter covering health-related matters for two decades, identifies seven policy questions raised by the rapid growth of health maintenance organizations in North Carolina.

Perhaps the most ambitious undertaking by this issue of *North Carolina Insight* is the section on the auto insurance regulation system, designed by the *Insight* editors and free-lance writer Steve Adams. This system has not been satisfactory to motorists or insurance companies, despite periodic attempts by the General Assembly to improve it. A re-evaluation and restructuring of the entire system, including its inner workings and mechanisms, is necessary—with a view toward recreating a system that is fair, reasonable, and consistent with a clearly stated public policy.

Commissioner Long has proposed that the 1985 General Assembly establish a study committee to overhaul the property and casualty statutes by 1987. Adams, who has reported on auto insurance issues for seven years, first explains the auto insurance regulation system and then breaks the ground for the proposed overhaul.

Buying insurance may in fact be no more fun than paying taxes. But just as we keep paying taxes, we will continue buying many forms of insurance. If you are in the business of affecting the policymaking process or reporting on this process—or if you simply want to be better informed on how the state of North Carolina regulates insurance—this issue of *North Carolina Insight* should be in your hip pocket.

After all, consider the alternative. □

FOOTNOTES

[1]8 Wall (U.S.) 168 (1868).

[2]U.S. Constitution, Article I, Section 8(3).

[3]322 U.S. 533 (1944).

[4]59 Stat 34 (1945), as amended, 15 USC sections 1011-1015.

[5]See "Insurance Regulation," a Report of the Legislative Research Commission, Insurance Study Committee, to the 1985 General Assembly, December 13, 1984.

Memorable Memo

North Carolina
Department of Administration
300 North Salisbury Street Raleigh 27611

Motor Fleet Management Division
Rilla Moran Woods, Administrator
(919) 733 6540

James B Hunt, Jr., Governor
Jane Smith Patterson, Secretary

October 5, 1982

Mr. H. G. Royall,
Dept. of Human Resources
Albemarle Building

Mr. Royall,

Mr. Royall the reason for two FM-11 for Carson Boon Annis, is that the original copy she sent to us was filled out on the wrong FM-11, instead of sending it back I just retyped the information on the right FM-11. But I'm sending both FM-11 copies back because on the one I typed it does not have the Department head signature on it. And the one that was sent to me, there was no place for Mrs. Woods to signed, so thats why I retyped it on to the right FM-11.

These are just the copy of Carson Boon Annis, to let you know that the Fm-11 has been approved by Mrs. Woods.

If you have any question call Linda Blackley at 733-6540.

STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
325 NORTH SALISBURY STREET
RALEIGH 27611

JAMES B HUNT JR
GOVERNOR

SARAH T. MORROW, M.D. M.P.H.
SECRETARY

TOM GILMORE
DEPUTY SECRETARY

TELEPHONE
919/733-4534

MEMORANDUM

TO: Shirley Hathaway

FROM: Faye Dasen

RE: Memo of July 17, 1981 regarding Susan Lupton's calls

According to the list you sent me along with her cash, the total due was $2.88. I am returning 2¢ for you to give to Susan as we do not want to deposit more than what was actually the cost of the calls.

Thanks.

/fd

These two gems survived the Hunt Administration. For those of you emptying your desks (and file cabinets?) and for you newcomers alike, send us your unforgettables. As always, anonymity guaranteed.

How the System Works

Regulating Rates

by Bill Finger and Jody George

On October 23, 1984, the North Carolina Rate Bureau held its annual meeting at the Velvet Cloak Inn in Raleigh. The 40 to 50 members present reviewed the annual report and elected five member companies to the Bureau's governing committee. Then, 25 minutes after it was called to order, the annual meeting of the Rate Bureau adjourned until next October.

"I can only remember one or two meetings that lasted longer," says Paul Mize, general manager of the Rate Bureau since it began in 1977. "It is very seldom that any controversial information comes up, and controversy should not arise if we are doing our job correctly."

Controversy or not, a 25-minute annual meeting hardly suggests the impact this group has on insurance rates in North Carolina. Since 1945, when Congress passed the McCarran-Ferguson Act,[1] the state of North Carolina has had increased responsibility for regulating insurance. The Rate Bureau, the Department of Insurance, and the legislature are the key actors in this regulatory process. Together, they must work to ensure that "rates shall not be excessive, inadequate, or unfairly discriminatory."[2]

G. D. "Red" Culp, N.C. Farm Bureau Mutual Insurance Company, presides at the 1984 N.C. Rate Bureau annual meeting (above). At right, insurance company representatives in attendance.

"Excessive rates are patently unfair to policyholders and give insurance companies unwarranted profits," says William Hale, an insurance specialist, formerly with the General Assembly's Research Division and now a deputy commissioner in the Insurance Department. "Inadequate rates, on the other hand, threaten the solvency of insurance companies, which must meet their expenses and be allowed to make a 'reasonable' profit, as required by state law."[3]

Until 1977, three separate rating organizations

collected statistical information and proposed uniform, statewide rates for workers' compensation, automobile, and fire and property lines of insurance.[4] In 1977, the General Assembly consolidated the three into a single N.C. Rate Bureau.[5]

"The work of the three bureaus was so interrelated that for the sake of efficiency it made sense to have them under the same roof and under the general management of the same person," says Hale.

The 1977 law defined the responsibilities of the Rate Bureau as covering three types of insurance informally called "essential" lines: private passenger (non-fleet) automobile, residential property, and workers' compensation. These lines are considered "essential" because they are an economic necessity for most consumers or are required by state law (see Table 1).

All other types of insurance are considered "non-essential" (even though health, credit, life, and other types of insurance are purchased by most people). In North Carolina, no rating bureau has jurisdiction over "non-essential" lines of insurance. See Table 1 for more on how various types of insurance are regulated.

All companies offering policies for an *"essential" line* of insurance must belong to the Rate Bureau. The Rate Bureau, in turn, has two principal duties: 1) to propose an industrywide system of rates; and 2) to establish standard policy forms. The Rate Bureau develops the rate schedule and the policy forms for private auto, property (includes homeowners' coverage), and workers' compensation insurance. This has a profound effect on virtually all consumers. The Department of Insurance usually *reacts to* what the Rate Bureau does, although the commissioner may call a hearing at any time to consider rate changes.

The N.C. Rate Bureau

The constitution of the N.C. Rate Bureau, a nonprofit organization, prescribes a 12-member Governing Committee and four standing committees: automobile (9 members), property (9 members), workers' compensation (10 members), and legal (6 members). Each company that belongs to the Rate Bureau, regardless of the amount of insurance business it writes in the state, has one vote in the election of the Governing Committee and in deciding any other matter that comes before an annual or a special meeting of its members. This ensures representation of the interests of the smaller companies.

The member companies bear the cost of operating the Rate Bureau. They pay in proportion to their respective North Carolina premium writings for the insurance lines under the Bureau's jurisdiction, with a minimum annual fee of $50 per company for each of the three lines for which the company is licensed by the Commissioner of Insurance.

The Rate Bureau—along with the North Carolina Reinsurance Facility, the North Carolina Insurance Guaranty Association, and the North Carolina Life and Accident and Health Insurance Guaranty Association—is located at 1700 Hillsborough Street in Raleigh. A 60-person staff runs these four organizations, varying its time among the four groups as necessary. The Rate Bureau requires about two-thirds of the staff time. Paul Mize heads all four groups (For a discussion of the Reinsurance Facility, see page 50.)

North Carolina Rate Bureau Governing Committee, 1984-1985

Stock-Held Company	Term Expires
Allstate Insurance Company	1987
Integon General Insurance Company	1986
State Capital Insurance Company	1985
The Travelers Insurance Company	1986
U.S. Fidelity & Guaranty Company	1987
U.S. Fire Insurance Company	1985
Non-Stock Company	
Harleysville Mutual Insurance Company	1986
Liberty Mutual Insurance Company	1985
Lumbermens Mutual Casualty Company	1987
Nationwide Mutual Insurance Company	1985
N.C. Farm Bureau Mutual Insurance Company	1987
Pennsylvania National Mutual Casualty Insurance Company	1986

Much of the insurance industry advocates "open competition" in lieu of rate regulation.

Setting Rate Schedules

The Rate Bureau files an *industrywide* rate schedule for each of its three lines with the Insurance Commissioner, under a "file and use" system. The rates go into effect on a date *specified by the Bureau*, following a mandatory 90-day waiting period. The commissioner may hold a hearing on the filings and may reject them entirely or in part. If the commissioner rejects some portion of the rate increase, the Rate Bureau must appeal the ruling to the N.C. Court of Appeals for the new rate schedule to take effect. Any rate increases must be kept in a separate escrow account until final resolution of the increase by the courts.[6] A similar escrow account must also be used if the commissioner orders a rate reduction which is appealed and not implemented.

The Rate Bureau develops its rate schedule using this process:

- companies report claims, premiums, and general costs of operation to the Rate Bureau;
- the Bureau hires private statistical organizations (usually the ISO, the Insurance Services Office) to compile the company data;
- Bureau actuaries use this data to propose new rate schedules to the Bureau's appropriate technical advisory committee (auto, property, or workers' compensation); and
- the Bureau's Governing Committee (see box on page 13) reviews the advisory group's recommendations and files the final schedule with the Commissioner of Insurance.

Individual companies may offer lower rates (or higher, which is possible) than the industrywide standard by requesting "deviations" directly from the Commissioner of Insurance. Approval of downward deviations is usually routine. The Rate Bureau has no authority over deviations, although they are filed with the Bureau as well as with the Department of Insurance.

Most non-essential lines of insurance—where individual companies or rating organizations file rate schedules with the commissioner—also operate under a file-and-use system (see Table 1). A significant exception is some health insurance filings, which follow a "prior approval" system. Under the "prior approval" system, used for all types of insurance until 1977, the Insurance Commissioner had to approve any rate increases *before* they could take effect.

Developing Policy Forms

In 1979, the General Assembly passed the Readable Insurance Policies Act, which required specific tests for format and readability for homeowners', private passenger automobile, life, and health insurance policies.[7] The act requires the Insurance Commissioner to review the forms to ensure that they are readable by a person of "average intelligence, experience, and education."

For homeowners' and private passenger auto insurance, the Rate Bureau had to rewrite all of the numerous policy forms and revise the rating manuals to correspond to the new forms. The job took almost two years to complete. "The companies must maintain separate forms for North Carolina," says Mize. "This adds to administrative costs."

To alter an existing policy form, either a member company, a rating organization (on behalf of a member company), or the Rate Bureau itself proposes a new form to a Bureau technical advisory committee (automobile, property, or workers' compensation). The auto and property committees each have a standing policy forms subcommittee. The workers' compensation committee uses an ad hoc subcommittee as necessary.

"The problem of policy forms does not rear its ugly head very often with workers' compensation because it is commercial insurance and the forms have been standardized for a long time," says Mize.

The technical advisory committees send any proposed policy form change to the Bureau's Governing Committee, which in turn files the proposed new policy form with the Insurance Commissioner. Unlike the rate schedules, policy forms follow a prior approval system. Companies may use these forms if the commissioner approves them or if no action is taken by the commisisoner in 90 days.[8]

Almost all "non-essential" lines of insurance follow the prior approval system for policy forms.

A Rate Bureau and Open Competition

Much of the insurance industry advocates "open competition" in lieu of rate regulation. This could take either of two forms: 1) competitive rates within a state regulated rate system or 2) an essentially unregulated market in which insurers set their own rates. To some extent, option one above describes the current North Carolina system.

Table 1. Regulating Insurance Rates and Policies in North Carolina, by Type of Insurance[1]

Type of Insurance	Whether Insurance is Required by Statute or by Lenders[2]	Groups Proposing Rates and Policy Forms to N.C. Dept. of Insurance	Regulatory Authority of N.C. Dept. of Insurance		Type of Insurance Covered by the Readable Policies Act[3]
			Rates	Policy Forms	
"ESSENTIAL"[4]					
1. Automobile (private passenger, nonfleet)					
a. Liability	Yes, NCGS 20-309	N.C. Rate Bureau[5]	File and Use[6]	Prior approval	Yes
b. Physical damage	Yes, by Lenders	N.C. Rate Bureau	File and Use	Prior approval	Yes
2. Property (residential):					
a. Fire, liability	Yes, by Lenders	N.C. Rate Bureau	File and Use	Prior approval	Yes
b. Personal property	Not Required	N.C. Rate Bureau	File and Use	Prior approval	Yes
3. Workers' compensation	Yes, NCGS 97-93	N.C. Rate Bureau	File and Use	Prior approval	No
"NON-ESSENTIAL"[4]					
4. Automobile (commercial)					
a. Liability	Yes, NCGS 20-309	Companies or Rating Organizations[7]	File and Use	Prior approval	No
b. Physical Damage	Yes, by Lenders	Companies or Rating Organizations	File and Use	Prior approval	No
5. Credit	Yes, by Lenders[8]	Companies[9]	File and Use	File and Use	No
6. Flood and Storm	Not Required[10]	Companies or Rating Organizations	File and Use	Prior approval	No
7. Health Insurance					
a. Blue Cross/Blue Shield	Not Required	Blue Cross/Blue Shield	Prior approval	Prior approval	Yes
b. Commercial Companies	Not Required	Companies	File and Use	Prior approval	Yes
8. Health Maintenance Organizations (HMOs)	Not Required	HMOs	Prior approval	Prior approval	Yes
9. Liability (products, professional and general)	Not Required	Companies or Rating Organizations	File and Use	Prior approval	No
10. Life and annuities[11]	Not Required	Companies	File and Use	Prior approval	Yes/No[12]
11. Mortgage[13]	Not Required	Companies	File and Use	Prior approval	No
12. Property (commercial)	Yes, by Lenders	Companies or Rating Organizations	File and Use	Prior approval	No
13. Title[14]	Yes, by Lenders	Not regulated	Not regulated	Not regulated	No

FOOTNOTES

[1]Includes only the major forms of insurance. Others not mentioned include accounts receivable, animal, boiler and machinery, crime and surety, crop, glass, marine, protection and indemnity, valuable papers, and water damage. Also, fidelity bonds are not covered by this chart.

[2]Banks, savings and loans, and others who loan money usually require borrowers to purchase insurance for the item for which the money is loaned. In this column, "lenders" indicates that *most lenders, but not all*, require such a purchase.

[3]The Readable Policies Act (NCGS 58-364 to 58-372) requires that insurance policies be written in simple and commonly used language.

[4]North Carolina law differentiates between "essential" and "non-essential" lines of insurance. Essential lines are private passenger automobile, residential property, and workers' compensation; non-essential lines are all other types of insurance.

[5]The N.C. Rate Bureau, created by the 1977 General Assembly, files and promulgates rates for private passenger automobile insurance, residential property insurance, and workers' compensation insurance.

[6]Under "file and use," the Rate Bureau files rates with the Insurance Commissioner. The proposed rates go into effect on a date specified by the Rate Bureau, following a mandatory waiting period of at least 90 days. Some analysts prefer to call the North Carolina system "modified" file and use, for this reason: If the commissioner disapproves the proposed rates, they may go into effect *only if* the commissioner's order is appealed *and if* the premium amounts considered excessive are deposited in a special escrow account during the appeal. The escrow provision—but not the waiting period—also applies to four "non-essential" types of insurance (commercial automobile, flood and storm, liability, and commercial property).

[7]A rating organization collects data and sets rates for member companies—usually small companies that do not consider it cost efficient to determine rates themselves.

[8]Credit insurance, not required by law, is almost always required by lenders. Unlike most types of insurance, under credit policies, the insured and the beneficiary are *different people*. The *borrower buys the insurance*, but the *beneficiary is the lender*.

[9]The rates for credit insurance are set out in NCGS 58-348 to 58-350. NCGS 58-347 requires insurers to file credit insurance rates with the Insurance Commissioner.

[10]In 1969, federally subsidized flood insurance became available through private insurance companies. In 1977, the federal government took over this joint program entirely, under the Federal Insurance Administration. Flood insurance is available in about 15,000 communities, which must agree to plan and carry out land use control measures to reduce future flooding.

[11]An annuity is a contract that provides an income for life or for a specified period of time.

[12]Life insurance policies are covered by the Readable Policies Act; annuities are not.

[13]Mortgage insurance pays off a mortgage balance upon the death of the income-earning homeowner.

[14]Title insurance protects a person's title to a piece of real property.

"In today's market, for the essential lines, you get away from the standard rates," says newly elected Commissioner of Insurance Jim Long. "You may have deviations of 5, 10, and sometimes 15 percent or more downward from that standard rate. So you are seeing more of a competitive nature in the market now in the essential lines."

In the non-essential lines, adds Long, "You see a great deal of competition. You will probably see this as a growing trend as you see more and more deregulation in insurance and banking."

Eliminating regulation entirely would, in theory, result in far more competition than the deviation-from-a-standard system. Robert Hunter of the National Insurance Consumer Organization points out that competition can work only when consumers can effectively comparison shop. Standardized policies assist consumers to some extent, but comparison shopping in insurance still seems far down the road. Going from a K-Mart to a Sears to a Belks to compare prices, quality, and service on household goods, for example, simply is not the method of shopping for insurance products.

In recent years, both Virginia and South Carolina have debated the issue of competition in making major changes to their rate regulation systems. As neighboring states, they are often used for comparisons in legislative debates. Moreover, the two states adopted contrasting regulatory systems within the context of open competition. As Table 2 shows, both Virginia and South Carolina generally embraced a system of "open competition"—that is, neither state has a rate bureau. But the extent of rate regulation in the two states lies at opposite ends of the spectrum.

Since 1974, Virginia has allowed companies to use any rates they wish, so long as they file them with the Department of Insurance. "We cannot disapprove rates as excessive as long as there are a sufficient number of companies offering [the coverage]," says Virginia Deputy of Insurance Paul Synnott. With a sufficient number of companies, Synnott explains, competition should keep rates down rather than letting them become excessive.[9]

The Virginia Bureau of Insurance can disapprove rates "only if they are so low as to endanger solvency or to be unfairly discriminatory," adds Synnott. The state has no standard for determining what rates are "unfairly discriminatory," he says, other than "not being supported by the reasonable expectation of the Virginia unfair trade practices laws." Under this system, he says, homeowners' rates have not gone up, after adjusting for inflation, and auto rates have increased only modestly. "The system works extremely well."

South Carolina, like Virginia, allows individual companies to compete on rates. No rate bureau sets industrywide standards. But unlike Virginia, South Carolina operates under a "prior approval" system, where the Insurance Commissioner must approve rates before they can go into effect. Prior approval allows for a more rigorous test of whether rates are excessive, inadequate, or unfairly discriminatory, says Joe P. Barnett, assistant to the Insurance Commissioner. "If you have compulsory [automobile liability] insurance, it would be recommended to have prior approval of rates," he says. Otherwise, companies would take advantage of poor people by raising their rates until the poor could not afford to drive, adds Barnett.

How would open competition affect other aspects of the ratemaking system, such as the hearing process and the monitoring of rates for consumers (see Table 2)? A full-scale examination of the systems used in Virginia, South Carolina, and other states would assist state policymakers in sorting through this complex question.

"Any insurance regulation system will work," says Long. "If you look at the 50 states, you will find variations and major differences, and all of them work reasonably well. The question is, 'Which works best for North Carolina?'"

Long hesitates to say, however, which system he prefers for this state. "You can crank any combination of factors into the system—the file and use system, the old prior approval, or competitive rating. Any of them will work," he says. "Finding the best absolute system for this state is going to take us some time. Us—being the Commissioner and the General Assembly, together with the companies being regulated, the agents, and the public." □

FOOTNOTES

[1]59 Stat 34 (1945), as amended, 15 USC 1011-1015.

[2]NCGS 58-124.19(1).

[3]NCGS 58-124.19.

[4]The three bureaus were: the Compensation Rating and Inspection Bureau of North Carolina, the North Carolina Automobile Rate Administrative Office, and the North Carolina Fire Insurance Rating Bureau.

[5]NCGS 58-124.17. See also Session Laws, 1977 (chapter 828, section 6) and 1981 (chapter 888, sections 1-3).

[6]NCGS 58-124.20 to 58-124.22.

[7]NCGS 58-364 to 58-372.

[8]NCGS 58-124.29.

[9]There are several exceptions to this system, says Synnott. For workers' compensation, uninsured auto coverage (mandatory in Virginia) and "assigned risks" (similar to the policies ceded to the N.C. Reinsurance Facility), companies operate on a prior approval system. Rates must ultimately be approved either by the commissioner or by the courts. Individual lines of health insurance operate on still another system.

Table 2: Ratemaking Systems, Selected States, 1984

Automobile (Private Passenger), Homeowners', and Workers' Compensation

State	Mandatory Rate Bureau in State[1]	System of State Regulation		Who Monitors Rates for for Consumers	Role of Commissioner in Rate Hearing
		Auto (private passenger) & Homeowners'	Workers' Compensation		
California	No[2]	None, Pure "open competition"	Prior approval	Rate Regulation Div., Dept. of Insurance	Appoints hearing officer
Florida	No	Use and file	Prior approval	Department field officers	Can appoint hearing officer
Illinois	No	None. Pure "open competition"	Use and file	Commissioner	None
New Jersey	No	Prior approval	Prior approval	Public Advocate	Acts on recommendation of Administrative Law Judge
New York	No	Prior approval; File and use[3]	Prior approval	Property Casualty Bureau	Appoints hearing officer
North Carolina	Yes	File and use	File and use	Commissioner	Consumer advocate or hearing officer
South Carolina	No	Prior approval	Prior approval	7-member Ins. Commission, Commissioner, and separate Consumer Affairs Div.	Appoints or acts as hearing officer
Virginia	No	File and use	Prior approval	Commissioner	Representative of Ins. Department

FOOTNOTES

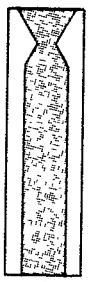
[1] Several states, such as South Carolina, require companies writing workers' compensation insurance to belong to a national, licensed rating organization.

[2] A mandatory rate bureau promulgates rates for workers' compensation.

[3] Private passenger automobile insurance operates under prior approval. Homeowners' insurance operates under file and use.

Chart by Jody George, from mail and telephone survey of selected states.

An Interview With James E. Long



James E. (Jim) Long, 44, was elected Commissioner of Insurance in November 1984. Born and reared in Burlington, Long attended N.C. State University and earned a B.A. in political science and a law degree from the University of North Carolina at Chapel Hill. Active in politics since childhood, Long followed his father and grandfather into the N.C. House of Representatives, where he served from 1971 to 1975 (D-Alamance). In 1975-76, Long was Chief Deputy Commissioner of Insurance under former Commissioner John R. Ingram. From 1980 to 1984, Long served as counsel to Speaker of the House Liston B. Ramsey. He has chaired the North Carolina Property Tax Commission (1981-84) and practiced law with his father and his wife in Graham, N.C.

Bill Finger and Jody George conducted this interview on October 9, 1984.

What are the main functions of the Commissioner of Insurance?

Everything stems from two main functions—regulating rates and monitoring solvency. We have to assure that the rates are at the lowest level possible but at the same time, at an adequate level to maintain company solvency. It really comes down to balancing between the two goals of low rates, yet adequate rates. We have to regulate agents, regulate companies, serve the consumer, and monitor company solvency.

What will be your primary goals if elected? Be as specific as possible.

My primary goal is to re-establish the lines of communication between the Insurance Commissioner and other involved parties, including the insurance companies doing business in North Carolina and the insurance agents licensed in this state. I don't believe an elected state official can regulate an industry without establishing rapport so that you can at least sit down and talk about mutual problems and concerns. The commissioner also needs to re-establish the lines of communication with the General Assembly and with consumer groups.

How do the campaign contributions you've received affect how you might perform as commissioner?

The last tracking we did on contributions, we had individual contributions from over 5,000 different people.[1] It represents most, if not all, of the counties in the state. We analyzed the contributions and found that about 38 to 40 percent came from insurance interests of some sort. The balance came from retired school teachers, doctors, lawyers, dentists, and about any segment of society that you could think of. It has been a close balance between the segments that are being regulated and that are buying insurance. We've been proud of that. We will continue to do that balancing.[2]

Taking a campaign contribution from anyone, be it an agent or an employee of an insurance company doesn't taint your thinking. It's similar to dealing with lobbyists in the legislative process. Fifteen years ago, when we did not have a fiscal research or legal research staff, we had to depend on lobbyists for a lot of leg work and research. You could either be independent in your thinking or be a tool of the lobbyists. I always had the philosophy as a legislator that lobbyists serve a very useful function. They furnish information to you.

Just taking contributions from various interests does not mean that I am going to be in their pocket. The only promises I made to them, and the only promise they have ever asked for me to make, is that I keep an open mind in my decisions, that I hear them out and make decisions on the evidence presented. I made that commitment—to always keep an open mind. I'm not always going to rule with them. There are going to be times of differences of opinion.

If elected, how would you begin?

We're already looking at the statutory and regulatory obligations of the department, to find out exactly what responsibilities we have to carry out. When we finish that, we will go back and try to determine the best alignment of the insurance department to carry out those obligations. Then we will try to determine what personnel we need to carry out those functions and duties and what people need to be in those slots. We need to do all this between the November election and the first of January.

We're going to have to work with the General Assembly to make sure we've got a sufficient budget—the personnel needed and specifically, computerization. The department is currently under a program to be computerized that is moving very slowly. The first division [being computerized] is licensing. I told the legislative Insurance Study Committee last week that we need to speed up that process, so we can get into the audit division—so we're no longer doing company audits with adding machines on the desk. In essence, we need to be in the 20th century. [The legislative Insurance Study Committee approved Long's requests.][3]

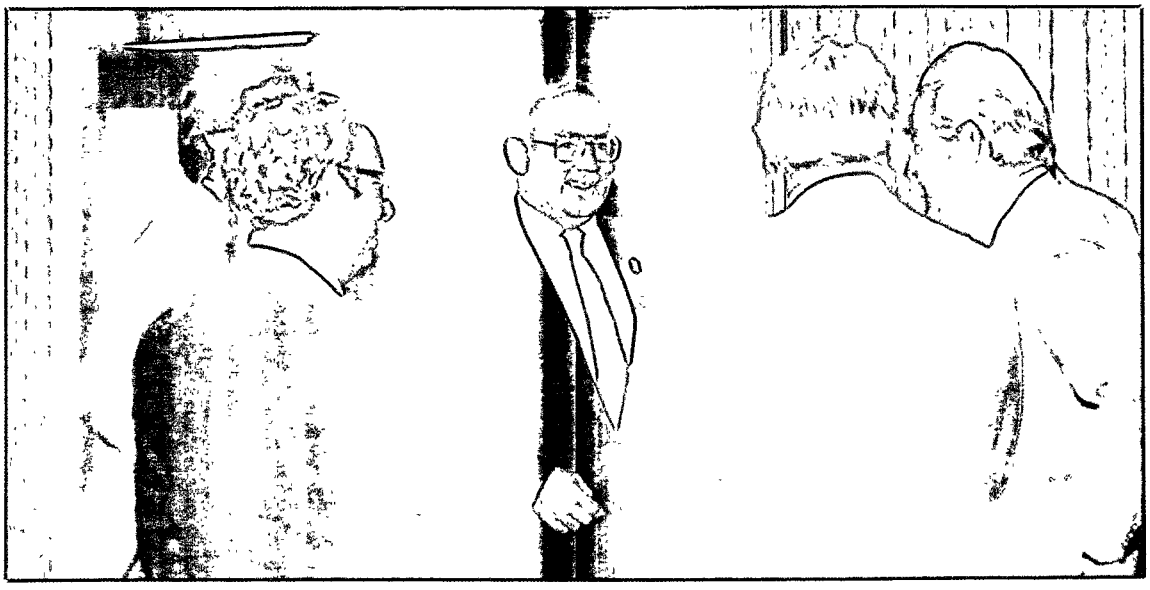
These days, you have the electronic transfer of funds by insurance companies, banks, and individuals. We need instantaneous communication with the NAIC [National Association of Insurance Commissioners] computer to track these transfers. Otherwise, we're always behind.

Do you want to be on-line with the statistical gathering groups, like the Insurance Services Office (ISO)?

That would be a goal, assuming that we continue the current ratemaking procedures. We need to have on-line capability with whatever groups, including the companies. That presents a problem. Companies are not likely to want us having access to their main frame computer overnight to find out what they're up to. We'll have to build some safeguards into the system to make sure we don't violate their business ethics and principles. We need that capability so that we're getting the data overnight instead of 4 to 17 months later—when it's stale and really doesn't tell us a thing about what's going on now in a particular company. A fast shift of assets within a holding company, for example, creates a real problem for us.

What legacies have the 12-year Ingram administration left?

I'm going to have a different style than Mr. Ingram. I'm willing to sit down with the different parties and try to work out their differences and listen to all the viewpoints they express before I make a decision. I think that's the way to regulate. Mr. Ingram has not always done that. What is right or wrong, I don't know. That's been



Jim Long (center) receives congratulations on his election victory at the November 8, 1984, meeting of the Insurance Study Committee.

his decision, and he has brought some innovative procedures to North Carolina, ones that are now being followed in other states. For example, he pushed very hard for the elimination of sex discrimination in auto insurance.

How strong is the insurance industry lobby in the legislature?

Very strong. It's always been rated by your organization as one of the stronger lobbying groups there.[4] Insurance is big business in North Carolina. They hire wealthy lobbyists, people who have a strong insurance background and who spend the necessary time and do the necessary homework to be able to present their case quickly to the legislators. [See list of the main lobbyists at right.]

In the 15 years I have been involved in the process, the insurance lobby has been very successful in the General Assembly. They have a great deal of influence in the legislative process. For example, in 1977, the General Assembly changed the law from a "prior approval" to a "file-and-use" system [see page 14 for explanations of these systems]. Obviously, the insurance lobbyists had a great role to play in that.

The insurance lobby has had more a winning record than a losing record in recent sessions. Some of that is due to this idea of an antagonistic commissioner or a lack of communication with all the parties involved in the system. Often, debates have come down to a contest in the legislative halls of who can round up more votes—Ingram or the lobbyists. The legislators have basically been caught in the middle of the process and have not always known who to listen to when they're making their decisions. For that reason, the lobbyists have been very successful.

Agents and companies don't always agree with each other, so every now and then you will see a fight among their lobbyists. Then the department would come down on one side or the other or with a third position. It's kept a lot of people employed as lobbyists.

How strong is the consumer lobby regarding insurance?

They are very weak. There are not very many and they are not adequately funded to reach the level of expertise that you find among the insurance or banking lobbyists. There is a consumer advocate position being expressed in the legislature. A lot of legislators, including myself when I was there, help express that position. But it is certainly not equally matched with the insurance lobbyists.

As commissioner, would you become involved with the legislative process?

Yes, because the commissioner, like the head of any state agency, has the responsibility to explain his position on various topics to the legislature. I will personally talk to legislators from time to time, but I won't be able to sit there every day in the halls as most of the lobbyists do and buttonhole legislators as they go back and forth to the various committee meetings. I have been involved in the legislative process as a member, as a lobbyist, and as counsel to the speaker. There are a lot of old time friends and acquaintances that I would want to see on a friendship basis, if nothing else.

In rate hearings, does the commissioner function both as a representative of consumer interests and as a judicial hearing officer? Should these duties be divided?

Under the Administrative Procedure Act (APA), which went into effect in February 1976, the responsibilities are already divided. When the commissioner sits as a hearing officer, the staff is responsible for presenting the public's viewpoint in a case. There's total isolation between the commissioner and the staff attorneys who are presenting the case. The hearing officer, who sits as an independent trial judge, cannot have any dealings with the staff presenting the case for the Insurance Department.

If the commissioner chooses to be involved in the hearing himself—by directing the staff, questioning the witnesses, case preparation, etc.—then under the APA, he must designate someone else to sit as the hearing officer.

If the commissioner did choose to represent consumers on a rate case, he would be presenting evidence to his own designee, say a chief deputy. Does that work?

If you pick good people, I don't see any problem with it.

So you think that the system we have is a good one?

Yes I do. I've seen it work with the Property Tax Commission, which I chair.[5] We sit there and rule on the basis of the evidence presented to us.

But as chairman of the Property Tax Commission, you are not the secretary of the Department of Revenue hearing your own employees present testimony.

I don't see that as an important difference. If as commissioner, I help present the case and one of my employees is sitting as a hearing officer, I certainly am not going to fire a person that rules

Major Insurance Industry Lobbyists

Lobbyist	Represents	Employer/Law Firm[1]
Brad Adcock	Blue Cross & Blue Shield of N.C.	Blue Cross & Blue Shield of N.C. (Durham)
J. Ruffin Bailey (former legislator)	American Insurance Assn.	Bailey, Dixon, Wooten, McDonald, Fountain & Walker (Raleigh)
Julian Bobbitt	Aetna Life & Casualty; Domestic Casualty Insurance Committee; Motors Insurance Co.	Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan (Raleigh)
John Bode	Independent Insurance Agents of N.C.	Bode, Bode & Call (Raleigh)
Richard Brantley	Independent Insurance Agents of N.C.	Independent Insurance Agents of N.C. (Raleigh)
J. Melville Broughton (former Highway Commissioner and candidate for governor)	Nationwide Insurance Co.	Broughton, Wilkes & Webb (Raleigh)
Charles Case	Alliance of American Insurers	Moore, Van Allen, Allen & Thigpen (Raleigh)
Philip P. Godwin (former legislator, Speaker of the House)	National Assn. of Independent Insurers	Godwin & Godwin (Gatesville)
B. Wade Isaacs	N.C. Automobile Dealers Assoc.	N.C. Automobile Dealers Assoc. (Raleigh)
Sam Johnson (former legislator)	N.C. Automobile Dealers Assoc.; N.C. Insurance Premium Services; N.C. Assoc. Industries/ Self-Insurers Trust	Johnson, Gamble, Hearn & Vinegar (Raleigh)
John R. Jordan Jr. (former legislator)	Assn. of N.C. Life Insurance Companies	Jordan, Brown, Price & Wall (Raleigh)
John B. McMillan[2]	Allstate Insurance Co.	Manning, Fulton & Skinner (Raleigh)
Howard Manning	Allstate Insurance Co.	Manning, Fulton & Skinner[2] (Raleigh)
Michael S. Olson	Carolina Assn. of Professional Insurance Agents	Olson Management Group Inc. (Raleigh)
David Permar	First Protection Life Insurance Co.	Hatch, Little, Bunn, Jones, Few & Berry (Raleigh)
A. Roger Philyaw	Blue Cross & Blue Shield of N.C., Sr. Vice-Pres.	Blue Cross & Blue Shield of N.C, (Durham)
W. Linville Roach	Pilot Life Insurance Co.	Pilot Life Insurance Co. (Greensboro)
Thomas A. Rose	Blue Cross & Blue Shield of N.C., President	Blue Cross & Blue Shield of N.C. (Durham)
Benjamin F. Seagle III	Aetna Life & Casualty	Aetna (Charlotte)
George M. Teague	State Farm Insurance Co.	Young, Moore, Henderson & Alvis (Raleigh)
Thomas J. White Jr. (former legislator and former chairman of the Advisory Budget Commission)	Interstate Insurors Inc.	White, Allen, Hooten, Hodges & Hines (Kinston)
Clyde Wootton	Blue Cross & Blue Shield of N.C., Gen. Counsel	Blue Cross & Blue Shield of N.C. (Durham)

FOOTNOTES

[1] All of the groups with multiple names are law firms.

[2] In January 1985, John McMillan became legal counsel to Lieutenant Governor Robert B. Jordan III. The law firm will no longer do any lobbying work while McMillan is counsel to the Lieutenant Governor.

Source: N.C. Secretary of State, registration of lobbyists for 1984. Research by Sharon Moylan, Center intern.

against me. I expect a hearing officer to do a creditable job. Then, of course, everything is subject to appeal by either party.

Administrative law is a different animal from civil trial practice. There is a switching back and forth of roles. It bothered me, as a trial lawyer, going into the department as chief deputy in 1975. But once you get into it, the [hearing] system does work—even with what seem to be some inherent conflicts.

I was in the department before the APA passed, and there *was* communication between the hearing officer and the staff presenting the case. With the barrier the APA sets up, it's a lot better system than we had in the old days.[6]

Do you see any need for a "public staff" similar to that in the utility regulation system?

No, because there's this barrier created by the APA. A new public staff would mean a significant increase in staff. Insurance hearings cover everything from automobile and homeowners' insurance rates to licensing an agent and registration of a holding company. Under the current structure, we have the flexibility to shift to each case. To have a public staff capable of getting into all these areas would mean having 2 or 5 or even 10 experts in various areas who would sit there year round with nothing to do except wait for a case to come up.

We don't have the volume of cases that the Utilities Commission has. We usually get one annual rate filing from the Rate Bureau. Each individual company doesn't file separate rates, like you have with utility companies. With a public staff, you would probably have a waste of time.

What is the role of the Attorney General's office in rate cases or other types of hearings?

The Attorney General represents the department's position in court. The department's staff attorneys represent the department's public policy position at the hearing level. Once an appeal is taken into the courts, then the AG's office steps in and acts as our lawyer.

The AG's consumer affairs division doesn't become involved in the case at the hearing level?

Not to my knowledge.

How do you view the role of the N.C. Rate Bureau?

The Rate Bureau acts in essence as one big insurance company. All its member companies make up the board and pay for the operation expenses. The Bureau serves as a statistical gathering mechanism—instead of the department having to analyze the data from each individual company. The Bureau basically acts as an information center in pulling that data together into one filing to the commissioner. [See article on page 12 for more on the ratemaking process.]

How would you deal with company requests for deviations from the industrywide rate schedule developed by the Rate Bureau?

In the past years, the general trend has been to approve deviations very routinely. I think all of them have always been downward rate requests. One of the things we'll have to watch in future years is to make sure that the downward deviation requests don't jeopardize company solvency.

Larger companies say the Rate Bureau serves mainly the small companies. Do you agree?

Yes. The larger the company, the more likely they are to have the necessary staff and expertise and mechanical processes to gather their own data, analyze it, and—in essence, if they could under state law—set their own rates. The smaller companies are less likely to have the in-house expertise and computerization necessary to do the statistical gathering and analyzing. From that standpoint, the Rate Bureau does help the small companies more than the large.

Should the Department of Insurance collect and distribute data on insurance risks and rates?

With the current staffing we have, we best serve as independent auditors of what the Rate Bureau or the ISO [Insurance Services Office] do. We don't have the capability to do our own data gathering and analysis now. If we're going to gather the data from the 300 or so companies writing auto policies in North Carolina, we've got to have the capability to perform test audits on those companies to make sure the data is credible.

At this point, what we can do is analyze and perform tests on the data being furnished to us by the Rate Bureau.

Assuming you had the people, would data gathering be a good role for the department?

It's a good role if the data being collected by the Rate Bureau is not valid. Not being in there yet, it's hard for me to be able to determine if the data is valid or not valid. After January 1st, we're going to start looking at the best system for gathering data. That will help determine the best regulatory system for North Carolina. With competitive rating—that is, open competition—you don't need all the data.

Do you need a rate bureau with open competition in rates?

Only for a limited purpose, to help do inspections of buildings for commercial risk ratings, for example. But if you go to competitive rating for auto or homeowners' insurance, you do not use a rate bureau. Then you get into lots of questions. For example, suppose company A sells auto liability policy form XXX for $100 a policy and company B sells the same standard policy for $95. Does the commissioner have the responsibility to check behind those rates? If we go to something like competitive rating, the legislature would have to work out those kinds of questions.

So North Carolina does not have competitive ratemaking now?

Not officially. We do in the sense that downward deviations are allowed. So we have some competition.

How did the 1977 changes in the regulatory system affect the commissioner's role?

Whatever the legislature tells us the law is going to be, we have to follow that and carry it out to the best of our ability. The 1977 change—from the prior approval system we had in North Carolina for 30 years to a file-and-use system—did alter the commissioner's role. Under prior approval, the rate filing had to be absolutely approved by the commissioner, subject to the final appeal through the court system. Now, the Rate Bureau can in essence put the rate increase into effect, pending appeal.

Does the current ratemaking system allow for a proper balance between the interests of consumers and the insurance industry?

Yes and no. There's no definite answer for you. Regardless of the system in place—be it file and use or prior approval—the system will work. The question is whether the details of the system are properly placed.

For example, with the SDIP [Safe Driver Insurance Plan] point schedule, the penalties for running a stop sign or speeding 70 in a 55 zone may be too steep. One theory has it that we are not collecting enough premiums from the safe driver and over-penalizing the driver with the infractions. We've got to find out where the responsibility for premium payment should be and whether it is now being collected from the various groups of drivers fairly. I have not seen any valid statistical analysis of whether safe drivers are paying too little or too much or whether drivers with say 6 SDIP points are paying too little or too much. That's one of the problems. [See auto section for more on this, particularly the statistical sections, pages 41-46.]

How will you give consumers better protection in rate filings, as your campaign material promises?

The employment of a property and casualty actuary is essential to provide the expert testimony in rate case hearings and to provide the analysis needed in policy form approvals. There's currently no actuary employed in the Insurance Department, even though the law mandates that. A life/accident/health actuary is also critical. Currently, staff people serve the function of an actuary but are not fully rated as actuaries. An actuary commands a very high salary, from $60,000 to $85,000 a year.

We need to look at the qualifications of current employees in the department. If they need further education or if we need better qualified people, we ought to have the wherewithal to hire them or send them back to school. We need the best technicians that we can afford on state salaries. They deal with the company examination process, the rate approval process, the policy form approval process, and the consumer complaint analysis.

Should the Rate Bureau include all investment income in calculating their rate schedule?

We're going to have to review that question. Right now, companies are running a combined loss ratio (losses paid plus claims expenses) of anywhere from 106 to 130 percent over and above the premiums. So they're losing money on every property and casualty line, including auto. They're making up for that loss with investment income.

Is it misleading to say an insurance company is "losing money" when you're referring to underwriting losses?

When payment on claims plus loss-adjustment expenses—for adjustors, for selling the policy initially, etc.—exceeds the premium dollar, there are underwriting losses.

But premiums are only one source of income for an insurance company.

Sure. When you send a $100 premium check into the company and it doesn't have to pay a claim for six months or six years, the company is obviously making money on that investment. So that is what is keeping the companies afloat right now.

What portion of the investment income should be included in rate cases?

A North Carolina case in the last two or three years defined the part of investment income that should be considered in the rate base.[7]

In his 12-year tenure, Commissioner Ingram was involved in some 44 appellate cases and won about 3. Should the courts be so involved in insurance?

The "44" doesn't concern me. The courts are always going to have the final control over insurance and any other administrative decisions made in the state agencies. That's the nature of government in this country—the three-way balancing between the executive, legislative, and judicial branches. You always have relief either through the legislative or the judicial process. The court's involvement doesn't concern me. It's a helpful part of the system.

But the [Ingram] track record in the appellate courts *does* concern me. We'll have to make sure that when our cases are appealed through the court system that we are fully prepared. I come back to my experience as chairman of the Property Tax Commission. Our cases are subject to appeals, and we get appealed on a regular basis. In my three years as chairman, we have been reversed twice now, I think.

There's always that right to appeal, but I will be more inclined to explore the possibilities of settling a case. I can't do that if I'm sitting as hearing officer, which I anticipate doing in some cases. But in many cases, I expect to be more of an advocate, trying to determine where the middle ground is. I fully anticipate sitting down with the opposing side in a rate case, or whatever the controversy may be, and trying to work out a possible grounds of compromise before the hearing officer has even given a decision.

I would act as any good trial lawyer would do in exploring with the other side any reasonable

Insurance Commissioner—Elected or Appointed?

When the General Assembly created the office of Commissioner of Insurance in 1899, it called for the commissioner to be elected by the legislature for the first four-year term and thereafter to be appointed by the governor. Eight years later, however, the legislature made it an elected post.

In 1944, the position became a constitutional office and the commissioner a member of the Council of State.[1] Although the office is now a constitutional one, the commissioner's power and authority emanate from the General Assembly and are limited by legislative prescription, according to recent litigation.[2]

Since 1899, eight commissioners have served an average of 10.75 years.[3] James E. Long, the ninth person to hold this office, believes the commissioner ought to be elected. "We have traditionally had a long ballot in this state," he says. "An elected official can be more responsive to the demands of the public. We need to keep in mind the old maxim that the most effective government is that which is closest to those being governed."

In 1968, the N.C. State Constitution Study Committee released a report concerning possible changes to the state constitution. Among them, the committee suggested that the Commissioner of Insurance (and several other members of the Council of State) be appointed rather than elected.[4] The report said the commissioner performed essentially a regulatory function and hence should be appointed, as were most others in the country.

In 1969, the General Assembly considered this recommendation but the bill was killed in committee.[5] Hence, in the 1971 new state constitution, all Council of State offices remained elected positions.

Among the 50 states, only 10 have elected commissioners of insurance (see chart at right). Of these 10, 7 are by constitutional provision and 3 are by statute. In 40 states, insurance commissioners are appointed in various ways—25 of them by the governor.

"With an elected commissioner," says Long, "you don't concentrate control in one or two constitutional officers, primarily the governor." □

FOOTNOTES

[1] *Constitution of the State of North Carolina,* Article III, Section 7(1).

[2] *State ex rel. Commissioner of Ins. v. North Carolina Rate Bureau,* 61 N.C. App. 262, 300 S.E.2d 586, cert. denied, 308 N.C. 548, 304 S.E.2d 242 (1983).

[3] For a list of the commissioners and their terms, see *North Carolina Manual,* published by the N.C. Secretary of State, 1983, p. 589.

[4] *Report of North Carolina State Constitution Study Committee,* published by this committee, Raleigh, 1968, see pp. 113-121. The N.C. State Bar and the N.C. Bar Association formed this blue-ribbon committee of North Carolinians following an address by then Gov. Dan K. Moore encouraging such a committee. For a good summary of the committee and the resulting revisions to the constitution, see "State Constitution Revisions" by John Sanders, *Popular Government,* Institute of Government, Vol. 36, No. 1, September 1969, p. 86.

[5] HB 880, killed by the House Committee on Constitutional Amendments, 1969 General Assembly.

compromise. Like most cases tried in civil court, many compromises are struck as you walk through the courthouse door together. If we cannot reach a compromise, so be it. We'll try it out and if we lose, we'll yield. If the other side loses, they'll yield. The ultimate decision rests with the N.C. Supreme Court.

Do you think more of the regulatory process should revert from the legislature and courts to the commissioner?

Yes, I think so. Let's resolve these problems in advance of even having to go to the formal hearing process. There will be a lot more communication between the various parties before a formal hearing—formal filing of documentation, lining up witnesses, and the things you go through.

What about a group concept for credit insurance? Debates over credit insurance have focused on the rate of return merchants are allowed to charge individual consumers. What about a proposal to allow the merchants to purchase group policies to protect themselves, without charging the individual customers credit insurance?

That might be an answer to some of the debate over the credit insurance rates. I have not thought that one through. The group concept is something I certainly would want to take a look at. That could be a very viable alternative to the current system we have. Anytime you're selling insurance on a group rather than an individual basis, the economy of scale should reduce the price.

I. ELECTED (10 States)

By Constitutional Provision		By Statute
Delaware	NORTH CAROLINA	Kansas
Florida[1]	North Dakota	Mississippi
Georgia[2]	Oklahoma	Washington
Louisiana		

II. APPOINTED (40 States)

A. BY GOVERNOR

No Confirmation	Confirmed by Senate		Confirmed by Other
Alabama	Arizona	New Jersey	Connecticut (either house)
Indiana	California	New York	Maine (appropriate legislative committee and Senate)
Kentucky	Idaho	Ohio	
Massachusetts	Illinois	Pennsylvania	New Hampshire (council)
Rhode Island	Iowa	Utah	
Tennessee	Maryland	Vermont[3]	
	Michigan	West Virginia	
	Nebraska	Wisconsin	

B. BY AGENCY HEAD

No Confirmation	Confirmed by Senate	Confirmed by Governor
Alaska	Missouri	Arkansas
Colorado		Hawaii
Montana[4]		Oregon
Nevada		
South Dakota		

C. BY BOARD OR COMMISSION

No Confirmation	Confirmed by Senate
New Mexico	Minnesota
South Carolina	
Texas	
Virginia[5]	
Wyoming	

Source: Compiled by Jody George from data in *Book of the States 1984-85,* the Council of State Government, Lexington, Ky., 1984, pp. 72-77.

FOOTNOTES

[1]State Treasurer also serves as Insurance Commissioner.
[2]Comptroller General is ex-officio Insurance Commissioner.
[3]The Insurance Commissioner's full title is "Commissioner of Banking and Insurance."
[4]State Auditor performs the function of Insurance Commissioner.
[5]The Insurance Commissioner is part of the Virginia Corporation Commission and is appointed by the three state corporation commissioners (also known as judges). The General Assembly elects the three corporation commissioners.

Should employers be allowed to offer group auto coverage just as they do health coverage? Should this "anti-group" statute be repealed?

The statute applies to auto and homeowners' insurance. I have not been able to find out why that law is on the books. I want to find out why and if there's a valid reason for it, we'll find out what the results would be if that statute is repealed—to see if that would result in lower rates or less service for policyholders.

Do you think mandatory automobile insurance should be expanded to include collision as well as liability? Or should mandatory liability be repealed?

As long as you are financing the purchase of an automobile, collision is mandatory in a practical sense. I have never heard of a lending institution not requiring collision coverage. It is not mandated by state law, but by the marketplace. I don't think that the state or society in general has an interest in whether you have physical damage coverage on your auto. If you want to assume the risk of your car being totally destroyed, that probably should be your own decision. The lenders obviously have some say-so in that, since it's their money on the line.

We'll have to take a look at the question of dropping mandatory liability coverage. It's one of the issues I want the legislative study commission that I've already proposed to be created in the 1985 session to take a look at. We've had mandatory liability in North Carolina since 1957. My understanding is it came about because we did not have uninsured motorist coverage at the time. If you abolish mandatory liability, you take some pressure off the ratemaking system. Whether you can make a more inherently fair system by mandating or not mandating liability coverage, I don't know. [For more on mandatory liability, see page 36.]

When you say relieve pressure on the system, are you thinking primarily of the Reinsurance Facility?

Primarily. We have a large number of people under the Reinsurance Facility now, about 21 percent, in that range—much higher than nearly every other state. [See page 49 for more on the Reinsurance Facility.]

Why do we have such a high percentage?

One theory is that we have inadequate rates on the voluntary market and that the losses are made up in the involuntary market, the Reinsurance Facility. Yet the safe drivers in the facility cause more losses in the system than those with SDIP points. The ones put in the facility without points are causing the most losses but they're not paying the penalty. So the system has gotten so very much out of kilter with the various details in it. I've told the legislature and anyone who will listen, let's quit worrying about the various details, like the SDIP schedule, and figure out the best overall system. Then we'll go back and piece together the details and make that system the most effective we can devise. The approach we've taken in recent years in the legislative halls has been to tinker with one particular aspect of the system. [For more, see the auto section, particularly the recommendations.]

How do you figure out the best system to use?

I proposed to the Insurance Study Committee last week that, during the 1985 session, an Insurance Study Commission be appointed with membership including the commissioner and House and Senate members. [The Insurance Study Committee adopted this proposal as part of its recommendations to the 1985 General Assembly.]

This commission would take the following 18 months to study the system and hopefully propose to the 1987 General Assembly a rewrite of the property and casualty insurance laws of this state. That commission would be charged to find the best auto rating system available and by 1987 to work out the details and present an overall, coherent plan. This means looking around the country and at neighboring states. Then, by the '89 session, I would hope to have a proposed rewrite of the life/accident/health laws.

Are you unclear as to which system will work best in North Carolina because of the flux of the Ingram years or because of the changes in the insurance industry?

There's a great deal of flux in the industry. Look at life insurance, for example. Thirty years ago, the only term we heard was whole life. Then term life came on the scene. Now we have universal life, annuities, you name it, with rates dropping rapidly. New policy forms are being developed in all lines of insurance very rapidly. The Insurance Department and the legislature have to be much quicker in their response time to these developments. The same things holds true for rating systems. There is no clear-cut answer to the best system for North Carolina. It's a very frustrating process for me to try to tell you the best system because I don't know it myself and in 14 months [of campaigning] I've tried my best to find the answer.

As commissioner, how would you regulate health maintenance organizations (HMOs)?

HMOs are currently regulated by the Insurance Department. We need to assure the solvency

of HMOs, that protection is there for consumers when called upon for payment. I see my role as encouraging HMOs, so long as we make sure they're financially solvent. Same thing for PPOs, preferred provider organizations, which are coming into North Carolina, and other concepts in the vanguard of the health insurance industry. HMOs are regulated. Currently, PPOs are not regulated, but they should be.

And we need to take a look at life-care communities for the elderly. That's a type of insurance, where you're paying a fee to be admitted to a facility and paying monthly maintenance fees. Investing your money and expecting something in return down the road is the same concept as life insurance, an annuity. In this case, the return is a service rather than a dollar return.

You get into the solvency issue again. Will that facility, three or four or five years down the road, be solvent? If one of those facilities goes bankrupt, the people who have invested their money in it have no place to go for housing, medical needs. And they may be completely bedridden by that point.

Is there any area of insurance that the state does not regulate for solvency?

None that I can think of. Solvency is going to be the problem area in insurance for the rest of the decade, not just in North Carolina but everywhere. We're seeing companies going insolvent right now. Accounting procedures for insurance companies haven't changed over the years, but the nature of the business is changing. People are investing their money in very different ways these days. Plus, banks are getting into the insurance business, which makes for an interesting discussion.

Commissioner Long with lobbyist Henry Mitchell of the law firm of Smith, Anderson, Blount, Dorsett, Mitchell, and Jernigan at an Insurance Study Committee meeting.

A bank's main thrust is to make money on its investment. An insurance company's main thrust is to make sure that the investment remains safe and provides a reasonable return. Insurance companies expect to pay losses. They expect to pay out money. Banks do not expect to pay losses. The whole concept of insurance is that the loss is going to be paid sooner or later. The only question is the timing of it. The lines between banking and insurance are becoming blurred. □

FOOTNOTES

[1]Through May 11, 1984, 193 contributors gave over $100 to Long; another 459 persons contributed over $100 through November 9, 1984, totaling 652 contributors. Only one person contributed over $100 to Richard Morgan, the Republican nominee. Also, one person gave over $100 to Billy Martin, a Democratic candidate defeated by Long in the primary.

[2]Post-election coverage of the Long campaign has pointed out that insurance company officials sponsored a "victory celebration" (at $250 a head) at a Greensboro Country Club. One company official apparently encouraged employees to contribute to the Long campaign before the election (see *The News and Observer* of Raleigh, Dec. 7, 1984, p. 1A).

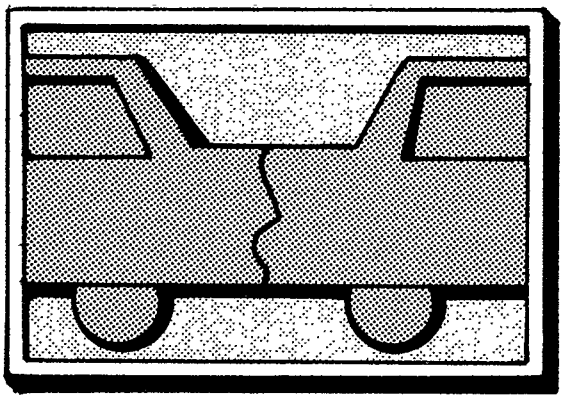
[3]In its final report, "Insurance Regulation" (December 13, 1984), the Insurance Study Committee of the Legislative Research Commission recommended that the Insurance Department be provided "with the electronic data processing equipment and additional in-house examiners and other personnel that will enable the Department to instantaneously verify the accuracy of financial statements, and run test ratios on the data in the statements similar to those in the NAIC early warning system" (p. 16). The committee did not recommend an appropriation level to accomplish that goal, however. "No appropriation amount was determined," says Long, "because the study committee was unable to get information from the Insurance Department as to the current expenditures for computerization or the projected costs for further computerization."

[4]Long is referring to the Center's series of publications called, *Article II, A Guide to the N.C. Legislature.* In the fourth edition, for the 1983-84 legislature, the Center listed the 15 "most influential" lobbyists, according to questionnaires completed by legislators, lobbyists, and capital correspondents (p. 214). The ranking did not cover industry groups but did include among the top 15 lobbyists those who have major insurance groups as clients—most prominently, John Jordan (ranked 1st, Association of Life Insurance Companies) and J. Ruffin Bailey (ranked 4th, American Insurance Association).

[5]Long's term as chairman of the Property Tax Commission was scheduled to end June 30, 1985. After being elected Commissioner of Insurance, Long resigned, effective December 1984.

[6]In recent legislative sessions, several attempts have been made to repeal or alter the Administrative Procedure Act. One proposal would have exempted Insurance Department hearings from the APA. The fate of the APA seems to rest, in large part, with the 1985 General Assembly.

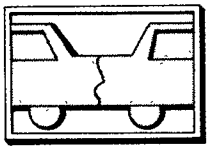
[7]See *Comr. of Insurance v. Rate Bureau,* 300 N.C. 381 (1980), especially Part D, "Summary." The court, in essence, confirmed the statute (NCGS 58-124.19): "that investment income from unearned premiums and loss reserve funds are appropriately considered in a ratemaking hearing... Neither prior cases nor statutes, however, have permitted consideration of invested income from investment capital" (p. 446).



by Steve Adams

Understanding the auto insurance regulatory system in North Carolina requires patience and persistence. This eight-part article first explains the system that has evolved, particularly during the 12-year tenure of John R. Ingram (1973-85). It then examines assumptions underlying the regulatory process, including: how demographic considerations affect statistical and *social equity in setting rates, why "reinsured" drivers are treated differently than drivers in the "voluntary" market, and how investment income affects consumer auto premiums. Finally, recommendations are offered to the legislature and Commissioner James E. Long, including: considering all investment income in the ratemaking process, allowing group auto insurance policies, consider eliminating the dual system of rates for drivers in the reinsured and voluntary markets, and reducing the excessive surcharges for drivers with bad driving records.*

Policy, Politics, and Philosophy: The Context for Auto Insurance



A farmer in eastern North Carolina buys a new 1984 Ford Escort. His driving record is unblemished. When he goes to his insurance agent to buy liability insurance, as state law says he must, he is told the annual premium will be $78.

On the same day, a 17-year-old in Charlotte applies for liability insurance on his new red Corvette. In a year and a half of driving, he has held on to his license despite convictions for speeding over 75 mph (twice), for a fender-bender resulting in damages of $750, and for passing illegally. He uses his car for work. The insurance agent tells the teenager his annual bill—for liability insurance alone—will probably be $1,727. This will buy no more coverage than the farmer gets for $78.[1]

The farmer and the teenager represent the range of rates North Carolinians pay for basic auto liability insurance, which covers damages to *others* in accidents in which *you* are at fault. Is it fair for one consumer to pay 20 times more than another for the same coverage? The question is complicated by two basic facts. The state regulates insurance rates, making them a matter of public policy, not just a matter of the marketplace. Second, liability insurance is a legal and practical necessity.

North Carolina law requires anyone who registers a car with the Division of Motor Vehicles to have liability insurance.[2] The insurance is on the vehicle, rather than the driver. For sake of simplicity, however, insuring the car and insuring the driver are used interchangeably in these articles.

The law also requires companies and agents that sell auto insurance in North Carolina to accept all applications for liability coverage.[3] If a company determines that a person is not a good risk—as it probably would in the case of the teenager—it can transfer or "cede" the policy to the N.C. Reinsurance Facility. The facility is a pool through which insurers share the losses of drivers they consider poor risks. Drivers whose policies are ceded to the facility are called "reinsured" drivers.

As new car owners, the teenager and the farmer would also need comprehensive and collision coverage. Although these are not legally required, lending institutions require them as a condition of issuing car loans. *Collision* covers damage to your car in accidents, regardless of fault. *Comprehensive* covers theft and other damages (fire, vandalism, etc.) caused by something other than a crash.

To keep this discussion in manageable bounds, the following articles focus on *liability* insurance. Despite some significant differences, rates for collision and comprehensive are set in basically the same way as liability rates. In approaching this topic, it is important to keep several distinctions in mind.

Setting Overall Rate Levels vs. Allocating Insurance Costs Among Drivers. Setting overall rate levels involves determining the insurance industry's revenue requirements. In contrast, allocating costs among drivers involves determining who pays—setting the odds, if you will—for individual drivers through a driver classification system. An oversimplified example shows the difference: Suppose the revenue requirements were $200, and there were only two drivers. The

---

Steve Adams, a Raleigh-based writer, has covered insurance issues for seven years, as a reporter and editorial writer. Photos and artwork by Carol Majors.

$200 could be obtained either by charging both drivers $100 or by charging one $150 and the other $50. Thus, determining the overall rate level ($200) and setting up a system for classifying drivers ($150 vs. $50) are separate issues.

Statistical Equity vs. Social Equity. One method of classifying drivers—the one the insurance industry appears to prefer—is similar to oddsmaking. This approach requires finding the most accurate way available for predicting which classes of drivers are likely to have accidents and charging them accordingly.

The result of such oddsmaking might be *statistically equitable* but *socially inequitable.* Many drivers, especially the poor, might be priced out of the market, perhaps on the basis of factors beyond their control. Driving is an economic necessity; liability insurance is legally required; and ratemaking is a matter of public policy. These are compelling social reasons to keep rates reasonable for all drivers. This might sacrifice statistical precision for the sake of social equity.

Demographic Characteristics vs. Driving Behavior. Historically, the insurance industry has classified groups of drivers according to such criteria as age, sex, marital status, place of residence, and car use. Such demographic characteristics, for practical purposes, are beyond a person's control. Insurance companies sometimes have also classified drivers by occupation and various personal characteristics, although this is not permitted in North Carolina.[4] Drivers in some categories appear to be more likely to cause accidents than others. Insurance underwriting is a *prospective* enterprise, attempting to estimate *future* losses according to *classes* of drivers. But demographic classifications inevitably penalize many safe drivers.

The alternative to demographic criteria is basing classifications on behavior. People with poor driving records may be expected to cause more than their share of accidents. People who drive many miles are more likely to have accidents than those who only putter around town. North Carolina's present system relies both on demographic criteria and on driving record, leaning more heavily on the latter. Mileage is considered only indirectly, except for the "car use" category that distinguishes between commuting more or less than 10 miles.

Ratemaking vs. Punishment. Should insurance ratemaking entail moral judgments? Should, for example, drivers convicted of drunk driving pay *more* than their fair share of the cost of the insurance system because they have done wrong? As a matter of public policy, there are compelling considerations against punitive rates. The strongest is that punishment for breaking the law is the proper province of the criminal courts and not a matter for profit by private businesses.

These four distinctions have become more evident in the last 12 years, as the state's insurance laws and regulatory system have been repeatedly revised. Throughout his tenure, former Insurance Commissioner John R. Ingram (1973-85) campaigned as a consumer advocate, doing battle with the insurance industry in the hearing rooms, in the legislature, and in the courts. The insurance industry, meanwhile, maintained one of the largest and most experienced core of lobbyists in the General Assembly and spared no expense to win administrative and judicial battles.

Like boxers, Ingram and the industry would retire to their corners after each round, then return to center ring, sparring again and again. The result was a series of piecemeal changes, observes William Hale, for many years an attorney in the legislature's General Research Division and now a deputy commissioner in the Insurance Department. (The "landmark dates" sidebar summarizes these changes.) The state has still not decided on a consistent approach to auto insurance regulation.

Ingram advocated rates based primarily on driving record rather than on demographic factors. In 1975, for example, at Ingram's urging, North Carolina took the national lead in banning age and sex as factors in determining insurance rates.[5] Before this law took effect in 1977, men under 25 (particularly single men) paid substantially higher premiums. Under the new law, the age and sex test has been replaced with an automatic 100 percent increase in rates for drivers with less than two years' driving experience.

The insurance industry, in contrast, tended to advocate setting rates much in the manner that oddsmakers set point spreads, preferring demographic driver classifications, particularly age and sex. John Hall, chairman of the insurance department at Georgia State University, explained this process to a North Carolina legislative study committee in 1982: "[T]here are significant, statistical, predictive differences between individuals .... The most satisfactory surrogate unit so far discovered for measuring these differences involves age and gender. Young drivers do have significantly greater average loss costs than those of us who are older. Young females have significantly better records, on average, than younger males."[6]

While the insurance industry lost the battle on rate discrimination based on age and sex, it won major concessions on overall rate levels. Most notable were the right to put rate increases

Landmark Dates in Automobile Insurance Regulation

by William K. Hale and Jody George

Insurance Commissioner in Office	Date	Action Taken
Daniel C. Boney (1927-42)	1931	First auto financial responsibility law enacted.
William P. Hodges (1942-49)	1947	Financial responsibility laws rewritten.
Waldo C. Cheek (1949-53)	1953	Financial responsibility laws rewritten; Assigned risk plan established;
Charles F. Gold (1953-62)	1957	Compulsory automobile liability insurance law enacted. NCGS 20-309; Safe driver reward plan established; Uninsured motorist coverage established. NCGS 20-279.21(b)(3).
Edwin S. Lanier (1962-73)	1973	N.C. Motor Vehicle Reinsurance Facility replaces assigned risk plan; higher rates not allowed for drivers in Facility. NCGS 58-248.27ff.
John R. Ingram (1973-85)	1975	Rates may no longer be based on age or sex of insured. NCGS 58-30.3; Driver Classification plan simplied. NCGS 58-30.4; Current Safe Driver Insurance Plan passed. NCGS 58-30.4.
	1977	"File and use" replaces "prior approval" system of regulation. NCGS 58-124.20; Deviations from mandatory rates permitted. NCGS 58-124.23; Drivers in Reinsurance Facility allowed higher rates than drivers in the voluntary market; facility rates require no waiting period, as do voluntary market rate filings. Reinsurance Facility required to break even and may recover losses by recoupments. NCGS 58-248.34; Six percent annual limit on rate increases (voluntary market and Reinsurance Facility) put into effect. NCGS 58-124.26.
	1979	"Clean risks" ceded to Reinsurance Facility do not have to pay higher facility rates. NCGS 58-248.33(1); Reinsurance Facility begins to implement recoupment surcharges; Underinsured motorist coverage authorized by law. NCGS 20-279.21 (b)(4)
	1981	Recoupment surcharges barred for drivers with no SDIP points in or out of the Reinsurance Facility. NCGS 58-248.34(f); Supreme Court rules that recoupment surcharges are not subject to review and approval of commissioner because they are not rates. *State ex rel. Hunt v. North Carolina Reinsurance Facility,* 302 NC 274; Six percent annual limit on rate increases taken off facility rates, so there is no maximum to these rates; Maximum annual rate increase for voluntary market tied to consumer price index (CPI).
	1983	"Clean risks" allowed one speeding violation (10 mph or less over limit and not in school zone) without being assigned points under Safe Driver Insurance Plan. NCGS 58-30.5; Annual limit on voluntary market rate increases (tied to CPI) expires by operation of law, so there is no maximum to these rates.
James E. Long (1985-)		

Table 1. Top 10 Auto Liability Insurance Writers in North Carolina, 1983 (for private passenger autos, in millions of dollars)

Nationwide Mutual Insurance Co.	$71.3
State Farm Mutual Auto. Insur. Co.	63.4
Allstate Insurance Co.	47.9
N.C. Farm Bureau Mutual Insur. Co.	30.7
Aetna Casualty and Surety	21.5
Integon General Insur. Co.	14.4
U.S. Fidelity & Guaranty Co.	11.4
Travelers Indemnity Co.	10.9
Lumbermens Mutual Casualty Co.	10.8
South Carolina Insurance Co.	10.6
Total for Top 10	$292.9
Total for All Companies	$486.8

Source: N.C. Rate Bureau

into effect under a "file-and-use" system and a complicated system of surcharges to offset losses of the N.C. Reinsurance Facility.

Despite the 12-year controversy and makeshift adaptations of the law, both consumers and the insurance industry have fared reasonably well. On average, North Carolinians pay among the lowest auto insurance rates in the nation. In recent years, the auto insurance industry has achieved profits in North Carolina at approximately the national average.[7] (For a list of the top ten auto insurance companies in North Carolina, see Table 1 above.)

In 1983, the average cost of insurance per car, for all types of coverage, was $237 in North Carolina, nearly a third less than the national average of $323. The state ranked 46th in cost of insurance among the 50 states and the District of Columbia. Only such rural states as Tennessee and Alabama had lower average rates. The highest rates were in New Jersey, New York, and Massachusetts, all heavily urban (see next page).

North Carolina's low rates, however, are not so much a triumph of consumer-oriented regulation as a reflection of the state's social climate and mostly rural character. "The basic characteristics of the legal, social, economic, and religious climate of the state generate lower losses," Georgia State's Hall explains. "Even at an adequate level, insurance rates in North Carolina should be lower than in almost any other jurisdiction in the United States."

Even though the state ranks 10th nationally in population, it has no city of more than 400,000. Accidents are more frequent in heavy city traffic than in less densely populated areas. Medical services and auto repairs also tend to be more expensive in urban areas, and large awards to plaintiffs by juries in some states have driven up insurance rates.

The protracted battle between the insurance industry and the insurance commissioner may have come to an end with the election of James E. Long as Ingram's successor. "I will have a more open-minded style," Long says. "I'll be willing to hear the facts before making decisions. The weaknesses in our system have been the confrontation between the department and the companies and/or the [N.C.] Rate Bureau [which files statewide rates on the companies' behalf], the confrontation between the department and the General Assembly, and the confrontation between the department and the agents. Those have combined to bring the whole system into one of confrontation rather than cooperation."

Long has not set an agenda for reform, although he does propose recodification by 1987 of the laws governing auto, homeowners, and workers' compensation insurance. His priorities as commissioner, he says, will be twofold: "to keep rates as low as possible and to maintain [rates] at an adequate level to maintain [company] solvency."

The issues before Long and the legislature, however, run deeper than balancing low overall rates against company solvency. This eight-part article explains why four areas, in particular, need attention. The sections that follow set forth the original research that leads to the assertions in this introduction.

1. Demographics. Classifying drivers on the basis of factors beyond their control remains an issue. The industry would like to set rates on the basis of age and sex, and some industry lobbyists are advocating deregulation in general. Since no violations or accidents are charged against 80 percent of the state's vehicles, driving record alone appears limited as the primary tool for setting varying rates. Moreover, the system of assessments for poor driving records is badly flawed because drivers are not required to report traffic violations to their insurers. Better reporting of accidents to insurers would improve the usefulness of driving records to predict which drivers will cause losses. A simple solution remains elusive, however. The best that can be done in this article is to explain the problems.

2. Equity. The current system of classifying drivers results in excessively high rates for drivers with poor records. Drivers like the teenager with the Corvette pay punitively high rates, according to the latest available data. In addition, there are so few drivers with bad driving records that their high rates do not significantly reduce the cost of insurance for "good" drivers. Thus the

driver classification system is neither statistically nor socially equitable and needs to be revised.

*3. **Overall Rate of Return.*** If the current formula for setting overall rates worked as it is designed to, it would produce unreasonably high profits for insurance companies. The formula ignores most income earned on investments, despite the fact that this is a major revenue source for insurance companies. The high profits have not materialized only because companies generally have not earned the five percent underwriting profit contemplated by the formula. The formula should be changed to reflect *all* investment income.

*4. **The Reinsurance Facility.*** Current law governing the N.C. Reinsurance Facility needs revising. Drivers who have had accidents or traffic violations pay higher rates (currently, 40 to 44 percent higher) if they are ceded to the facility. But there are no criteria whatever for assigning drivers to the facility; thus, insurance companies have the option of boosting some drivers' rates for any reason they please. Average rates charged to reinsured drivers with poor driving records appear excessive. In addition, the rate-making formula needs to be examined, specifically in relation to *total* investment income.

The following sections are intended as a guide through the maze of automobile insurance regulation in North Carolina. They describe how the system works, provide some statistical analysis, and conclude with proposed solutions.

Premiums by State—North Carolina Near the Bottom

In 1981, North Carolinians paid an average of $211 for automobile insurance—48th among the 50 states and the District of Columbia. Two years later, the average was $237, and the ranking was 46th (see list below). From 1981 to 1983, the average North Carolina auto premium jumped 22 percent, 5 percent higher than the national average.

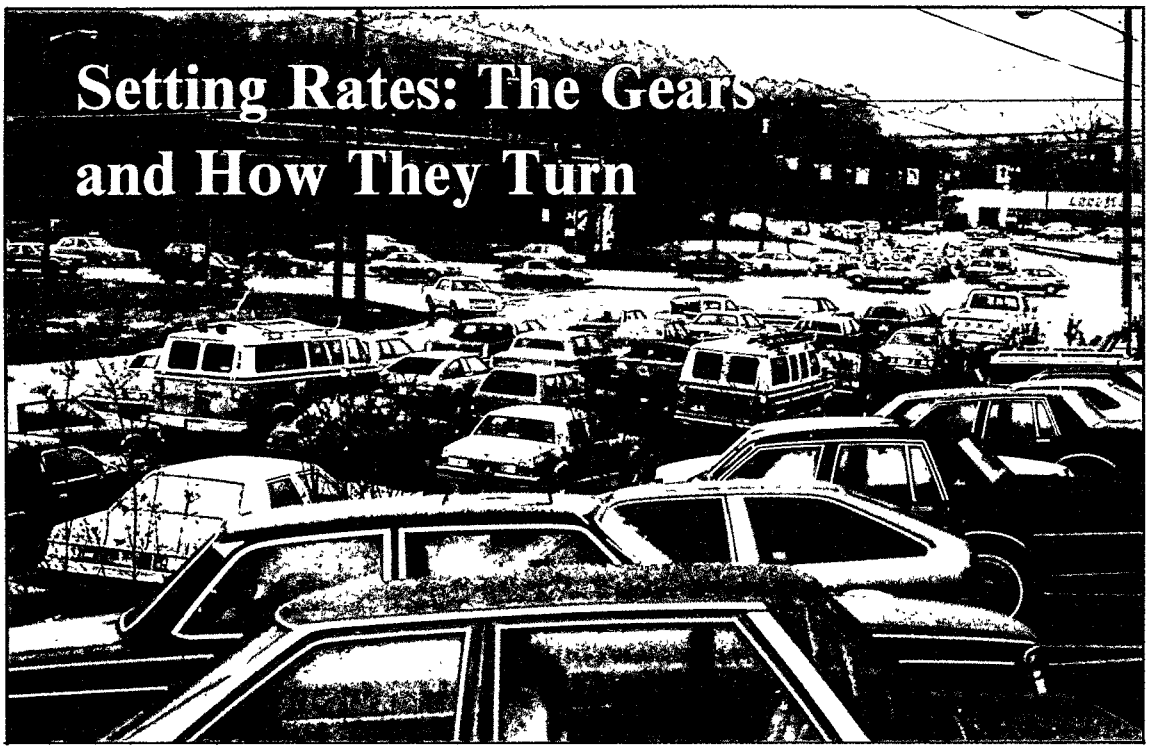
Best's Insurance Management Reports calculated these average premiums by taking the total direct premiums written and dividing by the number of auto registrations for each state. Premium data came from Best's Executive Data Services. Auto registration statistics are estimated totals from the Federal Highway Administration and are slightly inflated due to the inclusion of taxicabs.

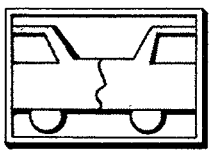
Average Automobile Premiums

1983 Ranking	State	1983 Average Premium	% Increase 1981-1983
1	New Jersey	$516.89	25.5
2	New York	429.20	22.1
3	Massachusetts	424.73	25.4
4	Alaska	399.80	19.0
5	Pennsylvania	390.93	22.6
6	Nevada	387.37	1.9
7	District of Columbia	384.67	50.5
8	Louisiana	377.57	8.5
9	California	368.17	9.6
10	Maryland	364.21	23.2
11	West Virginia	355.89	37.8
12	Hawaii	355.38	22.3
13	Arizona	348.38	19.7
14	Texas	340.55	40.0
15	Connecticut	339.34	14.5
16	Rhode Island	332.45	22.6
17	South Carolina	330.11	19.1
18	Michigan	326.81	8.7
19	Delaware	322.31	14.7
20	Colorado	315.01	24.1
21	Illinois	309.27	17.8
22	Oregon	302.09	11.7
23	Washington	301.05	13.9
24	Minnesota	298.25	6.9
25	Georgia	295.00	19.4
26	New Hampshire	292.45	24.9
27	Arkansas	287.98	31.5
28	Missouri	287.73	11.4
29	Virginia	282.61	23.6
30	Kansas	282.38	12.0
31	Florida	281.22	20.2
32	Oklahoma	281.19	19.6
33	Vermont	268.00	8.6
34	Utah	267.53	9.3
35	Wyoming	263.07	2.1
36	Nebraska	256.31	5.3
37	Indiana	255.94	12.0
38	Maine	251.43	8.4
39	Montana	250.64	-1.4
40	North Dakota	248.61	4.9
41	Idaho	246.28	6.1
42	Wisconsin	242.74	7.2
43	New Mexico	241.63	-2.0
44	Ohio	241.15	7.5
45	Kentucky	238.90	5.8
46	**NORTH CAROLINA**	**236.91**	**22.2**
47	Iowa	234.45	4.6
48	Mississippi	231.56	9.6
49	Tennessee	216.48	17.7
50	South Dakota	211.10	7.0
51	Alabama	205.86	10.0
National Average		**$322.63**	**17.4**

Source: Best's Insurance Management Reports, On-Line Reports, No. 26, December 3, 1984.
For more information, call *On-Lines Report* Editor Virginia Vogt, 201-439-2200.

Setting Rates: The Gears and How They Turn





Automobile insurance rates depend upon a complex system of gears. In addition to the legislature, two agencies are critical to this ratesetting system: the N.C. Rate Bureau and the Department of Insurance. The other important gears in the system are: where a driver lives, years of driving experience, car use, driving record, and the N.C. Reinsurance Facility.

N.C. Rate Bureau. State law requires automobile insurers to belong to the Rate Bureau, which annually proposes a single schedule of liability insurance rates to the Commissioner of Insurance. This schedule applies: 1) to all policies that are *not* ceded to the Reinsurance Facility—called the voluntary market; and 2) to policies ceded but considered "clean risks." (A clean-risk driver has a clean driving record and has been driving more than two years.) Under the current "file-and-use" system, rate increases may automatically take effect after a 90-day waiting period. Increases not approved by the commissioner must be kept in an escrow account until final resolution of the increase, by the courts if necessary.

Commissioner of Insurance. The commissioner has the dual responsibility of reviewing rate filings for fairness and ruling on the filings in a formal judicial hearing. The commissioner may serve as the hearing officer *or* function as the chief investigator of the filing and designate a deputy as the hearing officer. In addition, the commissioner rules on rate "deviations" proposed by individual companies. Through deviations, legal only since 1977, companies can offer rates below (or above, which would be unlikely) the industrywide schedule filed by the Rate Bureau. Approval is usually automatic, especially for downward deviations. Deviations are generally not available to reinsured drivers.

Driver Residence. Rates are calculated according to a territorial classification. There are 14 territories in North Carolina: 9 for the largest cities, 2 "small cities" categories, 1 for military bases, and 2 for rural areas. Urban areas and military bases, where most accidents occur, have higher rates than do rural areas.

Years of Driving Experience. For drivers with less than two years' driving experience, rates are doubled.[8] Since most people obtain a driver's license soon after they become eligible, this surcharge applies mainly to 16- and 17-year-olds. Thus, teenage drivers, as a group, generally pay higher premiums than does the general population.

Car Use. Rates vary depending on five categories of car use, which, going from cheapest to most expensive, are: farm, pleasure, driving to work less than 10 miles, driving to work more

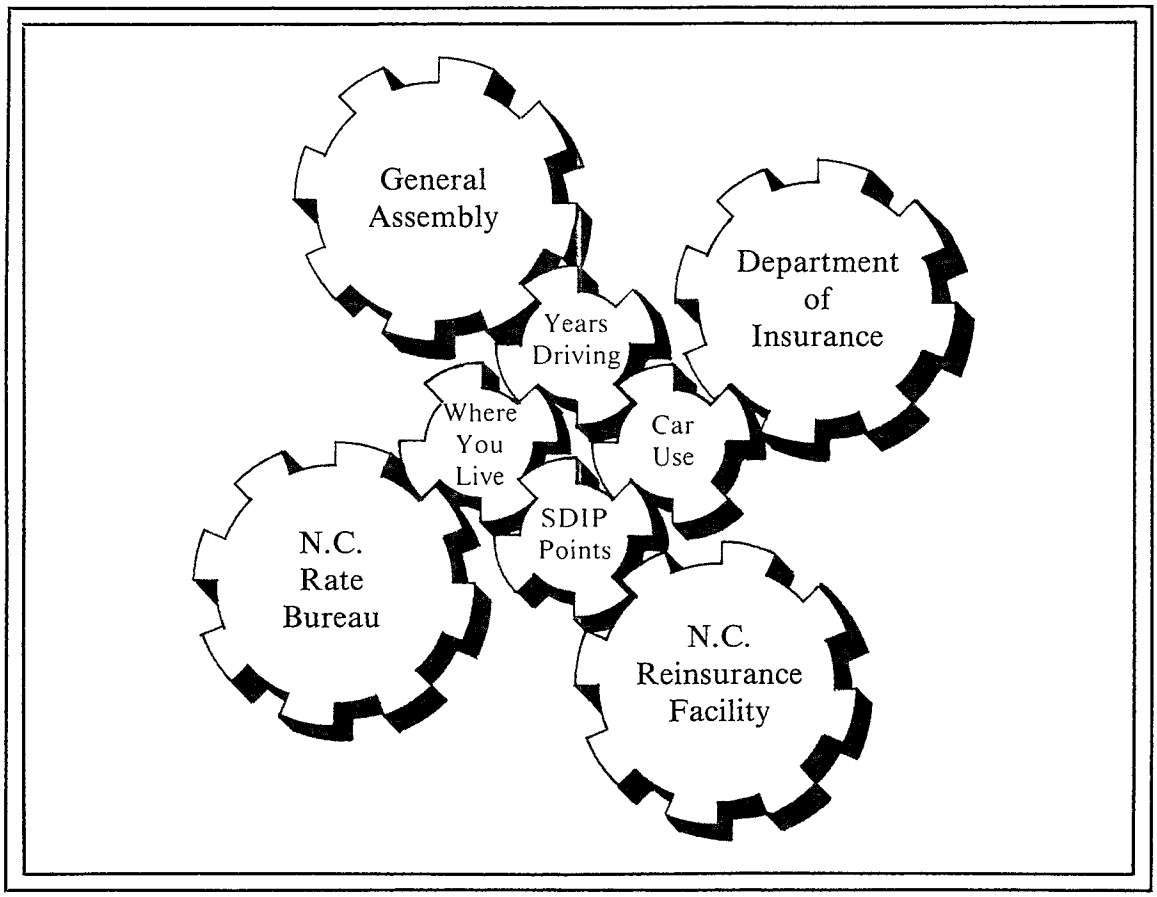
than 10 miles, and business.

Driving Record. When drivers cause accidents, are convicted of violations, or receive prayers for judgment continued, they are assigned from 1 to 12 points under the *Safe Driver Insurance Plan* (SDIP).[9] Drivers with SDIP points pay surcharges on their liability premiums for three billing years, beginning when a policy is renewed following the accident or violation. It is important to distinguish this SDIP 12-point system from the Division of Motor Vehicles (DMV) 12-point system. The DMV points affect only whether you can legally have a driver's license; they have no relationship to insurance rates.[10] The SDIP system affects insurance rates; it has no effect on whether you can have a license. The two point systems are often confused by the public, but they are unrelated, both legally and administratively.

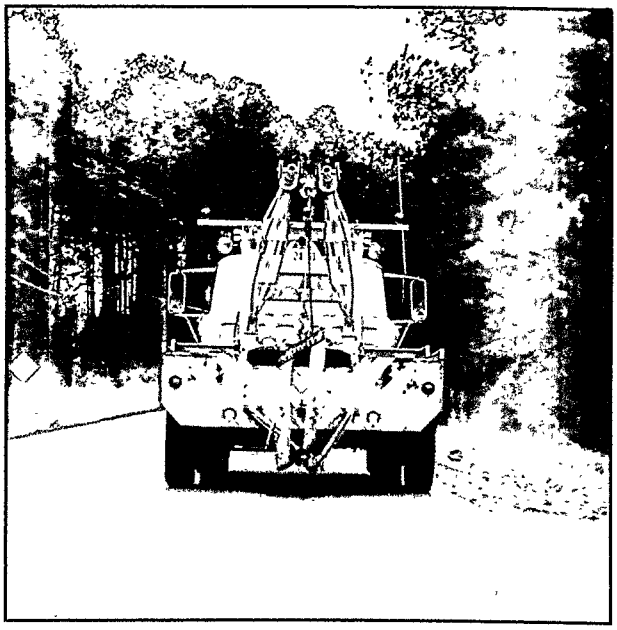
N.C. Reinsurance Facility. In North Carolina, auto insurers must offer liability coverage to all comers, but insurers may transfer liability policies to the N.C. Reinsurance Facility. A company does not have to offer collision and comprehensive coverage; no reinsurance facility exists for such coverage. The N.C. Reinsurance Facility is a complex mechanism, but in concept it is quite simple. It is a pool through which insurance companies share the losses of drivers they consider to be poor risks for liability coverage.

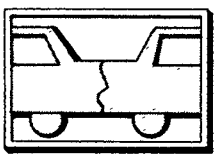
The Reinsurance Facility files a separate rate schedule with the commissioner for ceded policies having drivers with SDIP points or less than two years' experience. Clean risks in the facility pay voluntary market rates. The facility may impose rate increases without a 90-day waiting period. It must, however, put the proceeds in escrow, as companies do for increases in the voluntary market, if the increase is not approved and if the case is appealed into the courts.

To cover operating losses, the facility assesses insurance companies according to their share of the auto liability market. The companies pass along this charge through "recoupment" surcharges on *all* drivers with SDIP points *whether the drivers are insured through the facility or not.* All drivers with points also pay a surcharge intended to subsidize clean risks in the facility. In 1984, these surcharges together increased bills by 27.2 percent for drivers with points.[11]



Mandatory Liability Insurance





John Hall, the Georgia State professor, whose views have generally been in agreement with the traditional industry perspective put before the General Assembly, describes the North Carolina law this way: "The compulsory liability insurance system creates great pressure to make automobile insurance available. Perhaps most importantly from the viewpoint of insurers, it creates pressure to make automobile insurance affordable, regardless of the driver's hazard characteristics and ability to pay."

When drivers are accused of traffic violations, the importance of the availability of affordable insurance becomes clear. Lawyers, in advising their clients how to plead to a traffic violation, are often more concerned with the effect on their clients' insurance bills than with the fine, says Ben F. Loeb of the Institute of Government in Chapel Hill.[12]

The Division of Motor Vehicles certifies eligible drivers and, with the courts, oversees revocations and suspensions of drivers' licenses. This system is supposed to determine who can drive. As a practical matter, however, liability insurance rates may price some drivers out of the market—low-income persons more quickly than others. Insurance executives concede that very high liability rates cause two types of cheating: having a car registered in someone else's name and not reporting violations.

Mandatory liability insurance is designed to protect the assets of the insured, says Hall. It is unfair to the poor not because rates might be high, contends Hall, but because the poor have no assets to protect. "The economically disadvantaged tend to be judgment proof," Hall says. "The compulsory liability insurance system forces people to pay a high insurance premium relative to their income for the benefits of others. . . ."[13]

Most people have assets. They would be vulnerable in a civil suit and hence could not afford the risk of driving without liability insurance. They would continue to buy such coverage, reasons the industry, without the complications caused by a mandatory system. Meanwhile, uninsured and underinsured motorist coverage would protect drivers from those

who do not carry liability insurance or who carry lower limits. Much of the industry favors repealing the mandatory liability law.

In contrast to Hall's view, the North Carolina Supreme Court has held that "the primary purpose of the law requiring compulsory insurance is to furnish at least partial compensation to innocent victims who have suffered injury and damage as a result of the negligent operation of a motor vehicle upon the public highway."[14] In other words, if the state certifies a person eligible to drive, the state has an accompanying responsibility to ensure that every driver can meet to some degree any financial hardships caused by that driving. Mandatory liability coverage, reasoned the court, accomplishes that goal.

"Hall's point is valid, as is the court's," says Joseph E. Johnson, an insurance specialist in the Department of Business Administration at the University of North Carolina at Greensboro. "The key is that compulsory auto liability insurance laws distort the economic function of insurance."

The mandatory system adds political pressure to require insurers to accept all applications and to keep drivers from being priced out of the market. North Carolina has a fairly restrictive driver classification system, with relatively few categories compared to the thousands used in some other states. As a result, insurance companies must accept many policies at rates their actuaries (i.e., oddsmakers) don't like. From the company's point of view, the risk exceeds the compensation. And, if the company judges the odds to be too far out of line, for whatever reason, it cedes the policy to the Reinsurance Facility.

Commissioner Long, who expresses sympathies for both sides of the argument, has not taken a position on compulsory liability insurance. "We'll have to take a serious look at the question of dropping the mandatory liability insurance requirement," he says. "If you don't have assets to protect, if you don't want to buy non-mandatory liability, maybe that's the best way to go. It does relieve a great deal of pressure on the current system, primarily on the Reinsurance Facility."

Long sees the issue in a broad context: "Whether you can make a more inherently fair system by mandating or not mandating liability, I just don't know. We need to keep in mind the protection of the motorists on the highway from the other driver. That's the basic philosophy of insurance in the first place—to spread the risk."

Pressures in the ratemaking system can be addressed in many ways other than by repealing mandatory liability coverage. One way could be by allowing *group* liability insurance. True group coverage is illegal in North Carolina for reasons no one seems to remember.[15] Many drivers would benefit if it were available.

Group health policies are an obvious precedent for setting insurance rates which are commensurate with the risks of an entire group, without regard to individual risks. Premiums for all members of the group are usually the same, without regard to age or health. Obviously, the young and healthy subsidize the aged and infirm. If this is unfair, it does not seem to have caused any controversy.

Group insurance is far more efficient than individual insurance; sales and administrative expenses are honed to a minimum. The legislature, for example, could approve a group policy option for all state employees willing to buy auto liability coverage through a group policy. This would eliminate hours of administrative costs—and business for agents—in establishing and renewing policies.

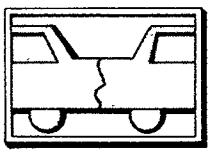
Similarly, in the private sector, IBM, for example, might provide auto liability coverage for its employees, similar to the company's health, life, and other coverage. Auto insurance could even become one of the offerings in the new "cafeteria-style" benefit system becoming popular in the private sector.

"Group automobile insurance has been approved in a number of states that have no specific enabling laws for group automobile insurance," says B. F. "Benjy" Seagle III, administrator for industry affairs of Aetna's Commercial Insurance Division in Charlotte. "These include Arizona, Michigan, Minnesota, Oregon, Washington, and Wisconsin. Other states that allow some form of group automobile coverage include Connecticut, Illinois, Colorado, and New Jersey."

Seagle points out that beside state regulations, three areas of federal regulation affect writing of group automobile plans: 1) Employee Retirement Income Security Act (ERISA), 2) Taft-Hartley Act, and 3) the Internal Revenue Code. "Approval of group automobile insurance in the states may offer a potential affordability answer for many insureds," says Seagle.

Even with group policies, many people would still need individual policies. Individual health policies cost far more than group coverage; so would individual auto insurance coverage be more expensive than group policies. The affordability of mandatory liability insurance through individual policies—plus the uncertainties involved in the early years of a new group system—would demand that the state remain involved in regulating liability rates.

Classifying Drivers: How Fair Are Demographics?



In 1975, North Carolina took the national lead in eliminating age and sex discrimination in automobile insurance. Seven years later, John Hall of Georgia State University still maintained before a legislative committee that age and sex are "the most satisfactory *surrogates*" for measuring the likelihood that individuals will have accidents.

Do young people, especially young men, account for a disproportionate share of accidents? Yes, but it may not be that simple. For example, insurers in some states (but not North Carolina) have offered small discounts to students with good academic records. And the industry's own classification plans suggest that youngsters tend to settle down when they get married.[16]

When representatives of the insurance industry speak of "fairness" in classifying drivers, they usually mean that there is a statistical correlation between certain characteristics, such as age and gender, and accidents. This concept of fairness refers to *statistical equity*.

"Private passenger auto insurance premiums must be established and charged before costs are known. This is the very nature of the insurance concept," explains Paul Mize, general manager of the N.C. Rate Bureau. "If all rates were equalized regardless of the statistical probabilities, the result would be inequitable and there would certainly be severe insurance market problems. It is not difficult to understand that insurance underwriters would, based upon known statistical probabilities, readily accept the 'good' and reject the 'bad'."

Other spokesmen for the insurance industry echo Mize, emphasizing the importance of using statistical probabilities in projecting insurance losses. "A person is a member of a class, and various classes of people will cause a certain level of losses," says John B. McMillan, a lobbyist for Allstate Insurance Company until his recent appointment as counsel to Lieutenant Governor Robert B. Jordan III. "You determine rates based on a group or class."

As a public policy matter, however, statistical equity is not the only type of equity to be considered. There is also *social equity*. Philosopher John Rawls contends that a just system is one people would accept as fair without knowing their lot in advance.[17] Applied to insurance, this definition suggests that socially equitable rating criteria should be 1) directly related to accident-proneness and not surrogate measures of something else, and 2) based on factors that are within the driver's control.

Table 2. Factors in a Statistically and Socially Equitable Driver Classification System

	Socially Equitable	Socially Inequitable
Statistically Equitable	Driving Record Mileage	Sex Age Territorial Rates Marital Status
Statistically Inequitable	Flat Rates Group Insurance	Race Income "Redlining" Personal Judgments Punitive Rates for Poor Drivers

Table prepared for *North Carolina Insight* by Steve Adams.

Statistical Equity

Many students of the insurance industry, including Georgia State's Hall, argue that age and sex are the best surrogates for the characteristic of accident-proneness. But statistics that appear to show that a group of drivers is accident-prone might really measure something else—something objectively measurable and not directly related to being a member of a certain group.

Men, for example, are involved in twice as many accidents and four times as many fatal accidents as women, according to 1982 data from the National Safety Council. But it turns out that men not only have twice as many accidents as women, but also *drive more than twice as many miles,* according to the Federal Highway Administration. One might conclude that mileage was a better predictor than gender. Still, if drivers' genders was the only information available, a logical person would bet on the women or demand better odds on the men.

The National Safety Council statistics also show that teenagers are about 50 percent more likely to have accidents than the average for all drivers. And this is despite the fact that they drive, on average, substantially fewer miles than older drivers. However, young men do drive more than young women, which may partly explain why they appear to be worse insurance risks.

Demographic measurements might be a crude substitute for assessing personality. Traditionally, underwriters have favored drivers who embrace stable, middle-class values. Underwriters for various companies, Andrew Tobias reports in *The Invisible Bankers,* have looked askance at renters, airline stewardesses, entertainers, messy housekeepers, homosexuals, and people with nicknames like "Shorty" and "Scotty." The list goes on and on.[18]

In 1971, Grinnell Mutual, an Iowa-based insurance company, gave a battery of personality tests to 30,000 drivers. Sure enough, drivers who the test indicated were aggressive and reckless were twice as likely as the meek and mild to have accidents and 10 times as likely to have fatal accidents.

North Carolina's state-regulated driver classification system spares drivers from being classified at the whim of an underwriter. And as discussed earlier, basing rates directly on the basis of age and sex is also prohibited in North Carolina.

Social Equity

Traditionally, most discussion of "fairness" of rates and classification systems has focused on statistical equity, not social equity. But even if the most statistically equitable system could be found and put into law, that system might not be socially equitable. This way of looking at the concept of insurance has received little attention.

If statistical equity alone becomes one's goal, demographic driver classifications have several serious drawbacks from a public policy standpoint.

*Demographic criteria penalize drivers by using broad categories. Members of certain groups—young men, for example—may *tend* to have characteristics that make them more accident-prone. But such generalizations are never universal. Many perfectly safe drivers inevitably will be condemned to higher rates because of factors beyond their control.

*Demographics can lead to unacceptable generalizations. What if the insurance industry proposed to charge higher rates to minorities and poor people? There are no data to suggest these groups are especially accident-prone, but such discrimination might be considered socially or politically intolerable, even if the statistics indicated they were. Is it any more appropriate to discriminate by age and gender than it is by race and economic level?

*Statistics are available only for the demographic categories the insurance industry chooses. Without comparative data, it is impossible to determine whether the industry has chosen the most appropriate categories. Interestingly, the N.C. Rate Bureau has not kept data by age and sex since age and sex discrimination was banned in North Carolina.

On the other hand, spokesmen for the insurance industry contend that it would be unfair *not* to use demographics in underwriting. "Many sawmills and restaurants never burn. Nevertheless . . . it is not equitable to charge all fire insurance policyholders the same rate because owners of dwellings would be subsidizing owners of restaurants and sawmills, which have been shown by experience to be more likely to burn," says Paul Mize. "To whatever extent youthful drivers as a group pay a smaller share of the total auto liability premiums than their share of the losses they cause, older drivers as a group must pay more to offset."

Industry representatives object most vigorously, perhaps, to the proposition that an individual in a group, for underwriting purposes, might be penalized because of the general characteristics of that group. "If one person caused an accident that cost an insurance company $3 million in a lawsuit, you don't turn around and charge that person $3 million," says John McMillan. "Insurance is a prospective business. You determine rates based on a group or class. A person is a member of that class. You can identify a *group* of people that should get lower rates—because you are not singling out an individual."

Statistical and Social Equity — Combined

The two examples put forward by Mize and McMillan—the sawmill vs. homeowner fire insurance rates and the $3 million settlement—sound convincing when considering statistical equity *alone*. These very examples, however, help to sharpen the distinction between statistical and social equity. Sawmills probably pose a higher risk of fire than houses *by virtue of being sawmills,* not because of some surrogate measurement. All sawmills produce flammable materials and use industrial equipment. Moreover, sawmills are businesses. Investors have chosen to put their money into the sawmill business, and the higher insurance rates are passed along to consumers in the price of the product. Running a sawmill and owning a home are entirely different propositions. Different insurance rates may be both socially and statistically equitable.

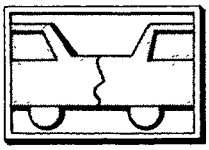
By contrast, private passenger auto insurance is not a business expense, but an essential, legally required, personal service. Moreover, in projecting auto losses, demographic criteria are *surrogate* measures of something else. Young, single men cause more auto insurance losses than others, not because they are young, single men, but because they *tend* to share some other characteristic—recklessness, perhaps. Not all young men share this characteristic, however. Demographic criteria may be statistically equitable. But it is socially *inequitable* to charge higher rates on the basis of criteria that are beyond a driver's control and are *surrogate* measures of characteristics that a particular driver may not share.

The most desirable rating system would be both statistically and socially equitable (see Table 2). Demographic driver classifications, such as age and sex, are inherently *socially* inequitable. They lump together drivers who may or may not share the intended characteristics. It may turn out that some such classifications are really surrogate measures for something else entirely, something that can easily be measured by an acceptable means.

Mileage appears to fall into this category. It is both measurable and directly related to the risk a driver poses to an insurance company. Yet, the current system of classifying drivers addresses mileage only indirectly through classification of car use—farm, pleasure, commuting to work (over or under 10 miles), and business. If North Carolina's driver classification system needs to be refined, the legislature, the Insurance Commissioner, and the insurance industry might consider mileage criteria.

Classifying by Driving Record:

The Safe Driver Insurance Plan



In 1975, the legislature banned age and sex discrimination as a basis for setting auto insurance rates. It also instituted the current Safe Driver Insurance Plan (SDIP).[19] Under the SDIP system, rates are based more on conditions under a driver's control—i.e., driving record—and less on demographics. Violations and accidents result in point assessments which in turn cause a surcharge on liability rates.

Serious violations, such as hit-and-run driving causing injury or death, bring 12 SDIP points and a 450 percent surcharge. Speeding between 55 and 75 mph results in 2 SDIP points and a 40 percent surcharge. Causing an accident results in either 2 points (over $500 in total damage) or 1 point (under $500); 1 point has a 10 percent surcharge. (See full list of violations, points, and surcharges below.)

Drivers assessed SDIP points have their base rate increased by the SDIP surcharge for

Infractions, points and surcharges

Here is a list of the infractions for which Safe Driver Insurance Plan points are assessed, and the surcharges those points carry. Keep in mind that this system differs from the one the state Transportation Department uses to determine whether a driver's license should be revoked.

12 points — 450 percent surcharge: Pre-arranged racing or lending a vehicle for pre-arranged racing; hit-and-run driving, causing an injury or death; manslaughter or negligent homicide from the operation of a motor vehicle.

10 points — 350 percent: Driving while under the influence of alcohol or drugs; driving while impaired; transporting illegal intoxicating liquors by motor vehicle for the purpose of a sale; highway racing, or lending a motor vehicle for a race.

8 points — 250 percent: Driving with an operator's license that is suspended or revoked.

4 points — 100 percent: Failing to report an accident; hit-and-run driving, causing property damage; leaving the scene of an accident in which there was property damage; reckless driving; passing a stopped school bus; speeding over 75 mph.

2 points — 40 percent: Illegal passing; following too closely; driving on the wrong side of the road; speeding between 55 mph and 75 mph; accidents involving personal injury or death; causing an accident in which the total damage exceeds $500 (effective Jan. 1, 1984; before then it was over $200 to either owned or non-owned property).

1 point — 10 percent: All other moving traffic violations, including speeding, unsafe movements, running red lights and stop signs and improper turning; causing an accident in which the total damage is under $500 (effective Jan. 1984; before then it was under $200).

Zero points: Speeding less than 10 mph over the speed limit, provided the citation did not occur in a school zone and the driver had no previous moving traffic violations in the previous three years; driving with an inadequate muffler; improper lights or equipment; failing to have an operator's license in possession if a valid one exists; failing to display the current inspection sticker.

Table 3. Liability Insurance Experience in North Carolina, 1982[1]

SDIP Points	Car Years (in 1000s)	Percent of Car Years	Earned Premiums (in $1000)	Total Losses (in $1000s)	Average Rate	Loss Ratio	Loss Per Car Year
0	2,730	79.9%	$261,143	$204,801	$ 96	78.4%	$ 75
1	154	4.5%	18,609	18,758	121	100.8%	121
2	240	7.0%	35,716	25,686	149	71.9%	107
3	79	2.3%	14,518	9,985	185	68.8%	127
4	61	1.8%	13,481	8,900	219	66.0%	145
5	26	.7%	6,402	3,966	251	61.9%	155
6	18	.5%	5,492	3,558	300	64.8%	194
7	8	.2%	2,893	1,786	346	61.7%	214
8	6	.2%	2,322	1,663	389	71.6%	279
9	3	.1%	1,320	666	447	50.4%	225
10	10	.3%	4,781	1,831	474	38.3%	182
11	2	.1%	1,313	659	548	50.2%	275
12	12	.3%	6,982	2,841	605	40.7%	246
Not Eligible[2]	54	1.5%	7,040	2,151	130	30.6%	40
TOTAL	3,403	100.0%	$382,012	$287,249	$112	75.2%	$ 84

FOOTNOTES

[1] Calculations were done before rounding, so some small variations might appear.
[2] "Not eligible" refers to non-fleet private passenger cars owned by partnerships or corporations.

Source: N.C. Rate Bureau (data on car years, premiums, and losses). Other calculations and table design by Steve Adams for *North Carolina Insight.*

three years. Moreover, the resulting rates are multiplied by a surcharge to offset losses incurred by the Reinsurance Facility and to subsidize "clean risks" in the facility. In 1984, this surcharge—which all drivers with SDIP points must pay—was 27.2 percent.[20]

Many of the drivers for whom the system was designed are not paying the consequences. According to a six-month study by UPI reporter Craig Webb, insurance companies assess only 39 percent of SDIP points that should be assessed (see sidebar on page 44). Even if this figure is understated by 10 or 20 percentage points—and there is no reason to believe that it is—the SDIP system has a major flaw.

Most of the missing SDIP points may simply fall through the cracks. There is no law or regulation requiring drivers to report convictions, as they must report accidents. In addition, the Division of Motor Vehicles charges insurance companies, like anyone else, $4 for a copy of a driver's record. Most companies apparently find that it is not cost-effective to check. And, despite the reporting requirement, insurance companies also appear to miss some accidents. "It's an even bigger problem chasing down [unreported] accidents than violations," says Aetna's Seagle.

While the primary problem may be the lack of an adequate reporting system, the SDIP system also breeds two kinds of cheating. Drivers with SDIP points might register their car in someone else's name but still drive the car regularly. (Remember, insurance technically covers a car, not a driver.) Secondly, while the Division of Motor Vehicles does maintain records of convictions, drivers legally do not have to report violations (unlike accidents) to insurance companies.

"Consumers realize through conversations with an agent that if they go elsewhere and don't tell about their violations, they're not going to be charged those extra two points," says Commissioner Long. "You do have cheating within the system."

Working with those SDIP points that were assessed, other important problems appear. In 1982, four of every five cars were assigned 0 SDIP points, according to the N.C. Rate Bureau. These cars caused 71 percent of all liability losses paid by insurers that year. Drivers with points, who did cause more losses *per car,* were responsible for only 29 percent of *total losses.* Table 3 summarizes the 1982 liability data, the latest available.

Figure 1. Loss Per Car Year—1982 (Actual) and Predicted

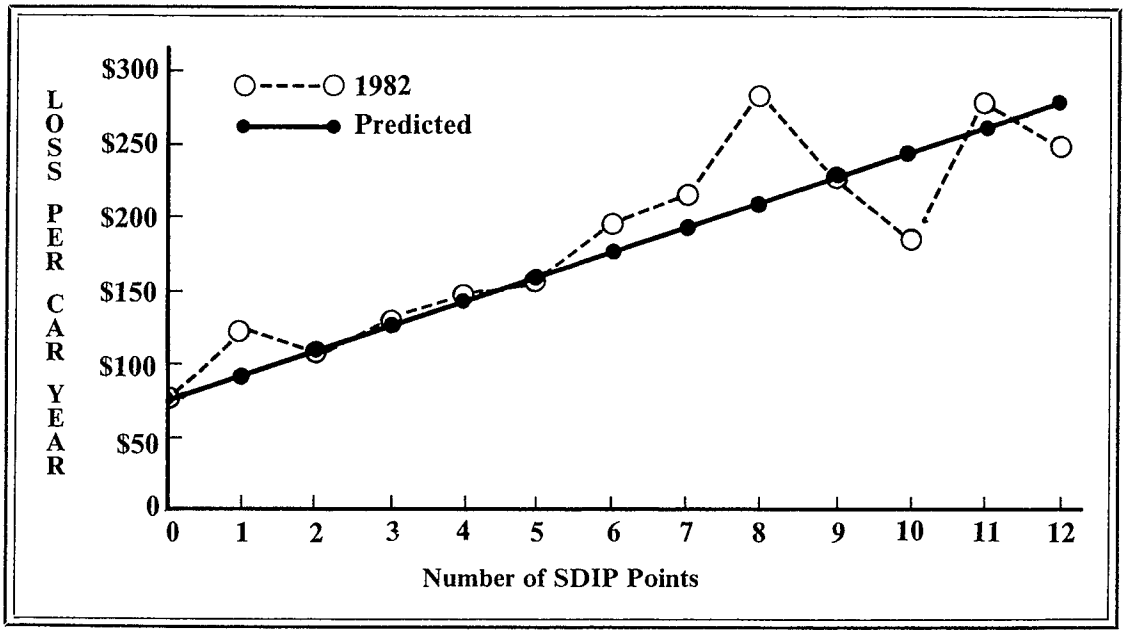


Table 4. Losses Per Car Year, Rates, and Surcharges—1982 and Predicted Levels, by SDIP Category[1]

SDIP POINTS	AVERAGE LOSS PER CAR YEAR 1982	AVERAGE LOSS PER CAR YEAR Predicted[2]	AVERAGE RATE 1982	AVERAGE RATE Predicted[3]	SDIP SURCHARGE 1982[4]	SDIP SURCHARGE Predicted[5]
0	$ 75	$ 76	$ 96	$102	1.00	1.00
1	121	93	121	124	1.10	1.22
2	107	109	149	146	1.40	1.43
3	127	126	185	168	1.70	1.65
4	145	143	219	190	2.00	1.87
5	155	159	251	212	2.30	2.08
6	194	176	300	234	2.70	2.30
7	214	192	346	256	3.10	2.51
8	279	209	389	277	3.50	2.73
9	225	225	447	299	4.00	2.95
10	182	242	474	321	4.50	3.16
11	275	258	548	343	5.00	3.38
12	246	275	605	365	5.50	3.60

FOOTNOTES

[1] Calculations were performed before rounding, so some small variations might appear.

[2] Data from linear regression analysis shown in Figure 1.

[3] Data calculated like this: a x b = c; a = c/b

Key: "a" — predicted rate
"b" — .752 (loss ratio for all drivers in 1982)
"c" — predicted loss per car (from Figure 1)

[4] The surcharge is expressed as the base premium (1.00) plus the surcharge percent for each SDIP group. For example, the surcharge for 8 points is 1.00 plus 2.50 (8 points carries a 250 percent surcharge), or 3.50.

[5] Data calculated like this: a x b = c; a = c/b

Key: "a" — predicted surcharge
"b" — predicted rate for 0 SDIP points ($100)
"c" — predicted rate for each SDIP category (from calculation above)

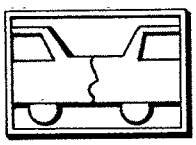
Source: For 1982 data, N.C. Rate Bureau. Table design and calculations prepared for *North Carolina Insight* by Steve Adams.

continued from p. 42

The SDIP system, in theory, groups drivers according to the losses an insurer expects them to cause. Drivers with 5 SDIP points, for example, are expected to cause more losses than drivers with 0 points—hence, the 230 percentage surcharge for drivers with 5 points. For this surcharge to be fair, the ratemaking system must accurately relate future losses to SDIP points. In examining the SDIP system, the best measurement of fairness is what the industry calls the *loss-ratio figure.*

In 1982, the average loss ratio for all drivers was 75.2 percent (see Table 3). Put simply,

Underassessment of SDIP Points Widespread



Auto Insurance

Craig Webb of United Press International reported in January 1984 that insurance companies assessed only 39 percent of the SDIP points that should have been assessed. Webb's investigation took six months. The results appeared as a five-part series in newspapers throughout North Carolina.

Insurance carriers file with the N.C. Rate Bureau the SDIP data for their policies. The court system and law enforcement officials report all traffic convictions and accidents to the N.C. Division of Motor Vehicles (DMV). Webb compared aggregate SDIP data from the Rate Bureau for FY 1982 with aggregate violation/accident data from DMV for the three preceding years (remember that SDIP points affect premiums for three years). Of a total of 4,502,365 points that might have been assessed, insurance companies assessed only 1,761,305 points, or 39 percent.[1]

To obtain an individual's driving record, an insurance company or agent must request a Motor Vehicle Record check (MVR) and must pay $4 for each MVR form. In interviews with the 10 largest auto insurance carriers in the state, Webb found that only three checked a driver's record at least once a year. (Policies are often renewed semi-annually.) The other seven checked no more than every other year. (See list of top 10 insurers on page 32.)

The reason is money and convenience. Paying $4 for each individual's record (plus the cost of ordering and reviewing the receipt) could cost more than the increased revenues the companies would earn for catching points that had not been reported, says Paul Mize, general manager of the Rate Bureau and the Reinsurance Facility. Further, insurance companies transfer the policies of most drivers with bad records to the facility — *the premiums as well as the policies.* For reinsured drivers, a company would not benefit directly from increased premiums for additional SDIP points even if it did profit from checking driving records of policies in the voluntary market.

Regarding reinsured policies, an insurer must obtain an individual's driving record from the Division of Motor Vehicles when first ceding that driver's policy to the facility. As long as that policy is written and ceded to the facility, the insurer must obtain the driving record from DMV at least once a year.

The state-approved driver classification system depends heavily on the SDIP points, yet DMV does not supply this information to insurance companies on an efficient or cost-effective basis. State policies conflict here. Two specific problems need attention, and neither involves a major tinkering with the ratemaking system: *the cost* and *the method* of getting the accident/violation information to the insurance companies.

The cost of each driving record was $1 until the legislature raised the fee to $3 in 1981 and $4 in 1983. "The $4 fee is there because the

companies paid out an average of 75.2 cents in claims and related expenses for every dollar of premiums collected. (Another way to think of a loss ratio, from a consumer's point of view, is a "payback ratio"—i.e., measuring the ratio in terms of what is "paid back" to the consumer, not "lost" by the insurer. The following discussion uses the standard industry terminology, but "payback ratio" could be substituted for "loss ratio.")

Comparing the loss ratio at each SDIP level with 75.2 percent shows whether average rates were fair. If a loss ratio for an SDIP group is *lower than the average,* then the insurance

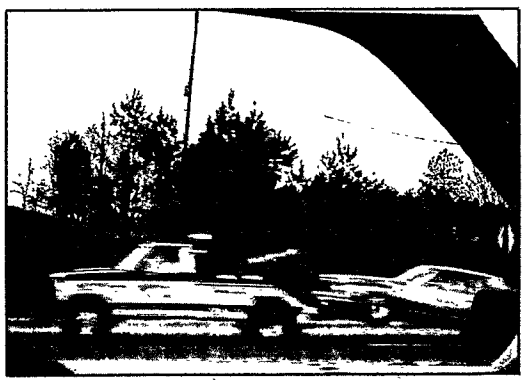
Highway Fund was short of funds several years ago," says Commissioner Long, who in 1981 was legislative counsel to the Speaker of the House. "The actual cost of processing [a driver's record at DMV] is in the range of 60 to 70 cents."

The cost is as much a deterrent to the agents as it is to insurance companies. "Some companies have started requiring the agents to furnish the form to them, and if it is furnished, to pay for it," Long continues. "The agents are making a commission of 15 to 18 percent on a policy, and $4 off that leaves little margin. The agents aren't going to spend the $4 and the companies aren't going to spend $4, so no one is checking your violations when you write or renew your policy."

Various steps might alleviate these problems:

- reduce the fee back to $1 (at a cost of $9 million per year to the Highway Fund, according to the legislature's Fiscal Research Division);
- require by statute that an agent or company must have the MVR form to renew a policy;
- mandate DMV to report driving records en masse to insurance companies;
- change the law to require drivers to report violations as well as accidents with some specific punishment for commiting fraud (this change would not require an elaborate computer reporting system);[2] or
- require clerks of court to send a notice of all guilty pleas or convictions for violations and prayers for judgment continued to insurance carriers, with the cost of the notice included in court costs rather than going to insurance companies.[3]

Commissioner Long, while recognizing these problems, is not ready to propose a solution. "It's going to be some time before we determine what is the best system for rating



auto insurance in North Carolina. Then we'll address the problem of that $4 form versus the $1 form and who has to pay for it. Instead of worrying about the detail of the MVR form, let's back off and look at the entire system." □

FOOTNOTES

[1]The number of points that might have been assessed could be overstated somewhat. Webb's methodology did not take into account, for example, the convicted drivers who had since died or moved away from North Carolina, those drivers who did not regularly drive an individually owned non-fleet private passenger car, those under long-term driver license suspension or revocation, or those in prison. But Webb did, in his methodology, take the conservative method of calculation in several instances. For example, Webb assigned all speeding convictions the lowest possible SDIP point assessment, even though speeding can count anywhere from 1 to 4 points.

[2]Webb found that 90 percent of the points that should have been assigned were from violations (4.1 million points), which are not mandatory to report to an insurer. Only 10 percent of the points that should have been reported came from accidents (443,000).

[3]This system would not pick up out-of state violations, but presumably that is a relatively small proportion of the violations.

companies made *more money than average* on that group of drivers.

For groups with 2 or more SDIP points, the loss ratio generally declined as the number of points increased.[21] This means 1) drivers with high SDIP points paid excessive rates, and 2) the insurance industry made more money on drivers with poor records than on those with good records—even before facility surcharges. Groups with 2 or more points had loss ratios below the average; these drivers paid too much for liability coverage, in relation to other SDIP groups. Drivers with 0 points had a loss ratio of 78.4 percent, near the overall average of 75.2 percent; relative to other groups, their rates were about right. Drivers with 1 point had a loss ratio of 100.8 percent, considerably over the average; their rates were too low, relative to other SDIP groups.

The data in Table 3 incorporates rate variations from territories, driver experience, car use, policies ceded to the Reinsurance Facility, and of course, SDIP points. These figures *do not,* however, include the recoupment surcharge assessed against all drivers with SDIP points to offset losses incurred by the Reinsurance Facility. Adding this surcharge to the calculations would make the rates for drivers with SDIP points even more excessive.

Table 3 is a snapshot of a past year's liability activity. In setting the odds on individual policies, however, insurance underwriters try to anticipate future losses. One way to determine whether SDIP points predict future claims is to apply what statisticians call a "linear regression analysis." This, in short, straightens out the jagged line of actual experience and determines the level of correlation, in this case between SDIP categories and loss per car year.[22] Applying a regression formula to the loss-per-car data in Table 3 results in a projection of anticipated or *predicted losses.* In Figure 1, the straight line connects the *predicted losses;* the jagged line shows actual 1982 losses.

In Table 3, rates appeared excessive for persons with a high number of SDIP points because the loss ratio declined as the SDIP points increased. Using the 1982 average loss ratio for all drivers, 75.2 percent, Table 4 shows *how excessive* rates and surcharges were—if no other part of the ratemaking system were changed. Table 4 shows average rates and surcharges that would have been fair for each SDIP category.

Predicted Rates. In 1982, drivers with 0 and 1 points paid slightly under what would have been fair ($96 rather than $102, $121 rather than $124, respectively). But drivers with 2 points or more paid too much. The more points, the more excessive was the rate. People with 12 points paid $605, a rate of $365 would have been fair—a difference of 66 percent.

Predicted Surcharges. Drivers with 1 or 2 points had too low a surcharge (1.1 rather than 1.22, 1.4 rather than 1.43, respectively). But the drivers with 3 or more points had too high a surcharge. Drivers with 10 points, for example, would have paid a fair amount with a surcharge of 3.16 rather than 4.50. Given those findings about the current SDIP system, most surcharges should be reduced.

In 1983, the N.C. Rate Bureau proposed that the commissioner reduce surcharges for high SDIP points. The bureau's calculations, like the tables included here, showed that drivers with a high number of points paid more than the loss ratio indicated they should. The bureau's proposals fell below the reductions indicated on Table 4. For example, the bureau proposed that the maximum surcharge be lowered from 450 percent to 400 percent. Commissioner Ingram rejected the bureau's proposal, however.

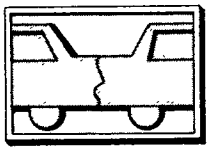
Tables 3 and 4, along with the Rate Bureau proposal of 1983, show that drivers with high SDIP points generally pay excessive rates. More importantly, perhaps, the SDIP system has gradually evolved from a way of anticipating losses for ratemaking purposes to a means of punishing drivers for violations or accidents through insurance rates. This system of penalizing drivers with SDIP points for three years goes against all the studies about past accidents and violations as predictors of future accidents.

The Highway Safety Research Center at the University of North Carolina, for example, found that "a majority of accidents are sustained by a majority of drivers . . . . [E]ven among so called 'high-risk' drivers, a very significant proportion of them have no future accidents." The study concludes that "if a very stringent suppressive program were brought to bear on drivers with a violation record . . . the majority of this group are drivers who in fact would have clean accident records in the future."[23]

If the surcharges were lowered, the SDIP system could again play the purpose for which it was designed—to anticipate losses based on driving record rather than on demographics. But even if the surcharges were lowered, the Rate Bureau would still make rate filings based on the critical loss-ratio figure.

The calculations in Tables 3 and 4 hinge on using a 75 percent average loss ratio for all drivers. Does a 75 percent loss ratio provide the auto industry with a reasonable profit? Or does such a loss ratio result in excessive rates?

Underwriting and Investment Income— How Much Profit?



The N.C. Rate Bureau bases its auto filings with the Insurance Commissioner on a loss ratio of 67 percent, says Bureau General Manager Paul Mize. Put another way, the Rate Bureau files rates anticipating that for every $1 in earned premiums, it would have to pay out 67 cents in claims and related expenses. The difference in the $1 and 67 cents, says Mize, is 28 cents for all administrative costs (including commissions, taxes, licenses, and fees) and 5 cents in underwriting profits and contingencies. (These figures apply to the Rate Bureau filings for the voluntary market and to clean risks ceded to the Reinsurance Facility, but not to the other policies ceded to the facility.)

In his book, *The Invisible Bankers,* Andrew Tobias points out that a bank safeguards money for little charge while living off the investment income the deposits earn but that insurance companies are unable to do this. "For every dollar we collectively 'deposit' with an auto insurer, for example, only 65 cents or so is available for our collective withdrawal," writes Tobias. "The rest of our dollar, *plus* the interest the insurance company earns on it, goes to expenses, overhead, and profit."[24]

The administrative costs of the insurance industry are one major reason for this difference. "It takes 1.9 million people to staff the insurance industry," Tobias reported in 1982. "The banks presided over three times as much money, handled vastly more 'transactions'—and yet managed to make do with about a quarter of a million fewer people."

Cutting administrative expenses through group policies and other streamlining efforts is a potentially explosive issue. Agents, underwriters, and administrative staff could lose their jobs. The number of superfluous insurance industry employees in 1982 was probably close to a million, Tobias calculated.

Joseph Johnson of UNC-Greensboro says that Tobias' "facile and surface analysis" does not adequately explain that banks charge service fees on demand deposits and are able to modify interest rates on both the cost and income side at will. Johnson goes on to say that a discussion of excessive administrative costs should consider the issue of deregulation. "To date, at least, deregulation in other industries—banking, airlines, telephones—has met with mixed reviews as to efficiency gains," he says.

The National Association of Insurance Commissioners (NAIC), the Conference of Insurance Legislators, and other independent national groups should examine the issue of administrative expenses since it is a critical factor in setting rates. Commissioner Long could pursue this issue within the NAIC, a group that has recently tackled some tough issues, such as investment income.

In North Carolina, Rate Bureau filings are calculated to yield 5 percent in *underwriting profits*—i.e., earned premiums less claims and related expenses, and less administrative costs.[25] The National Convention of Insurance Commissioners, the predecessor of the NAIC, established the 5 percent standard in 1921. More than 60 years later, investment opportunities for the insurance industry have increased dramatically, as has the volume of money it manages.

B. F. (Benjy) Seagle III of Aetna, at the 1984 annual meeting of the N.C. Rate Bureau.

In June 1984, the National Association of Insurance Commissioners released a report on a three-year study by its Investment Income Task Force. Composed of insurance regulators from 10 states, the task force had an advisory committee chaired by Richard J. Haayen, president of Allstate Insurance Company. The 95-page report included charts, tables, and financial jargon as well as some clear language for the layman.

The 1921 profit formula or any other formula based on "an arbitrary and unsupported percentage of premiums . . . is no longer appropriate for use in those states which engage in the direct approval of property/casualty rates," the report concluded.[26] "If the industry were to currently earn 5 percent of premiums in addition to investment income (which historically it has not), its total rate of return on net worth after tax would be approximately *25 percent*" (emphasis added).

North Carolina, like most states, does not allow rates to be "excessive, inadequate, or unfairly discriminatory."[27] Allowing companies to charge rates that could produce a 25 percent profit appears excessive.

Interest rates, which vary from year to year, have a substantial effect on investment income. The NAIC found that in 1983, an underwriting *loss of 5.5 percent* would have yielded a 16 percent return on net worth, a level more appropriate to 1983 investment opportunities. Unable to find any economic justification for the traditional 5 percent allowance, the NAIC recommended "for those states which engage in direct approval of rates . . . that the rate-making/review process include a measure of profitability based upon a *total return to equity analysis*" (emphasis added).[28] In North Carolina, only a portion of return on investments is considered in ratemaking.[29]

Some auto insurers were not happy with the NAIC report, and the industry issued a formal response, says Benjy Seagle of Aetna. Seagle also points to a resolution passed by the NAIC's Commercial Lines (D) Committee as another indication that the investment issue is a complex one. "The NAIC recognizes that any methodology for reflecting investment income in the ratemaking/rate review process should be flexible in its application," the resolution reads.

The Rate Bureau calculates that a 67 percent loss ratio figure will produce a 5 percent underwriting profit. If that is true, the 75 percent loss ratio of 1982 would produce a 3 percent underwriting loss. But in 1982, industry spokesmen did not complain publicly about low profits, as they had in earlier years.

Even if the Insurance Department begins considering all investment income in reviewing auto rates, it cannot consider as income the recoupment surcharges assessed to all drivers with SDIP points to cover the Reinsurance Facility losses. The N.C. Supreme Court has ruled that recoupment surcharges are not rates and therefore not subject to review by the Insurance Commissioner.[30]

Such an approach to recoupment is proper, says Mize, because the purpose of the recoupments is for the insurers to recover already paid assessments. Mize points out, for example, that as of June 30, 1984, auto insurers had paid $27 million in loss assessments to the Reinsurance Facility which *they had not yet recouped* from their policyholders. "This is money which, if the carriers had it, would be utilizable to produce investment income," says Mize.

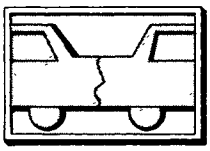
Hence insurers, reasons Mize, go through a period when they cannot earn investment income on their recoupment surcharges. But Mize seems to stop short in describing the full financial cycle. After the companies *have collected* the $27 million—the figure used by Mize (see paragraph above)—then the funds *are* available for investment. This surcharge system removes much of the risk from reinsured business. This $27 million must be collected specifically to cover the facility assessments, but it is still $27 million going to insurance company bank accounts.

The companies have a capital investment surplus sufficient to cover the outlay, while the Reinsurance Facility does not have such a capital surplus. To an investment portfolio, $27 million in recoupment charges is not different from $27 million in direct premiums, despite the lag time.

The ruling by the N.C. Supreme Court suggests the important and complex role the Reinsurance Facility has come to play in regulating auto rates.

The N.C.

Reinsurance Facility



The teenager in Charlotte with an abysmal driving record pays $1,727 a year for liability insurance to earn the legal privilege of driving while the farmer with a clean record pays only $78. The teenager might in fact be a terrible gamble for an insurance company because of his age, his gender, his car, or his personal recklessness. But there is an escape for his insurance company. Any auto insurer in North Carolina must offer liability insurance to this teenager, but it may cede this policy to the N.C. Reinsurance Facility if it wishes.

All states have some sort of "shared" or "involuntary" market to provide coverage for high-risk drivers. In 1981, one of every four of the state's cars were insured through North Carolina's involuntary market, the Reinsurance Facility. Only two states had a higher percentage, and only 10 states had more than 10 percent of its cars in the involuntary market.[31] In 1982, the percentage in North Carolina declined slightly to 22 percent.

In 1973, the legislature replaced the "assigned risk" plan with the Reinsurance Facility.[32] At first consumers had no need to be concerned if their policies were ceded to the facility, because the rates were the same as in the voluntary market. But the facility was sustaining heavy losses, and the auto insurers had to absorb these losses without being able to pass them along to consumers through recoupment surcharges.

By 1977, the insurance companies were complaining loudly about inadequate rates in general and the facility in particular. There had not been an auto liability rate increase since 1973, and the facility losses totaled $62 million in the first three years of operation. In response, the legislature adopted two key industry proposals: 1) allowing the facility to charge higher rates for ceded policies; and 2) allowing the industry to charge all drivers (those in the voluntary and involuntary market) recoupment surcharges to cover facility losses. For drivers with no SDIP points, the legislature later forbade both higher rates in the facility (1979) and recoupment surcharges (1981).

Allowing higher rates inside the facility gave birth to a dual ratemaking system. Car use, territorial variations, SDIP points, and driver experience apply to both systems. The Reinsurance Facility Board of Governors, however, files an entirely separate rate schedule with the Insurance Commissioner. (For more on exactly how the facility works, see sidebar on next page.)

Table 5. Percent of Car Years Ceded to N.C. Reinsurance Facilty, 1982

SDIP	% Ceded
0	17%
1	30%
2	30%
3	45%
4	57%
5	66%
6	77%
7	83%
8	85%
9	87%
10	85%
11	88%
12	92%
Not Eligible	20%
TOTAL	21%

Source: N.C. Rate Bureau

At first, rates in the facility were only about 10 percent higher than in the voluntary market, says John Watkins, assistant general manager of the Reinsurance Facility and the Rate Bureau. By 1984, however, those rates were 40 to 44 percent higher for drivers with SDIP points.

Insurers may cede as many policies as they wish to the facility and for any reason they wish. Driving record appears to be a major factor. Two of every three policies with 5 SDIP points, and more than 90 percent of those with 12 points, were ceded to the facility in 1982 (see Table 5). But a major criterion for ceding had to be something other than driving record: 63 percent of all reinsured cars in 1982 had 0 points (see Table 6).

The driver classification system, in theory, is supposed to allocate the cost of insurance among

Administering the N.C.

All auto insurance companies writing policies in North Carolina must belong to the Reinsurance Facility. The member companies and the Commissioner of Insurance choose a board of governors, which hires a general manager (see board listing below). Paul Mize has headed the facility since it began in 1973. The board establishes rates for reinsured policies, working closely with the ratemaking committee of the N.C. Rate Bureau.

By law, the facility operates on a nonprofit, no-loss basis. This means that once an insurer cedes a policy to the facility, the company can neither earn a profit nor suffer a loss from that policy. Insurers service claims on ceded policies; the facility does not have a

NORTH CAROLINA REINSURANCE FACILITY BOARD OF GOVERNORS. 1984 - 1987

Voting Members (3-year terms)

Company[1]	*Represents*
Aetna Casualty & Surety Company	American Insurance Association
Allstate Insurance Company	National Association of Independent Insurers
Lumbermens Mutual Casualty Company	Alliance of American Insurers
South Carolina Insurance Company	All Other Stock Insurers
State Farm Mutual Automobile Insurance Company	All Other Non - Stock Insurers
Licensed Agent[2]	
J. Earl Ramey	_____
John Riley	Carolinas Association of Professional Insurance Agents
John Wooten	_____
Richard Yarbrough	Independent Insurance Agents of North Carolina

Non - Voting Members

Commissioner of Insurance — North Carolina Department of Insurance

FOOTNOTES

[1]The three company associations select their representatives according to their own procedures. Companies not affiliated with the associations select representatives at the Reinsurance Facility's annual meeting.

[2]The Commissioner of Insurance selects these, all of whom must be licensed, resident North Carolina insurance agents. For each of the association representatives, the commissioner must choose from two names submitted by each association. There are no such restrictions on the other two agents.

drivers. Since reinsured drivers with points pay higher rates on the basis of whatever criteria an insurer chooses, the dual ratemaking system subverts the classification plan. The Reinsurance Facility has become a *de facto* part of the classification plan—with no criteria for who is ceded to it.

Regulating the criteria for ceding drivers to the facility would force insurers to comply with the spirit of the North Carolina law. Now, insurers may cede policies on the basis of age and sex, for example, thus legally skirting the ban against using those factors in setting rates.

The unwritten criteria that insurance companies use for ceding policies must have some logic. Reinsured drivers do cause more losses than drivers with the same SDIP points in the

continued, p. 52

Reinsurance Facility

staff of agents, adjusters, and underwriters.

When the facility suffers losses, the board assesses member companies based on each company's share of the auto liability market in North Carolina. The companies pass this expense on to consumers through "recoupment surcharges" to all policyholders with SDIP points. This surcharge must be "identifiable" on a person's bill.

If a company cedes a policy to the facility, it must notify the policyholder *only* if the cession results in a different premium than the policyholder would have in the voluntary market. Drivers with 0 SDIP points and more than two years' experience, called "clean risks," may not be charged an increased rate in the facility. But clean risks in the voluntary market often pay a lower rate than those in the facility because of downward "deviations." Deviations from the industrywide rate schedule are allowed in the voluntary market but rarely, if ever, occur in the facility.

If a ceded policy results in a higher premium, the company must inform the policyholder:

- that the policy is ceded and subject to facility rates;
- of the difference between the facility rate and the voluntary market rate; and
- that he/she may request a written explanation of why the policy was ceded; and that the insurer must supply a specific reason (or reasons) on request.

A policyholder may seek insurance through a new agent or company after being notified that his or her policy has been ceded to the facility.

Rates for the facility are set independently of rates for the voluntary market. The automobile committee of the Rate Bureau proposes separate rate schedules to the governing boards of both the Rate Bureau and the Reinsurance Facility. The facility board files a rate schedule with the Commissioner of Insurance under a file-and-use system. There is no 90-day waiting period before the increases may go into effect. But an escrow account must be used for increases not approved by the commissioner, if the case is appealed into court.

The Rate Bureau is not responsible for developing facility rates but doing so saves time and money, Mize says. "Nobody questions who is stepping on toes," he says. "It makes sense to streamline in order to avoid duplication of effort." □

John Watkins, assistant manager of the N.C. Reinsurance Facility, reports on facility operations at the 1984 annual meeting. Facility Manager Paul Mize is seated.

Table 6. Comparisons Between Voluntary Market and Reinsurance Facility, 1982

SDIP	% OF CAR YEARS		AVERAGE RATE		LOSS RATIO		LOSS/CAR YEAR	
	Voluntary	Reinsurance Facility	Voluntary	Reinsurance Facility	Voluntary	Reinsurance Facility	Voluntary	Reinsurance Facility
0	84.8%	63.0%	$ 94	$103	66%	136%	$ 62	$140
1	4.0	6.3	115	134	88%	127%	101	170
2	5.8	10.0	142	165	59%	97%	84	160
3	1.6	4.9	172	200	59%	79%	102	157
4	.9	4.8	203	232	47%	79%	94	183
5	.3	2.3	222	266	52%	66%	116	175
6	.1	1.9	271	308	51%	68%	140	211
7	.1	.9	311	354	48%	64%	149	227
8	.0	.7	344	397	91%	69%	314	273
9	.0	.3	380	456	92%	45%	351	207
10	.1	1.1	439	481	27%	40%	120	193
11	.0	.3	441	562	44%	51%	192	286
12	.0	1.4	511	613	52%	40%	266	244
Not Eligible	1.6	1.4	127	144	31%	28%	40	40
TOTALS	100%	100%	$102	$150	65%	102%	$ 66	$152

Source: Basic data, N.C. Rate Bureau. Calculations and table design, *North Carolina Insight.*

voluntary market. Reinsured drivers caused, on the average, $152 in losses per car year compared with $66 for the voluntary market (see Table 6).

In both the voluntary and reinsured markets, loss ratios generally decline as points increase. Reinsured policies with 0 and 1 points had loss ratios substantially above the facility average, and thus paid too little in premiums, relative to other reinsured drivers. Drivers with more SDIP points had lower-than-average loss ratios. Rates were too high for drivers in the high-point categories both within and outside the facility. (However, in the voluntary market, particularly, the number of drivers in the higher point categories is too small to permit reliable generalizations.)

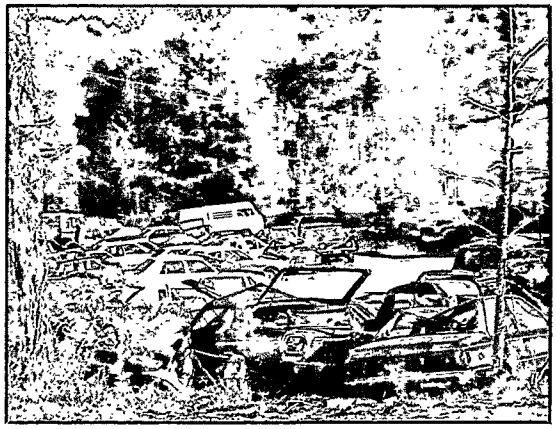
Breaking down the voluntary and involuntary markets by SDIP point groups shows more about which categories might be paying too much. Clean risks in the facility are not paying their fair share. Their loss ratio was more than double that of drivers in the voluntary market with 0 points, but they paid only 10 percent more in premiums ($103 compared with $94).

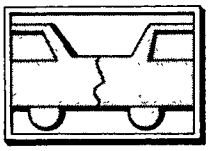
Under the current arrangement, setting fair rates is difficult. Two rate schedules must be filed with the commissioner, one for the voluntary market and one for the reinsured market. The industry is supposed to make profits or sustain losses only in the voluntary market. Moreover, the Rate Bureau does not consider all aspects of investment income in its formula, nor are recoupment charges legally considered premiums. Finally, the Reinsurance Facility has some investment income of its own ($11 million in 1983), yet insurance companies continue to earn interest on the "surplus" (funds held in reserve) that backs up policies in the facility. Thus, companies would make a profit on reinsured drivers if the facility, standing alone, broke even, as the law requires.

Ratemakers are caught in a mathematical maze. What rates are fair? Predicted loss ratios can be calculated separately for the voluntary and involuntary markets for 1982. Again, the predicted rates are calculated to give each point group a 75.2 percent loss ratio—the same as the actual loss ratio for the combined voluntary and involuntary market.

The results indicate that the predicted and actual losses of high-point drivers in the facility are not a great deal higher than they are for drivers with comparable records in the voluntary market. Since most drivers with high numbers of points are ceded, this is not surprising. According to the predicted rates for the voluntary and involuntary markets, the only drivers who are paying too little are reinsured drivers with fewer than 5 points. All other drivers pay more than their fair share.[33]

Conclusions and Recommendations





The auto insurance regulation system in North Carolina is out of kilter. While most close observers agree that the system needs changing, no consensus has developed as to what changes should be made. The 1985 General Assembly and the newly elected Commissioner Long will probably enjoy a traditional "honeymoon" period. Hence major changes may not be forthcoming soon.

One major change on the minds of many analysts of the industry is deregulation. "We feel it is the most responsible system," says John McMillan, who discussed the matter when still a lobbyist for Allstate. "We're in a very competitive business. We can be responsible in the marketplace if there is price competition among the companies. If market factors allow us to make reductions, we need to have the ability to make that reduction—provided the statute also permits us to react to the market factors that necessitate rate increases. That's the quid pro quo."

Benjy Seagle of Aetna adds, "The NAIC Advisory Committee study on competitive rating recommended a regulatory system based on price competition as the system most responsive to the needs of consumers and the industry."[34]

Consumer advocates, however, worry about the effects of a deregulated system. "Despite the complicated system we have now, it's better for consumers generally than open competition," says legal services attorney Mike Calhoun. "With competition, the industry underwrites on the basis of surrogates and extreme subjectivity, which works heavily against poor people."

Much of the insurance industry favors competition in lieu of regulation. Competition might protect consumers against excessive *overall* rates. But would competition protect *individual* drivers against socially inequitable rating criteria? The best evidence is that it clearly would not. Much of the industry continues to advocate age and sex discrimination, and many industry representatives seem to consider only statistical equity—not social equity—as a measure of fairness. Therefore, there is a need for continued regulation of the driver classification system, even if companies are allowed to compete freely within that structure.

The framework of this article departs in at least three significant ways from traditional propositions put forth by most industry representatives. First, industry representatives do not appear to distinguish between statistical and social equity. Second, they generally favor charging higher rates for reinsured drivers. The third difference in approach concerns investment income.

Many representatives of the industry seem to reject—or perhaps fail to acknowledge—the distinction between statistical equity and social equity in forecasting which groups of drivers will cause insurance losses.

There is no question that reinsured drivers do cause more losses than drivers in the voluntary market. However, there are no criteria for ceding drivers to the Reinsurance Facility and no record of why companies choose to do so. There is no way of determining whether the higher rates are socially equitable. This is unacceptable, particularly given the industry's penchant for socially inequitable rating criteria, such as age and sex.

In North Carolina, only income earned on "policyholder" funds is considered in setting rates. These include unearned premiums (money) paid in advance) and unallocated loss reserves (money soon to be returned to the policyholders). Yet, according to the NAIC, North Carolina's ratemaking formula would yield exorbitant profits if one considers *all* investment income, including the return on the "surplus" that stands behind insurance policies.

As Joseph Johnson of UNC-Greensboro points out, surplus "represents capital belonging to shareholders." Yet, money earned on surplus is part of the shareholders' total return on investment. If regulation is to stand in lieu of competition to protect consumers against excessive rates, regulators must consider *all* investment income. This is particularly problematic in the Reinsurance Facility, since companies retain the surplus behind reinsured policies.

Commissioner Long has proposed that a new legislative study commission redraft by 1987 all property and casualty statutes, which includes auto insurance. Perhaps the suggestions below can help to prepare those who will rewrite these laws. Meanwhile, some short-term changes would make the proposed 1987 overhaul more meaningful in the long run.

Short-term Recommendations

1. Improve the Data Reporting System of SDIP Points. As many as 60 percent of the SDIP points that should be assessed are not. This flaw in the SDIP system must be addressed before policymakers can determine what structural revisions are needed. Currently, insurance companies do not monitor often enough official driving records kept by the Division of Motor Vehicles; convictions for violations do not automatically result in SDIP points. This system could be improved in several ways, such as reducing fees for the critical "MVR" form, requiring drivers to report violations to insurance companies, or requiring clerks of court to send notices of convictions to insurance carriers. Possible solutions to this problem are summarized in the sidebar on pages 44-45. Any of these changes would require some action by the General Assembly.

2. Reduce the Surcharge Percentages for Drivers With More Than Two SDIP Points. Persons with high numbers of SDIP points pay excessive rates, primarily because surcharges for SDIP points are too high (see Table 4). Any major changes in the SDIP system should be made in the larger context of the proposed 1987 overhaul of the whole auto regulatory system. Meanwhile, Commissioner Long and the Rate Bureau have the administrative authority to give immediate relief to drivers with high points. These drivers should not have to wait until 1987 for equity. Administrative action on the surcharge would not involve major structural changes. This change would require "increasing the base rates, which would impact drivers without points, and this has been the political difficulty," says Paul Mize. "It would take courage to correct."

3. Allow Group Liability Rates. Currently forbidden by law, true group liability coverage could reduce pressure on the ratemaking system. Administrative costs could be cut drastically, and the rating system might be altered along the pattern of group health insurance.

Long-term Recommendations

Since 1973, piecemeal tinkering and political confrontation have resulted in a contradictory and complex auto insurance regulation system. The recommendations below should be viewed in the context of an overhaul of the entire system.

The insurance industry "does not oppose revisions to the driver classification system or in the Safe Driver Insurance Plan," says Aetna's Seagle. "We support more equitable plans than what we presently have, but one must realize x number of dollars is needed from our rate projections and if the SDIP surcharges are adjusted, base rates would also have to be adjusted to compensate for that difference."

While each recommendation can stand alone, all are interrelated, and should be understood in that way.

1. ***Revise Driver Classification System.*** As currently structured, the ratemaking system is neither statistically nor socially equitable. A person's driving record seems inadequate as the primary tool for ratemaking because so few drivers cause most of the violations and accidents. On the other hand, demographic measurements, such as age and sex, are unfair because they penalize too many people who are good drivers. A driver classification system should attempt to be both statistically and socially equitable, where possible. Specifically, it should:

a. ***Use Mileage Driven as an Explicit Factor in Setting Rates.*** Currently, mileage is considered indirectly in the car use category (farm, pleasure, commuting, business). It should be an explicit factor for rates; mileage is measurable, socially equitable, and statistically related to the risk a driver poses to an insurance company.

b. ***Reject Efforts by the Insurance Lobby to Restore Age and Sex as a Rating Factor.*** Age and sex are actually surrogate measures for other driving characteristics, such as recklessness. Penalizing all persons in such a demographic group with higher rates is unfair to the good drivers in that group.

2. ***Revise the Safe Driver Insurance Plan.*** In 1982, 80 percent of the cars were rated at 0

SDIP points. Hence, too few had enough points to bear a large portion of the cost of the insurance system through excessive rates. The current SDIP penalty schedule may not measure accurately the relative severity of various accidents and violations in relation to the likelihood of future insurance losses. One driver could be assigned 10 points either for a single conviction for driving while impaired while another would have 10 points for *five* accidents causing injuries or damages in excess of $500. Do these drivers represent the same risk to the insurance company? This is the proper question to answer with the SDIP system. Punitive rates for drunk driving, for example, are not appropriate within an insurance rating system, but should be dealt with through the judicial system. Specifically, policymakers should:

a. ***Adjust Surcharges to Reflect Anticipated Losses.*** In the total market, drivers with 2 or more points paid too high a rate in 1982 (see Table 4). The higher the number of points, the more excessive were the rates. With reduced surcharges, the SDIP system can play its proper role: to anticipate losses according to driving record. With the current excessive rates, the SDIP system is punitive.

b. ***Eliminate Facility Surcharges, or Remove Link to SDIP System.*** Clean risks in the Reinsurance Facility pay the same rates as comparable drivers in the voluntary market, even though they cause more losses. In addition, the facility continues to lose money even though its rates are supposed to be self-sustaining. These revenue shortfalls are offset by surcharges against all drivers with SDIP points. The Supreme Court has ruled that these surcharges are not premiums and thus are beyond the regulatory reach of the Insurance Commissioner.

As a result, the already excessive cost of insurance for drivers with SDIP points is increased even further, and a proportion of the facility's operation is essentially unregulated.

The need for surcharges could be eliminated by a revision of the driver classification plan, consideration of investment income, and a change in the way facility rates are set. The SDIP system was not designed as an auxilliary to the involuntary market mechanism, which is what it has become.

3. ***Consider Eliminating Higher Rates in the Reinsurance Facility.*** Nationwide, North Carolina has among the highest percentages of auto policies in the involuntary market. Mandatory liability insurance puts pressure on companies to cede drivers to the facility. But one of every five policies is now ceded, resulting in a dual system of rate regulation in the state, with drivers in the facility who are not "clean risks" paying 40 to 44 percent higher rates in 1984. The higher rates in the facility, as a practical matter, subvert the classification plan; the facility itself has become part of the classification system through the back door, as it were.

Originally, higher rates were not allowed for drivers whose policies were ceded to the facility; different rates have existed only since 1977. Eliminating this difference could greatly simplify the ratemaking process, and would probably be the easiest way to achieve social equity among all drivers—whether in the voluntary or reinsured market.

4. ***If the Dual Rate System Is Not Eliminated, Consider Other Revisions to the Reinsurance Facility.***

a. ***Require Criteria for Ceding Policies to the Facility.*** Companies may cede as many policies as they wish for whatever reasons they wish. This allows companies to subvert the North Carolina law prohibiting ratesetting according to age and sex. If a company chooses to cede a policy because of age, sex, or other demographic factors, the rate on that policy is automatically 40 to 44 percent higher—if that policy has any SDIP points or if the driver has been driving less than two years (i.e., any policy that is not a "clean risk"). In effect, the facility is now part of the classification plan, without criteria.

b. ***Reduce Rates for Reinsured Drivers with Points.*** Rates are excessive for drivers in the facility who are not "clean risks." Predicted and actual losses of high-point drivers in the facility are not a great deal higher than they are for drivers with comparable records in the voluntary market, yet the reinsured drivers pay much higher rates.

c. ***Increase Rates for Reinsured Drivers with 0 SDIP Points.*** Clean-risk drivers do not pay their fair share. In 1982, 63 percent of the reinsured drivers had 0 points. Low rates for these drivers resulted in a loss ratio of 136 percent, far above the overall average loss ratio for the facility (see Table 6).

5. ***Include All Investment Income in the Rate Formula.*** The N.C. Rate Bureau files rates based on a formula that anticipates a five percent underwriting profit for insurance companies. The National Association of Insurance Commissioners, whose predecessor group set the five percent standard in 1921, has found that an arbitrary underwriting income percent is no longer an appropriate standard. The NAIC, and other

national analysts, contend that an overall projected income approach should be incorporated into the rate formula and that the underwriting margin should vary from year to year, depending upon interest rates for a given year. In North Carolina, only some investment income is currently considered in setting rates.□

FOOTNOTES

[1] Rates calculated by John Watkins, assistant general manager, N.C. Rate Bureau and N.C. Reinsurance Facility. He based them on the North Carolina minimum liability coverage of 25/50/10; 25/50/10/ means that the insurance covers up to $25,000 per person for bodily injuries, up to $50,000 per accident for total bodily injury payments, and up to $10,000 for property damage liability.

[2]NCGS 20-309. Technically, compliance with the financial responsibility law may be by means other than automobile liability insurance, but for all practical purposes, North Carolina has mandatory liability insurance.

[3]For companies, NCGS 58-248.31(a); for agents, 58-248.32(a).

[4]Insurance companies may, however, cede drivers to the Reinsurance Facility for any reason they choose.

[5]NCGS 58-30.3 and NCGS 58-124.19 (4).

[6]"Statement on Automobile Insurance Regulation before the Insurance Study Committee, State of North Carolina," John W. Hall, September 16, 1982, p. 24ff.

[7]See profitability studies put out by the National Association of Insurance Commissioners, which provide raw data on computer tapes according to states and lines of insurance.

[8]NCGS 58-30.4 enables the N.C. Rate Bureau to provide for a surcharge for people with less than two years of driving experience.

[9]A first speeding violation, if less than 10 mph and not in school zone, does not result in an SDIP point. NCGS 58-30.5.

[10]NCGS 20-16 (a) (5).

[11]The 27.2 percent surcharge is really two surcharges: 1) the loss recoupment surcharge and 2) the surcharge to offset inadequate rates for "clean risks" in the facility. Clean risks are drivers with no points and more than two years' driving experience. In 1984, the loss assessment surcharge was 22.4 percent; the clean risk surcharge was 4.8 percent.

[12]Ben F. Loeb, *Motor Vehicle Laws of North Carolina,* Institute of Government, University of North Carolina at Chapel Hill, 1984.

[13]Hall's 1982 "Statement" (see footnote 6), p. 34ff.

[14]*Allstate Ins. Co. v. Hale,* 270 NC 195, 154 SE2d 79 (1967).

[15]NCGS 58-30.2 and Regulation 10.0305. The statute is somewhat ambiguous. It appears that group insurance is not prohibited if the rates under a master policy are not lower than those charged for individual policies covering similar risks. "But this is really a prohibition against true automobile group insurance," says Benjy Seagle of Aetna.

[16]The best known industry plan, perhaps, is the "260 Plan" developed by the Insurance Services Office. The plan included, among other features, declining rates for young males as they got married and settled down.

[17]John Rawls, *A Theory of Justice,* The Belknap Press, of Harvard University Press, Cambridge, Mass., 1971.

[18]Andrew Tobias, *The Invisible Bankers,* The Linden Press, Simon & Schuster, New York, N.Y. 1982, p. 194.

[19]NCGS 58-30.4 & .5. Because of litigation between the industry and the commissioner, the SDIP system did not take effect until 1977.

[20]See footnote 11.

[21]In Table 3, the loss ratio does not always decline at the upper point levels, probably because the categories had such a small number of drivers.

[22]The coefficient of correlation in the linear regression analysis was .95.

[23]J. Richard Stewart and B.J. Campbell, "The Statistical Association between Past and Future Accidents and Violations," The University of North Carolina Highway Safety Research Center, December 1982.

[24]Tobias, *op. cit.,* pp. 15-16.

[25]Paul Mize, general manager of the Rate Bureau, says that a rate calculation presupposes that all companies will actually charge the Rate Bureau's rates, in full, and will pay no dividends to policyholders. In calendar year 1983, adds Mize, the total of the dividends to policyholders and the rate discounts allowed through deviations amounted to approximately 3.4 percent of the premiums which would have been written had all companies utilized the rates filed by the Rate Bureau, on voluntary business, without deviation.

[26]*Report of the Investment Income Task Force to the National Association of Insurance Commissioners,* June 1984, p. 8.

[27]NCGS 58-124.19 (1).

[28]*Report of Investment Income Task Force. op. cit.,* pp. 8-9.

[29]See NCGS 58-124.19. The law requires ratemakers to consider investment income earned or realized by insurers from their unearned premiums and unallocated loss reserves generated from business within this state.

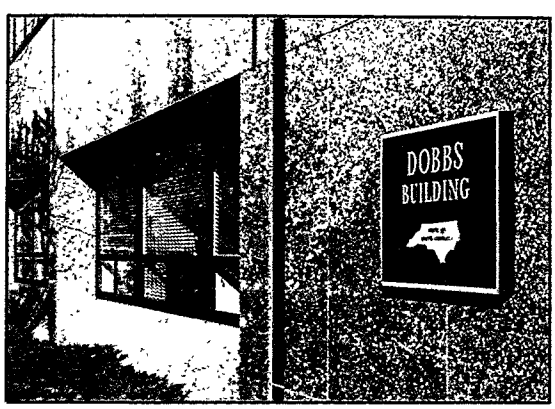
[30]*State ex rel. Hunt v. North Carolina Reinsurance Facility,* 302 NC 274, 275 SE2d 399 (1981).

[31]Insurance Information Institute, *Insurance Facts, 1983-84 Edition,* New York, N.Y., 1983, p. 43.

[32]Under the assigned risk plan, persons (risks) who were unable to obtain insurance in the voluntary market were assigned to insurance companies. The distribution of risks among the companies was based on each company's proportionate share of the insurance business in the state for each particular coverage.

[33]The results of these calculations are available from the North Carolina Center for Public Policy Research.

[34]*The Report of the Advisory Committee on Competitive Rating to the National Association of Insurance Commissioners, May 1980.*



Resources

Government Reports, 1977 to 1984

"Fire and Casualty Insurance Rate Regulation, Report to the 1977 General Assembly," Legislative Research Commission, Jan. 12, 1977.

"Insurance Rate Regulation and the Automobile Reinsurance Facility, A Report to the Joint Senate/ House Insurance Committee, N.C. General Assembly," John W. Hall, May 16, 1977.

"Insurance Laws, Report to the 1979 General Assembly of North Carolina," Legislative Research Commission, Jan. 10, 1979. Committee findings and recommendations on automobile, workers' compensation, and property insurance laws.

"Operational Audit: North Carolina Department of Insurance," State Auditor Henry L. Bridges, May 1980; and "Report on Audit: North Carolina Department of Insurance," State Auditor Edward Renfrow, June 30, 1981.

"Insurance, Report to the 1981 General Assembly, 1982 Session," Legislative Research Commission, May 20, 1982.

"Statement on Automobile Insurance Regulation Before the Insurance Study Committee, State of North Carolina," John W. Hall, Sept. 16, 1982.

"Insurance, Report to the 1983 General Assembly of North Carolina," Legislative Research Commission, Jan. 12, 1983. Findings and recommendations on insurance regulation, state government risk management, and credit insurance.

"Insurance Rate Regulation and the Motor Vehicle Reinsurance Facility in North Carolina," Research Division, Legislative Services Office, N.C. General Assembly, 1983.

"1983 Insurance Legislation, General Assembly of North Carolina, First Regular Session," Research Division, Legislative Services Office, N.C. General Assembly, no date. Summarizes legislative bills on auto insurance, health insurance, insurance agents, and other issues.

"Insurance Regulation," Report to the 1985 General Assembly of North Carolina, Legislative Research Commission, Dec. 13, 1984. Findings and recommendations regarding financial regulation of insurance companies, insurance guaranty funds, and workers' compensation laws.

"A Glossary of Insurance Terms," Research Division, Legislative Services Office, N.C. General Assembly, no date.

General Reference Materials

"Auto Insurance," Craig Webb, United Press International, January 1984. This special five-part series ran in papers throughout the state and summarized the politics surrounding auto insurance.

Insurance Handbook for Reporters, A Practical Primer, Allstate News Bureau, Allstate Insurance Company & Allstate Life Insurance Company, Allstate Plaza, Northbrook, Ill. 60602, July 1979.

Insurance Facts, 1983-84 Edition, Property, Liability, Marine, Surety, Insurance Information Institute, 1983. A fact-filled handbook, essential.

Interim Report, Volume I and *Final Report, Volume II,* N.C. Commission on Prepaid Health Plans, Raleigh, N.C., 1979 and 1980, respectively.

The Invisible Bankers, Andrew Tobias, The Linden Press, Simon & Schuster, N.Y., N.Y., 1982. Book-length treatment of the insurance industry from a consumer perspective.

Motor Vehicle Laws of North Carolina, Ben F. Loeb, Institute of Government, University of North Carolina at Chapel Hill, 1984.

"The Report of the Advisory Committee on Competitive Rating to the National Association of Insurance Commissioners," published by the National Association of Insurance Commissioners, May 1980.

"Report of the Investment Income Task Force to the National Association of Insurance Commissioners," published by the National Association of Insurance Commissioners, June 1984.

"Risk... Reality... Reason... in Financial Services Deregulation, A State Legislative Perspective," Report of the Conference of Insurance Legislators Task Force on Regulatory Initiative, Senator John R. Dunne, Chairman, September 14, 1983.

"Servicing the Shared Automobile Insurance Market," Project Director J. Finley Lee, Julian Price Professor of Business Administration, University of North Carolina, August 1977.

Sharing the Risk: How the Nation's Businesses, Homes, and Autos Are Insured, Insurance Information Institute, New York, N.Y., March 1981.

"The Statistical Association between Past and Future Accidents and Violations," J. Richard Stewart and B.J. Campbell, The University of North Carolina Highway Safety Research Center, December 1972.

Insurance Organizations

Best's Reviews and Best's Weekly News Digest, A.M. Best Company, Oldwick, N.J. 08858. Publishes reports and weekly newsletters on life/health insurance and on property/casualty insurance.

Insurance Information Institute, 110 William St., New York, N.Y. 10038, (212) 669-9200. A trade association, supported by 250 property and liability insurance companies. Provides public relations services and publishes the annual yearbook, *Insurance Facts.*

Insurance Services Organization, 160 Water St., New York, N.Y. 10038, (212) 487-5000. Provides a wide range of services related to property and casualty insurance, from actuarial and statistical expertise to the development of policy forms and rate schedules.

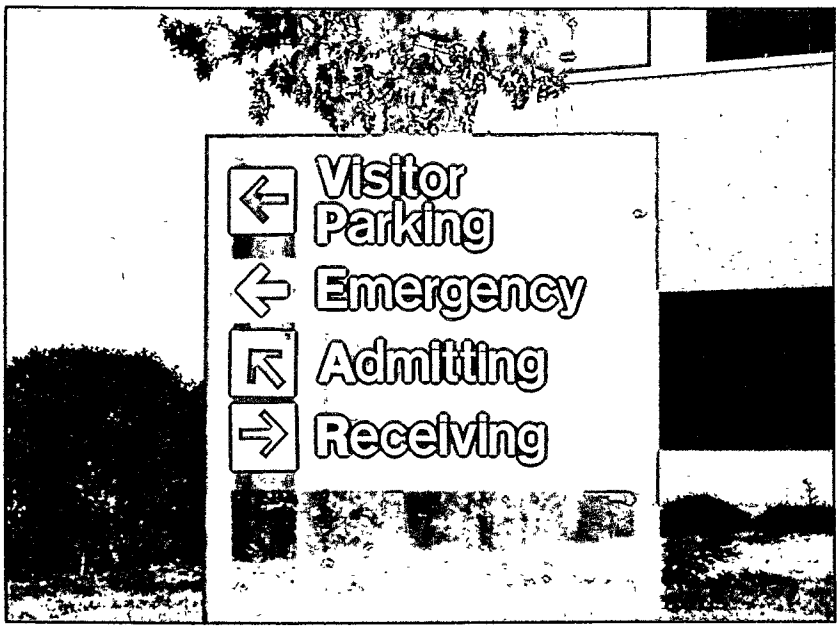
National Association of Insurance Commissioners, 1125 Grand Ave., Kansas City, Mo. 64106, (816) 842-3600. Does solvency surveillance of insurance companies, develops model legislation, sponsors major studies, and holds periodic conferences.

National Insurance Consumers Organization, 344 Commerce St., Alexandria, Va. 22314, (703) 549-8050. Provides various consumer-oriented services, primarily through the work of its director, Robert Hunter.

N.C. Insurance News Service, Lamar Gunter, Manager, P. O. Box 11526, Charlotte, N. C. 28220, (704) 372-3810, Stephen J. Bennett, Manager, P.O. Box 1801, Raleigh, N.C. 27602, (919) 832-9045. Publishes reference materials and news bulletins.

NOW Legal Defense and Education Fund, Marsha Levick, Legal Director, 132 West 43rd Street, New York, N. Y. 10036, (212) 354-1225. Sponsors litigation against using sex as a factor in the underwriting and sale of insurance policies.

Women's Equity Action League (WEAL), 805 15th St., N.W., Suite 822, Washington D.C., 20005, (202) 638-1961. WEAL monitors and reports on various insurance issues, particularly related to sex discrimination.



Carol Majors

Health Maintenance Organizations Arrive in North Carolina

What are Health Maintenance Organizations (HMOs) and where did they come from? What are the main differences in group practice and individual practice association HMOs? What are the advantages and disadvantages claimed by HMO supporters and skeptics? Specifically, do HMOs help hold down health care costs? Finally, what policy questions lie ahead for North Carolina policymakers and regulators? This article answers these questions in an effort to provide a primer on the HMO wave hitting the North Carolina health care scene.

by Robert Conn

Nearly five decades after it began in California, a prepaid approach to health care has finally taken hold in North Carolina and is growing rapidly. The approach is called a Health Maintenance Organization, HMO for short. HMOs aim at holding down costs while improving care. While critics have raised questions about whether HMO can adequately serve the entire population as well as traditional fee-for-service health care, HMO advocates point to the benefits for consumers, doctors, and businesses.

To the consumer, HMOs mean an end to nearly all medical claims forms, co-payments, deductibles, and other inconveniences Americans have come to expect in getting medical care. Instead, people who choose to become a member of an HMO pay a set monthly fee in advance for comprehensive primary health services—check-ups, routine tests, immunizations, treatment of illness and injury, and hospitalization.

Robert Conn, a reporter for The Charlotte Observer *and* The Charlotte News, *has covered health-related stories for more than two decades.*

To the doctor, HMOs reverse incentives, from an approach in which more service means more money to an approach in which income can increase as costs are held down. HMOs accomplish this by having doctors share in the financial risk when their patients get sick. In other words, doctors can benefit by working to keep their patients well.

To the businessman, HMOs offer a chance of stanching the hemorrhage on their company's profits caused by ever-rising health care costs. HMOs can dramatically lower the use of hospitals and perhaps paperwork as well.

The wave of HMOs hitting North Carolina has brought added responsibilities to state officials. The growth of HMOs poses a threat to some hospitals because HMO members use hospitals far less often than people with traditional health insurance. Health policy planners will have to incorporate the HMO model into their long-range planning. In addition, and more immediately, HMOs offer new challenges to the N.C. Department of Insurance, which has the responsibility for licensing and monitoring the operation of HMOs in this state.

Currently, at least six different HMO plans are operating around the state, several of them in more than one city (see box on page 62). North Carolina has one veteran HMO, called Winston-Salem Health Care Plan, which R.J. Reynolds has operated for its employees for years. In the last two years, several major national HMO organizations have come into the state. And there is talk of more.

In 1982, Blue Cross and Blue Shield (BC/BS) of North Carolina started the first publicly available HMO in North Carolina. Called the Personal Care Plan, it has signed up, in Forsyth County alone, 50 percent of the employees of Forsyth County, 45 percent of those at Piedmont Publishing Co., and 60 percent at Unique Furniture Makers. "We're averaging 30 to 35 percent," said John Sharp, executive director of alternative delivery systems for Blue Cross and Blue Shield of North Carolina. "Normally 10 to 12 percent is very good."

In 1984, HealthAmerica, the nation's largest independent, investor-owned, operator of HMOs, began functioning in the state. In seven months, it has signed up 17,800 members. Among employee groups, the participation rate has reached as high as 66 percent (Durham city employees, 820 out of 1,250).

Three other major groups have laid the groundwork—getting licensed, signing up doctors, preparing the administrative base, etc.—and are scheduled to begin serving patients in early 1985: Kaiser Permanente, PruCare, and Carolina Medical Care. By January 1, 1985, an estimated 36,600 North Carolinians were enrolled in the five HMOs open to the public.[1]

The growth of HMOs in North Carolina trails the national trend. From 1977 to 1983, membership in HMOs nationally more than doubled, from 6.3 million to 13.6 million.[2] By the end of 1983, 290 HMOs were in operation, according to an analysis by InterStudy, a Minneapolis-based health policy research organization. The report shows 48 metropolitan areas have at least four HMOs. Boston, Los Angeles, San Francisco, Providence, Anaheim, and Philadelphia have at least 10.

In California, HMOs claim 21 percent of the population as members, followed by 17 percent in Minnesota, 12 percent in Oregon, 11 percent in Wisconsin, and 10 percent in Arizona. Nationally, InterStudy projects 50 million HMO members by 1993. At least six national HMO organizations—Kaiser Permanente, Blue Cross and Blue Shield, HealthAmerica, Prudential, CIGNA, and Maxicare—are rated by experts as strong enough to go into virtually any new market with assurance of success.

The gains have come despite a shaky period in the 1970s, when a number of HMOs failed. Today, complete HMO failures are rare, thanks in part to tightening state and federal laws and tougher supervision by state insurance departments around the country. In addition, national HMOs have been willing, even eager, to assist and perhaps take over floundering local HMOs. Usually, these weak HMOs become sound under new management.

In 1980, for example, HealthAmerica, a for-profit organization, came to the rescue of Penn Group Health Plan in Pittsburgh. Founded in 1974 and in financial trouble by the late '70s, Penn Group required shoring up by millions in federal loans. HealthAmerica offered capital, management, and marketing expertise to Penn Group in exchange for a long-term management contract and an option to buy. Since then, Penn Group has grown from 19,000 to over 50,000 members, and HealthAmerica has moved to exercise its option to buy.[3]

In another example, Kaiser Permanente Medical Care Program has taken over the operation of several financially troubled HMOs, one in Washington, D.C., and one in Hartford, Connecticut, and made them successful. Since Kaiser Permanente rescued the Georgetown Community Health Plan in Washington, its membership has grown from 50,000 to 140,000.

Yet all HMOs do not survive. The Moshannon Valley Comprehensive Health Care Program, sponsored by Pennsylvania Blue Shield and Blue

Cross of Western Pennsylvania, stopped operating last July.[4]

Experts express concern that most states, North Carolina among them, have not yet geared up insurance department staffing to properly monitor HMOs. And there is a more fundamental concern.

"As the HMO achieves a more pivotal role in the nation's health care delivery system, the responsibilities of state regulators become more difficult and more important," says a report by Aspen Systems Corp. prepared for the Federal Bureau of Health Maintenance Organizations.[5] "Officials must be aware of the delicate balance between too much or inappropriate regulation that impedes HMO development and operation and too little regulation which may endanger HMO subscribers. Clearly, some regulation of HMOs is necessary and desirable to protect the consumer of HMO services from fraud or financial loss."

How HMOs Work — the Basics

The HMO movement began in 1929 with the Ross-Loos plan in Los Angeles, where physicians formed a group practice prepayment plan. It is still in existence today, as are two other early HMOs—the Kaiser Permanente Medical Care Program, founded in California in 1934, and the Group Health Association, formed in Washington, D.C., in 1937. Today, Kaiser Permanente serves 4.6 million members and is signing up members in North Carolina.[6]

Numerous variations have evolved on the basic HMO theme, but there are two broad types: the Group Practice Model and the Individual (or Independent) Practice Association (IPA). Both types of HMOs deliver comprehensive health services for a fixed prepaid monthly fee. Under both systems, HMO patients are guaranteed specified services regardless of how many times they see the doctor, and the doctor gets paid even if the patient rarely needs attention. Joining an HMO is always voluntary, and a person has a choice, annually, whether to change plans. An HMO, the group practice or IPA model, might be for-profit or not-for-profit, and either model could be part of a national chain or a local, independent organization.

Group Practice Model. Group practice HMOs provide out-patient services in one or several medical offices owned or operated by the plan. All primary care is provided in those facilities, which usually offer extended hours and essentially one-stop service. With group practice HMOs, patients have fewer choices of primary care physicians than with the IPA model.

Three of the groups now either operating or

What is an HMO?

A health maintenance organization provides comprehensive health care under a fixed, prepaid fee arrangement. Patients are guaranteed care for this price, regardless of how many times they visit the doctor. Doctors contract with the HMOs and usually have some financial incentives to help keep patients well. HMO models range from single clinic sites with staff physicians (where patients have a minimum of choice as to doctor) to arrangements where most doctors in the city can affiliate with an HMO (allowing most patients to keep their same doctor). HMOs fall into two general categories: the group practice model or the IPA (Individual Practice Association) model (see main article for more).

If HMOs are "federally qualified," they probably achieve added credibility. In past years, federally qualified HMOs also could receive federal financial assistance. To be federally qualified, an HMO must offer these minimum servcies:

- Physician services—including primary care doctors, consultants, and referrals.
- Inpatient and outpatient hospital services.
- Emergency services, both in and outside the HMO's service area.
- Diagnostic laboratory services.
- Both diagnostic and therapeutic radiology.
- Home health services.
- Preventive health services, including periodic health examinations for adults, well-child care from birth, pediatric and adult immunizations, family planning and infertility services, and eye and hearing exams for children.
- Health education.
- Medical social services.
- Mental health services, including up to 20 outpatient visits.
- Diagnosis, treatment, and referral for alcohol and drug addiction.

in the planning stages for North Carolina are following the group practice model. The California-based Kaiser Permanente Program which is non-profit, is starting a group practice HMO in the Raleigh-Durham-Chapel Hill area.

Called the Kaiser Permanente Medical Care Program, the HMO will initially provide primary care by developing their own medical group (probably only four doctors in the beginning). This for-profit group, called Carolina Permanente Medical Group, will be responsible for all professional services to the HMO members and for contracting with local physicians for specialty care. The group physicians work entirely with HMO members, who may choose their personal doctor among the group's physicians.

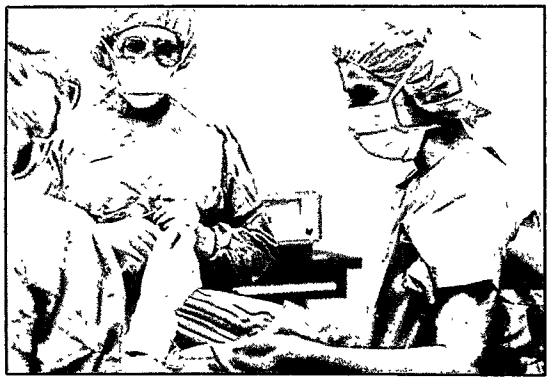
The Kaiser Permanente HMO will have enough doctors to take evening calls, said Alvin Washington, vice president and regional manager for the national Kaiser Permanente organization, and will contract with area specialists as needed. Eventually, the group will add specialists to the full-time staff and projects having 14 physicians by the end of 1985. Washington does not expect the group to operate a hospital, like some Kaiser Permanente units on the west coast, but rather to contract with existing community hospitals for in-patient care.

Another group practice model in North Carolina is PruCare of Charlotte, a subsidiary of the Prudential Insurance Company of America. PruCare is affiliating with the Nalle Clinic, a multispecialty group practice with more than 50 physicians at three sites. PruCare members will go to the Nalle Clinic for primary care, and for most specialty care.

The Winston-Salem Health Care Plan is an even more restrictive group practice arrangement. It uses a staff model with salaried physicians. It does make referrals for specialty care.

The Individual (or Independent) Practice Association (IPA). HMOs following the IPA model use existing primary care physicians who work in their own offices and continue to see their traditional fee-for-service patients. In most IPAs, the patient has a choice among participating primary care doctors—internists, family physicians, pediatricians, and sometimes obstetrician-gynecologists. Doctors may belong to more than one IPA group, as many have done in Charlotte. Three of the six HMOs in North Carolina are using the IPA model.

The Blue Cross and Blue Shield Personal Care Plan, the oldest IPA in North Carolina, has signed up about 900 physicians in the Research Triangle area, including primary-care doctors and specialists. So far, 15,000 people have enrolled as patients. The BC/BS plan has a similar track



record in Winston-Salem (140 doctors and 3,500 patients signed up) and in Charlotte (135 doctors and 250 patients).

A key element to the BC/BS HMO is its risk fund. Specialists agree to accept reimbursement from the plan as payment in full, with part of that payment going into a risk fund. If the program has a surplus, the doctors get back the money from the risk fund at year's end. In addition, doctors receive half of the year's overall surplus in the program, a further incentive to hold down costs.

The second IPA model to develop in the state is the HealthAmerica variation, where *primary care* doctors contract with the HMO. HealthAmerica refers to these physicians as the "gatekeepers" of the HMO members' health care needs. The primary care doctors determine when their patients need specialists and then arrange for that care on a fee-for-service basis. The primary care doctor has financial incentives to find a cost-effective specialist—one who offers the most appropriate care at the most reasonable cost. The specialist, for example, could charge more for his services but get the patient out of the hospital faster, making the overall bill lower than that from another doctor with lower fees. Unlike some IPAs, HealthAmerica does not restrict referral. Primary care doctors may use the services of any appropriate specialist.

The number of primary care doctors in HealthAmerica's network are: 41 doctors in 13 locations in Charlotte, 76 physicians in 26 locations in the Triangle area, 73 physicians in 32 locations in the Triad, and 28 doctors in 5 locations in Greenville, where the group began service in January.

The third IPA-type program is Carolina Medical Care in Charlotte, where primary care doctors will receive a fixed monthly fee. Specialists will be paid based on a set of uniform fees. All participating doctors will share in hospital savings. In all, 378 Charlotte doctors have joined Carolina Medical Care. When the overwhelming majority of a city's primary care doctors have

HMO Enrollment in North Carolina, January 1985

HMO	Location	Doctors	Enrollees
Blue Cross and Blue Shield of N.C.: Personal Care Plan	Triangle	900	15,000
	Winston-Salem	140	3,500
	Charlotte	135	250
	Greensboro	100	250
	Total	1,275[1]	19,000
Carolina Medical Care	Charlotte	128 (prim. care) 250 (specialists)	300
	Total	378	
HealthAmerica	Triangle	76 (prim. care)	6,300
	Triad	73 (prim. care)	8,900
	Charlotte	41 (prim. care)	1,300
	Greenville	28 (prim. care)	1,300
	Total	218 (prim. care)[2]	17,800
Kaiser Permanente	Raleigh	4 (prim. care)[2]	600
	Durham (March 1)	—	—
	Charlotte (July 1)	—	—
Pru-Care[3]	Charlotte	55	—
Statewide Totals		1,930[4]	36,600

FOOTNOTES

[1]This figure includes both primary care doctors *and* specialists. It includes medical school physicians who treat patients but not those who only teach or only do research.

[2]Both HealthAmerica and Kaiser Permanente do not plan to sign up specialists at the present. Kaiser Permanente will contract with specialists as needed; HealthAmerica expects its primary care doctors to arrange for specialty care as needed.

[3]As of mid-December, Pru-Care was still awaiting state approval, so had not enrolled anyone. The 55 doctors are members of the staff of the Nalle Clinic; only Nalle Clinic doctors will serve this HMO.

[4]The statewide total for doctors is artificially high, because many doctors in Charlotte, Winston-Salem, and Raleigh have signed up for more than one HMO.

Source: Telephone interviews by Robert Conn.

affiliated with an IPA, as is the case with Carolina Medical Care, the odds are great that a person can sign up for the IPA and go on seeing the same doctor.

Federal Regulations and State Responsibilities

The national corporations may use different models in different locales to suit the local situation. Blue Cross and Blue Shield has 57 HMOs nationally, with 1.8 million members. They include 8 staff models, 10 group practice models, and 39 that are classified under federal standards as IPAs, although 26 are variations.

Christina Bowesz of the federal office of HMOs points out that since federal law requires employers, if asked, to offer both an IPA and a group practice HMO, companies starting business against a dominant local HMO will nearly always opt for the other model.

The federal requirement stems from the HMO act, which Congress passed in 1973. The act encouraged the development of HMOs by providing money for new ones, overriding restrictive state laws, and granting federal qualification to any HMO that met specific requirements (see box on page 60). The 1973 law requires an employer of 25 or more persons to offer employees the option of joining an HMO *if*

the company provides conventional health insurance and if a federally-qualified HMO asks the company for access to the employees.

The Reagan administration has since eliminated the grants, but the rest of the program is intact. More and more HMOs, including most of those in North Carolina, say they are seeking federal qualification. Kaiser Permanente, for example, became federally qualified in the state, effective January 1985.

The entrance of HMOs into North Carolina came about as the direct result of the actions of the N.C. Commission on Prepaid Health Plans, which recommended the establishment of a nonprofit corporation to stimulate alternative health programs. The result was the N.C. Foundation for Alternative Health Programs, which not only has stimulated development of HMOs, but also encouraged other cost-cutting measures.[7]

Glenn Wilson of the UNC School of Medicine, who chaired the commission, is proud of another result—revision of the state's HMO act. He said the revisions made the act substantially better than the national model act proposed by the National Association of Insurance Commissioners.

North Carolina's HMO Act, Chapter 57B of the N.C. General Statues, is considered close to the national model HMO law, with some major exceptions. The law gives the N.C. Insurance Commissioner the job of granting HMOs a certificate of authority (i.e., a license to operate) and the task of monitoring their operations. The type and degree of monitoring depends in large part upon the skill of the Insurance Commissioner and his staff. The law allows for monitoring of virtually all aspects of an HMO operation, from its advertising to its contracts with doctors. The state law, unlike the federal law, does not, however, specify the minimum services an HMO must deliver.

Advantages of HMOs

In promotional literature, HMOs list at least five reasons why *employees* like HMOs:[8]

1. Comprehensive coverage that stresses preventive care. Because checkups, immunizations, and pregnancy care are provided under the single monthly fee, HMOs are far more comprehensive than traditional health insurance.

2. No hidden or surprise costs. The patient doesn't have to worry about taking a checkbook to the doctor's office, nor about deductibles or coinsurance.[9] Instead, HMOs turn medical care into a fixed monthly cost, rather than one of the scariest variables in a household budget.

3. Quality care. This claim is more difficult to document, and in fact is one area in which traditional health insurance companies challenge HMOs. But HMOs argue that since the primary care doctor becomes the patient's advocate in selecting specialists, higher quality specialists are chosen than when the patient is left to his own devices. In addition, HMOs point to their organized quality assurance system, a system that does not exist in most fee-for-service situations.

A recent American Medical Association study noted the difficulty in measuring quality, but found after studying HMOs, "The medical care delivered by the HMOs appears to be of a generally high quality." The comment is important because at one time, organized medicine opposed HMOs.[10]

In 1980, Dr. John Williamson of Johns Hopkins School of Hygiene and Public Health and one of his students analyzed 27 studies that compared care received by group practice HMO members with those in fee-for-service. In 19 studies, the quality of care in HMOs was superior, and in the remaining 8, it was rated as equivalent. None of the studies showed HMOs had lower quality. They concluded, "There is little question that facility-based HMO care [i.e., group practice] is at least comparable to care in other health care facilities, if not superior."[11]

4. No claims forms. They're not needed except in rare instances when a patient goes outside the prepaid system for a service that is included.

5. Guaranteed access to health care. A consumer always has a place to go—the HMO doctor. Under the traditional fee-for-service system, patients might have trouble finding a doctor.

The promotional literature says *employers* like HMOs because they:

1. Help control health care costs. Not only are hospitalization rates substantially lower than under traditional fee-for-service plans, but doctors are given incentives to increase efficiency and cut costs while maintaining quality of care.

2. Stimulate competition. The HMOs cite studies in New York, Minneapolis-St. Paul, Hawaii, and Rochester that show that traditional health insurance becomes more comprehensive when faced with HMO competition.[12]

3. Encourage good health habits, aimed at handling problems before they become expensive to treat. Because prevention is covered, members can justify annual physicals.

4. Reduce paperwork. They point to a hidden cost of most traditional insurance plans—the need for companies to have squads of clerks to cope with forms and claims and ques-

tions about coverage. Virtually all of this disappears with HMOs. Some national companies say those savings don't always hold, because they can deal with one insurance carrier nationally, while having to cope with a myriad of HMOs in each community.

Do HMOs Hold Down Costs?

The most important advantage claimed by HMOs is holding down health care costs. Though difficult to document, the evidence is mounting. "The evidence has been accumulating since the early 1960s that the out-of-pocket costs are significantly lower for persons involved in group practice HMOs than for persons with traditional health insurance," said Glenn Wilson of UNC.

... HMOs stress going to the doctor at the first sign of illness rather than waiting until you have to ...

All three major automakers now claim HMOs are saving them money. According to a report in *Business Insurance,* Ford Motor Co. says the 23 HMOs it offers employees will save it $7 million this year over the traditional health plans. The premiums are 16 percent less than those from traditional insurers, according to Ford officials. Last year, Ford documented $5 million in savings. Ford is planning to add HMOs in Florida, primarily for its retirees.[13]

According to *Business Insurance,* Chrysler is so supportive of its 12 HMOs that it gave away $50,000 to HMO members who signed up non-members, at the rate of a $50 savings bond for an individual, $100 bond for a couple, and $250 bond for a family. Delores McFarland, benefits administrator for General Motors, estimates GM's savings in the millions.

Other companies, like American Telephone and Telegraph and International Business Machines Corp., aren't so sure they save money, and are still studying the question.

Meanwhile, long-term research studies add to the evidence. The most convincing is a study by the prestigious Rand Corporation recently published in the *New England Journal of Medicine.*[14] This study represents a distinct departure from previous ones, because freedom to choose an HMO was eliminated. Healthy patients who had been getting traditional fee-for-service care were randomly assigned to continue fee-for-service care or go to an HMO. The HMO was the Group Health Cooperative of Puget Sound (GHC), a 37-year-old HMO in Seattle that has an enrollment of 324,000 people—roughly 15 percent of the Seattle-area population. The results were compared to a control group of regular GHC members. Under this study design, the Rand Corporation compared HMOs to fee-for-service systems while both were serving comparable populations with comparable benefits. The results were striking.

The rate of hospital admissions in both GHC groups was just over 8 for every 100 patients, about 40 percent less than in the fee-for-service group, which averaged nearly 14 admissions for every 100 patients. Overall health expenditures were about 25 percent less in both GHC groups ($439 per year in the GHC experimental group, $469 per year in the GHC control group) than in the fee-for-service group ($609 per year). But visits to the doctor's office occurred at roughly the same rate in both groups—a little over four visits per year.[15]

The two GHC groups turned out to be similar in the mix of health risks, which suggests there is no substantial difference between people going for traditional medical care and those who choose HMOs. The Rand team notes the overall results were in line with previous studies showing HMOs had 10 to 40 percent fewer hospitalizations than fee-for-service physicians. The Rand study concludes, "The style of medicine at prepaid group practices is markedly less 'hospital intensive' and consequently, less expensive."

An editorial in the same issue by a well-known expert on health care costs, Dr. Alain Enthoven of Stanford University, noted that about 40 comparison studies have been done. They found that prepaid group practices reduce per capita costs some 10 to 40 percent, "largely as a result of a 25 percent to 45 percent reduction in hospital use. Although these findings have been replicated in many different employee groups and in studies that controlled for age and sex and sometimes tested for measurable differences in

The Latest Wrinkle in Health Insurance: Preferred Provider Organizations

In a nutshell, preferred provider organizations—PPOs—agree to provide service to a specific pool of individuals, usually from an employer or group of employers, at a previously agreed fee. The individual can continue to go to doctors who don't participate in the PPO, but the plan usually pays a larger share of the bill if the patient goes to the PPO. The key is the discounted fees.

According to a report from the N.C. Medical Society, "This concept is attractive to the employers as a means of identifying cost-effective providers for their employees."

Three PPOs are in operation in North Carolina: the Triad Physicians Health Care Plan in Forsyth County, Health Point Preferred in Forsyth County, and Med-Select of Guilford County.

There's a question whether preferred provider organizations can or should be regulated, because they are still based on fee-for-service. Some argue they are sufficiently like HMOs to be regulated like HMOs. Regulation of PPOs is currently being debated around the country. They are not regulated in North Carolina.

FOOTNOTE

[1]"Alternative Delivery Systems in North Carolina: A Status Report," published in the *N.C. Medical Society Bulletin,* August 1984. This four-page report includes a glossary and a chart outlining the various components of four HMOs and three PPOs.

health status," he said, "the suspicion has always remained that somehow these savings might be explained by a self-selection of healthy people for membership in group practices."

Enthoven concluded the *New England Journal* editorial by emphasizing the practical implication of the Rand study: "The conclusion is now well established: the lower cost at GHC and others like it cannot be explained by differences in the population it treats."

The studies keep emerging, many of them focusing either on lower hospitalization rates or lower surgery rates—with both types addressing the overall issue of lower costs through HMOs. In Wisconsin last year, for instance, hospital admissions under the standard health plans averaged 124 for every 1,000 members, compared to 80 for Madison-area HMOs, and 83 for Milwaukee-area HMOs.[16] Sidney Wolfe, director of Public Citizen's Health Research Group, cites studies showing the number of operations performed is less under HMOs than under fee-for-service.[17] One study showed fee-for-service patients had 1½ times as many hernia operations, twice as many hysterectomies, gall bladder operations and appendectomies, and four times as many tonsillectomies.

Another cost-saving factor in all types of HMOs is prevention. Doctors try to head off illness through immunization, by promoting lifestyle changes, and by catching a disease early when it is still inexpensive to treat. This means, in contrast to most standard health insurance plans, that physicals and immunizations are free. Hence, HMOs stress going to the doctor at the first sign of illness rather than waiting until you have to go. Preventing illness may mean fewer employee absences, a hidden benefit of HMOs. The test is in the success of prevention. Early detection of clogging arteries may help doctors head off heart attacks and strokes. Indeed, one major crippling stroke easily could cost more to treat than the cost of annual physicals in an HMO with 1,000 members.

The American Medical Association's Council on Medical Services sums up the cost-saving issue: "HMOs appear able to provide care for their members at a lower total cost (premiums plus out-of-pocket) than most other health care delivery and financing systems."

Disadvantages of HMOs

Critics of HMOs include among their list of disadvantages the areas outlined below. Some often-stated disadvantages of HMOs are disappearing as laws and regulations change.

1. HMOs save money by enrolling younger, healthier people who don't need much care—a practice known as skimming the cream. People who already are sick are reluctant to change doctors in midstream. A switch to an HMO often requires a shift in doctors because the family

doctor isn't affiliated with the HMO.

Large corporations who have studied the matter challenge the cream skimming thesis. Xerox Corp. officials now believe, according to *Business Insurance,* that those who have had illnesses or anticipate hospitalization are more likely to join HMOs.

HMO officials say they can do little to influence selection. Most employers offer the choice of HMO or traditional health insurance to every employee, regardless of whether they are sick.

While the Rand study found no difference between these groups, the *New England Journal of Medicine* editorial took both sides. "In some Medicare experiments, it appears that the beneficiaries who were more willing to change doctors and join a prepaid group practice were those who had not been sick recently," said the editorial. "On the other hand, if the fee-for-service insurance plan has sizable coinsurance or deductibles or poor coverage of office visits, patients with chronic conditions will be attracted to the comprehensive coverage offered by a prepaid group practice."

2. HMOs fail to serve the elderly, whose medical expenses are often highest. If this has been true in the past, it is rapidly changing. Under the latest Medicare regulations—the so-called TEFRA Act, which is expected to take effect by year's end—Medicare recipients in areas where there are HMOs will get the chance to choose an HMO for medical care. This has the potential for opening up the large Medicare market to rapid penetration by HMOs or competitive medical plans. Margaret Heckler, Secretary of Health and Human Services, predicts 600,000 Medicare recipients will sign up with HMOs in the next three to four years.[18] Besides, some HMOs, such as HealthAmerica, already enroll Medicare members who have retired from a participating employer.

3. HMOs fail to serve the poor and medically indigent. Growing numbers of Medicaid recipients across the country are getting the chance to sign up with broad, community-based HMOs. All HMO members have access to the same care, whether their monthly fee is paid by an employer, Medicare, or Medicaid. (In the 1970s, some HMOs were made up predominantly of poor people, which meant services were not as comprehensive.) California has found that it costs 17 percent less to enroll low-income people in HMOs than it does to pay for care under its Medicaid program, MediCal. Furthermore, state officials say audits show the quality of care for low-income people is higher with HMOs than fee-for-service.

Barbara Matula, director of the N.C. Division of Medical Assistance, which oversees the Medicaid program, said, "We're ready to go once the HMOs are ready. We've had authority to buy in from the General Assembly, and approval from the [federal] Health Care Financing Administration to do it."

People who are already sick are reluctant to change doctors in midstream.

4. Patients don't have much choice about what's done to them. The primary care doctor, not the patient, often chooses the specialist. Sometimes, the HMO is so small that there's no choice at all, which means the HMO patient has little to say about which doctor operates on him or which specialist treats his most severe illnesses. "You often are not told what your options are," said Clark Havighurst of Duke University. "The HMO doesn't hospitalize as often, and that means you may be deprived of hospital care without it being offered to you. The HMO does what it thinks is best."

5. Doctors may stop treating patients when the money runs out. There's no evidence that happens, according to a number of experts, who cite both the quality of care studies and the studies showing that malpractice suits occur at about the same rate among HMOs as they do in fee-for-service.[19]

6. A number of HMOs have collapsed. This threatens patients with loss of medical care despite having paid for it. Anthony Buividas, a consultant for Carolina Medical Care from the American Health Management and Consultant Corp., said most HMOs that failed have been poorly managed. They made inadequate projections of expenses on which to base premiums. Sometimes, they simply didn't achieve the membership projected, or fell short of the break-even point, he said. Recent changes in the model law, largely adopted in North Carolina, attempt to head off any questions of insolvency.

7. HMOs are corporate practice of medicine. That charge has been leveled against HMOs from the beginning. But the argument probably

is not nearly so strong in North Carolina as it is elsewhere, because most HMO members in North Carolina belong to IPAs. Consequently, doctors are treating their HMO patients alongside traditional fee-for-service patients. Even doctors belonging to some group practice HMOs, such as PruCare, will continue to have fee-for-service patients.

The AMA's study found, "Some HMO members do express dissatisfaction with the perceived lack of personal physician-patient relations . . . . However, members generally appear to find the system more acceptable as they become used to it and balance 'impersonality' against availability of technical expertise and the HMO's perceived financial advantages."

But Havighurst is concerned that IPAs are too close to organized medicine, that often IPAs are formed under the auspices of the local medical society or by doctors who have been in medical society leadership. "Some of these plans were created to scare off other HMOs," he said.

Currently, N.C. law does not speak to this issue explicitly.

What Policy Questions Are Ahead?

In the months ahead, the state is likely to see increasing competition among HMOs, as they reach out to most employers in the state, as they seek a hand in treating the huge number of state employees, as they go after Medicare and Medicaid business. Furthermore, most HMO officials say the HMOs themselves do better when they compete, with increasing percentages of the population becoming involved with HMOs. One critical job of the state Department of Insurance is to make sure that competition is fair. But what does "fair competition" entail, as a practical matter, when it comes to state regulation, monitoring, and oversight? As the Department of Insurance begins coping with the HMO boom coming to the state, seven major policy questions will have to be addressed.

1. What should the Insurance Department do to properly monitor HMOs? HMOs are regulated by insurance departments in nearly every state.[20] The theory is that HMOs are like insurance companies because people buy care for a specified period of time. In some states health officials also are involved, particularly in examining quality of care. In North Carolina, the Department of Human Resources was involved in monitoring HMOs under the original HMO statute, passed in 1977.[21] In 1979, the legislature placed this responsibility under the Insurance Department.

Today, the Insurance Department appears more prepared for the licensing function than for other responsibilities regarding HMOs. Gordon Church, general manager of HealthAmerica of North Carolina, found the Insurance Department staff members "very thorough" in their review of the firm's application for a license to operate in the state. The license period took from September 1983 until March of 1984, a period more extended than in Virginia, Louisiana, and Alabama where HealthAmerica applied at about the same time.[22]

"In each case, the licensure process was less extended than it was here in North Carolina," Church said. But he added that the Nashville-based HealthAmerica was the first national organization to establish an HMO in this state.

Many analysts point out, however, that the key national problem is lack of adequate staffing in insurance departments trained to monitor HMOs, *once licensed.* People both in and out of state who had looked at the North Carolina law and the N.C. Department of Insurance repeatedly echoed that concern.

"The whole health end of the Insurance Department's staff need to be beefed up," said Jim Bernstein, president of the N.C. Foundation for Alternative Health Programs. The department has been too laissez-faire in the past on health matters, he said. But now, with HMOs, the health end is "taking on such importance it needs a whole bunch of new people."

The new Insurance Commissioner needs to add first class staff both to the HMO side and the health insurance side, continued Bernstein. Staffers "don't know things they should know." For one thing, no one knows the people who have been carrying health insurance and drop it because of a rate increase. "I see a real problem in a rural state with people going bare or with so little insurance it is meaningless."

Under the law, the N.C. Insurance Department has to review quarterly financial statements by HMOs, approve rates and changes in benefits packages, and approve advertising. Erling

Hansen, general counsel of the Group Health Association of America, the organization for Group Practice HMOs, said under present law, the N.C. Insurance Commissioner "does have sufficient authority to keep fly-by-night operations out of the state."

But he warned that as HMOs become successful in North Carolina, the state may see "an influx of less esteemed operators. It has happened around the country." Insurance Department staff members must be ready to cope with such HMOs, he said. Many states are "beefing up the quality and size of the HMO regulatory staff," added Hansen. In states like North Carolina, where HMOs are just beginning, understaffing is common.

The two really critical issues, as Hansen sees it, are the continuing financial solvency of the HMO and the protection of HMO members in the event of HMO failure so patients won't be billed for care they have not received.

Christina Bowesz of the federal office of HMOs said that many states have ineffective systems "to do the work that the statutes require." Oftentimes, state insurance examiners "don't know how to examine HMOs." Bowesz cited California, Illinois, New York, and Texas as states where HMO staffers are the best, and the most technically knowledgeable.

2. Should states monitor quality of care in HMOs? The question is explosive. To Hansen and other HMO defenders, the issue really boils down to equity—what does the state do to monitor quality in the fee-for-service sector of health care? "We should be regulated in an equivalent manner," said Hansen. "The industry believes that the quality of care in an HMO setting is equivalent to, if not better than, the fee-for-service sector."

The Institute of Medicine found no evidence that HMOs have provided a poorer quality of care than other components of the health care system, nor did the Johns Hopkins or AMA studies.

Federally qualified HMOs are required to have a quality assurance program. A state might consider whether similar standards should be established for HMOs that are not federally qualified. However, this raises the interesting question: Would the quality assurance program apply only to the IPA patients of doctors who see both IPA patients and fee-for-service patients?

3. Are major changes needed in the state HMO Act? Few people think so. Wilson, who chaired the N.C. Commission on Prepaid Health Plans, said the N.C. law is better than the national model law, because it focuses on fiscal responsibility, on meaningful contracts ("so HMOs deliver what they say they will deliver") and on honest straightforward information on rates and benefits. The national model law attempts to mandate measurement of health status and "nobody knows how to do that."

"My preference is for a fairly flexible law," said Bernstein, "and a first class administration of the law by the Insurance Commissioner."

National experts agree that the N.C. law is a good one. Erling Hansen said the law is not only good for monitoring HMOs but also is "good from the consumer standpoint."

4. Should there be minimum services required under state laws or regulations? There are no minimum standards now under the state law—certainly nothing like the list of minimums required under federal law (see box on page 60). Virgil Marsh, manager of alternative delivery systems for the national Blue Cross and Blue Shield Association, pointed out one important twist to requiring minimum services. Many insurance departments have a political connection, he said. State regulators who insist that HMOs must cover a broad range of services may be doing so to make the HMOs noncompetitive with traditional insurance plans. For instance, several states have recently attempted to require HMOs to cover prescription drugs, a step that could cause HMOs financial hardship. Then companies who support the commissioner could keep the bulk of the business. The issue is complicated, especially when linked with mandatory "dual choice" (see number 5 below).

5. Should state law be amended to require "dual choice"? Dual choice means that employers

Recommendations on HMOs

1. Supervision of Health Maintenance Organizations should remain within the Department of Insurance. Staff should receive increased training to deal with the vastly increased business expected. A task force should be appointed to determine whether enough appropriate statistics are being kept and whether department staffers are being properly trained.

2. The state should negotiate with some or all HMOs to enroll Medicaid recipients.

3. The state should quickly move to offer HMOs to all state employees, perhaps using the equal pricing system.

4. Private employers should pay the same premium to each available health-care option—HMOs and traditional health plans.

who offer health insurance must in addition offer HMOs, if the HMO asks to be offered. The federal HMO law already requires such choice (if 25 or more employees)—if the HMO meets the federal qualifications. Indeed, that's a major incentive for HMOs to become federally qualified.

But the issue is a tricky one, because of the lack of minimum services for state HMOs. HealthAmerica's Church said that "dual choice may be helpful, if the state law is amended." If a new state law does require dual choice, however, added Church, it must include a minimum benefits package, and that might make it tough to regulate.

Others argue strongly against dual choice, saying it removes the flexibility of HMOs to compete with traditional health insurance. A special industry advisory committee, for instance, recommended against the mandated approach.

The issue may be moot, anyway, since HMOs are reluctant to use the law to force an employer to give them access to employees. A business could bow to the law and permit the HMO to come in, while quietly sabotaging the HMO effort. "I used to think mandatory dual choice was important," said Wilson. "Now I wouldn't worry about it."

Instead, most HMOs seek federal qualification because it amounts to a federal seal of approval. But Hansen pointed out that some of the nation's best HMOs—including the Group Health Cooperative of Puget Sound, the one studied by Rand—are not federally qualified.

6. Should employers (or the government) pay an equal amount for each available health plan option—traditional health insurance, group practice HMO, or IPA—with employees picking up the difference? According to the Rand research team, many employers are actually paying more for traditional health insurance than they would for HMOs. "If employers did pay an equal sum, price competition between HMOs and fee-for-service insurance plans could well increase."

In Wisconsin, the state decided on that approach for state employees, beginning in October 1983, and the percentage of state employees opting for HMO coverage jumped from 15 percent to 66 percent. In Dane County (Madison) this year, the state pays $67.72 a month for individuals and $169.34 for families for health care, whether an employee chooses an HMO or the traditional insurance plan. But health insurance costs $76.33 a month for singles and $188.16 for families, which means single employees must add $8.61 a month and families pay $18.82. All the HMOs are cheaper, and one asks for nothing from employees.

The new arrangement was not successful everywhere in Wisconsin, however. In Milwaukee County, most of the HMOs were more expensive than health insurance, and the majority of state employees stayed with the standard health insurance.[23]

7. Should the state Medicaid program provide HMOs as alternatives to traditional care? The crux of the argument for HMOs is their effort to prevent illness, to find disease early, and to deliver a package of health care services efficiently. Traditionally, because poor people could not afford routine medical care, they waited to seek help until the problem was severe. That often meant visits to hospital emergency departments—one of the most expensive ways to get care—and long hospitalizations.

But states increasingly are using HMOs to try to hold down Medicaid costs while encouraging Medicaid recipients to get substantially better medical care. In Wisconsin, contracts have been signed with many HMOs to permit Medicaid patients to sign up. Enrollment is expected to reach 10,000 in Madison and 30,000 in Milwaukee by 1985. But Glenn Wilson points out that such an arrangement doesn't begin to deal with poor people who don't qualify for Medicaid.□

FOOTNOTES

[1]Figures based on telephone interviews by the author; see the chart that details where these people are enrolled.

[2]From "HMO Status Report, 1982-83," published by InterStudy, the Minneapolis-based Health Policy Research Organization. These figures also are summarized in the Sept. 28, 1984, *American Medical News*, which also includes a useful U.S. map showing state-by-state percentages of the population enrolled in HMOs. Blue Cross and Blue Shield publishes similar figures, showing national enrollment in all HMOs of 12.4 million in June 1983, of which nearly 1.4 million were in Blue Cross HMOs. By June 1984, Blue Cross HMO enrollment was nearly 1.8 million; total HMO national figures weren't available. (See footnote 4 for more on resources available from Blue Cross and Blue Shield.)

[3]See the extended discussion of the Penn Group Health Plan in HealthAmerica's 1983 Annual Report, page 8.

[4]"Blue Cross and Blue Shield Plan Activity in Health Maintenance Organizations, 1984 Mid-Year Report," a publication of the National Marketing Division of Blue Cross and Blue Shield Association in Chicago, page 10, contains a wealth of information on HMOs run by Blue Cross and Blue Shield, including overall enrollment, summaries on numbers by type of HMO, top ten HMOs by enrollment, by growth, by sponsor, as well as detailed information on each Blue Cross HMO.

[5]From the sixth edition of "A Report to the Governor on State Regulation of Health Maintenance Organizations," prepared by Aspen Systems Corp. for the Bureau of Health Maintenance Organizations and Resources Development of the U.S. Department of Health and Human Services, page 6. This report includes 12 major charts giving dozens of state-by-state comparisons, from whether a state requires consumer representatives on HMO boards to the size of required cash reserves to financial reporting requirements. It was prepared under the direction of Karen S. Greenwood, J.D., editor, HMO Law Manual.

[6]See the extended discussion of the history of HMOs in the "Kaiser Permanente Medical Care Program Annual Report 1983, a 50-year perspective on American Health Care," pages 7-24.

[7]See *Interim Report, Volume I* (1979) and *Final Report, Volume II* (1980), N.C. Commission on Prepaid Health Plans. The N.C. General Assembly created this commission in 1978 (see Chapter 1291 of the 1977 Session Laws, 2nd Session).

[8]See, for instance, the promotional literature put out by PruCare.

[9]Deductible is what you have to pay before insurance pays anything. Under many plans, that may be $100, or even $500. Coinsurance is the portion of the bill you have to pay once beyond the deductible. Under many plans, insurance pays 80 percent of the doctor's bill and you pay the other 20 percent.

[10]See the executive summary to "Health Maintenance Organizations," a 1980 report from the American Medical Association's Council on Medical Service. The main 183-page report studies 15 HMOs (5 IPAs, 5 group practice models, and 5 staff models), looking at numerous measures of performance, including cost of care, quality of care, and accessibility of care. There is also the formal report to the AMA's House of Delegates.

[11]From "The HMO Approach to Health Care" in the May 1982 issue of *Consumer Reports,* monthly magazine of the Consumers Union, which cites and details the 1980 Johns Hopkins study.

[12]From HMO promotional literature.

[13]See "HMOs, A Decade of Growth," *Business Insurance*, Dec. 19, 1983. Besides giving the figures from the automakers, the 10-page report says that employers find few gripes about HMO performance. The report also describes the various forms of HMOs, the advent of PPOs, and how the government has nurtured the growth of HMOs.

[14]"A Controlled Trial of the Effect of a Prepaid Group Practice on the Use of Services," by Willard G. Manning and five other members of the Health Sciences Program of the Rand Corp., *New England Journal of Medicine*, Vol. 310, No. 23, June 7, 1984, page 1505.

[15]The experiment was actually a bit more complex than that. From the report: "We compared four groups. The first three were samples of the Seattle-area population who were not enrolled in GHC in 1976.... Participants in the first two groups were assigned to plans that covered virtually all health services from fee-for-service physicians and ancillary personnel, such as speech therapists. In the first group, the services were provided at no cost to the participant; this plan is referred to as the 'free fee-for-service plan'." (Many N.C. employers now pay for health insurance for employees, and that insurance may cover virtually all costs—so this group is an important one.)

"In the second sample, participants had to share the costs of their medical care. They paid 25 percent or 95 percent of their medical bills, subject in most cases to a limit on out-of-pocket expenditure of up to $1,000 per family (less for the poor)...."

"Participants in the third group, the GHC experimental group, received free services at GHC.... The fourth group... was a random sample of GHC members in 1976 who otherwise met the eligibility requirements... and had been enrolled in the cooperative for at least one year."

Not surprisingly, once patients started paying for a hefty chunk of their bills, their admission rates dropped. Those paying 25 percent of their costs averaged 10 hospital admissions per year, though their bills average $620 per year; those paying 95 percent of their costs averaged $459 per year.

[16]"HMO Competition for Wisconsin's State Employees," by John Luehrs and Dale Hanson, *Business and Health*, September 1984, page 39.

[17]"Rating our Health Care Systems: You're better off with a health maintenance organization," by Dr. Sidney Wolfe in *Public Citizen.*

[18]See, for instance, the discussion on how new regulations open HMOs to Medicare beneficiaries in the Federation of American Hospitals Review, July/August 1984, page 9.

[19]The AMA analysis, for example, says, " 'Underutilization' has been suggested as a potential drawback of HMOs, resulting from their emphasis on cost-effectiveness. However, nothing in the literature indicates that HMO savings result from enrollees receiving less care than they need...."

[20]Aspen Systems Corp. report, page 6, see footnote 5.

[21]See NCGS 57A (now repealed) and Session Laws, c. 580, s. 1 (1977).

[22]HealthAmerica has introduced group practice model HMOs in these three states.

[23]For a complete comparison of the five HMOs in Dane County and the five HMOs in Milwaukee County, see "HMO Competition for Wisconsin's State Employees," by John Luehrs and Dale Hanson, *Business and Health*, Sept. 1984, page 37ff. Only one HMO, CompCare, is in both counties. Luehrs is senior staff associate for health policy studies with the National Governors' Association, and Hanson is deputy secretary in the Department of Employee Trust Funds for Wisconsin.

Other Resources on HMOs

In addition to the sources cited in the footnotes above, *Business Insurance* (December 19, 1983) lists these resources:

"Employer Attitudes toward Health Maintenance Organizations," available from the Division of Private Sector Initiatives, Office of Health Maintenance Organizations, Department of Health and Human Services, Rockville, Md. 20857.

The Group Health Association of America, Inc., the HMO trade association, has booklets and a library of HMO publications, Suite 700, 624 Ninth St., N.W., Washington, D.C. 20001.

"A History of Achievement, a Future with Promise," a report of the HMO industry produced by the National Industry Council for HMO Development, available from the Council at 5600 Fishers Lane, Room 17A55, Rockville, Md. 20857.

The National Association of Employers on Health Care Alternatives has booklets available at 1134 Chamber of Commerce Building, 15 S. 5th St., Minneapolis, Minn. 55402.

"The 1983 Investor's Guide to Health Maintenance Organizations," available from the Division of Private Sector Initiatives, Office of Health Maintenance Organizations, Department of Health and Human Services, Rockville, Md. 20857.

"The 1983 National HMO Census," which includes data through June 1983, is available through InterStudy, 5715 Christmas Lake Road, P.O. Box S, Excelsior, Minn. 55331, at a cost of $20. The annual census for 1984 should be available shortly.

ARTICLE II

A Guide to the 1985-86 North Carolina Legislature . . .

If you've seen any of the first four editions of *Article II*, you know what we're talking about. If you haven't, this is your opportunity to discover an interesting and informative publication designed for . . .

WHO?

For every concerned citizen who wants information about the members of the 1985-86 General Assembly . . . for journalists, lobbyists, students, librarians, educators, politicians, attorneys, business and industry leaders, government workers, and legislators.

WHAT?

The fifth edition of the Center's unique and comprehensive guide to the North Carolina Legislature. Each legislator's entry includes:

- Important addresses and telephone numbers
- Counties represented
- Education and occupation
- Committee assignments in 1985
- Selected bills introduced in 1983 and 1984
- Votes on 15 important issues during the 1983-84 session
- A rating of his or her effectiveness in the General Assembly compiled from surveys of legislators, lobbyists, and capital correspondents.

WHY?

Because essential information about state senators and representatives is hard to get. Some of this material is available elsewhere, and some is not. But *no* other single source has so much data about North Carolina legislators for quick reference and continual use . . . and no other source gives you an indication of each legislator's clout in the General Assembly.

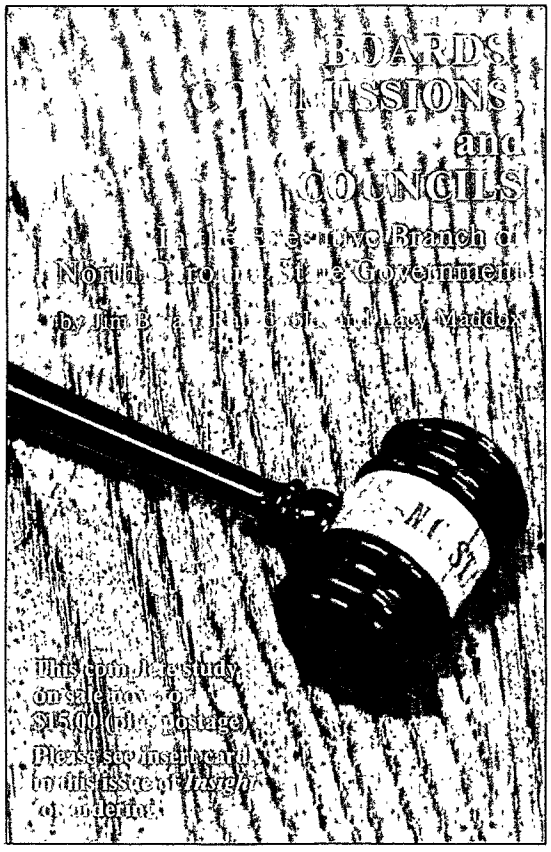
WHEN?

Article II will be published in the spring while the legislature is still in session, so you can use it to contact your legislator. The General Assembly convenes February 5; order your copy now to receive it early.

HOW (MUCH)?

$6.00 (plus postage and handling)

Please see insert card in this issue of *Insight* to order.



GRANT-SEEKING IN NORTH CAROLINA

A Guide to Corporate and Foundation Giving

by Anita Gunn

A must for everyone in the state seeking up-to-date information on North Carolina philanthropy

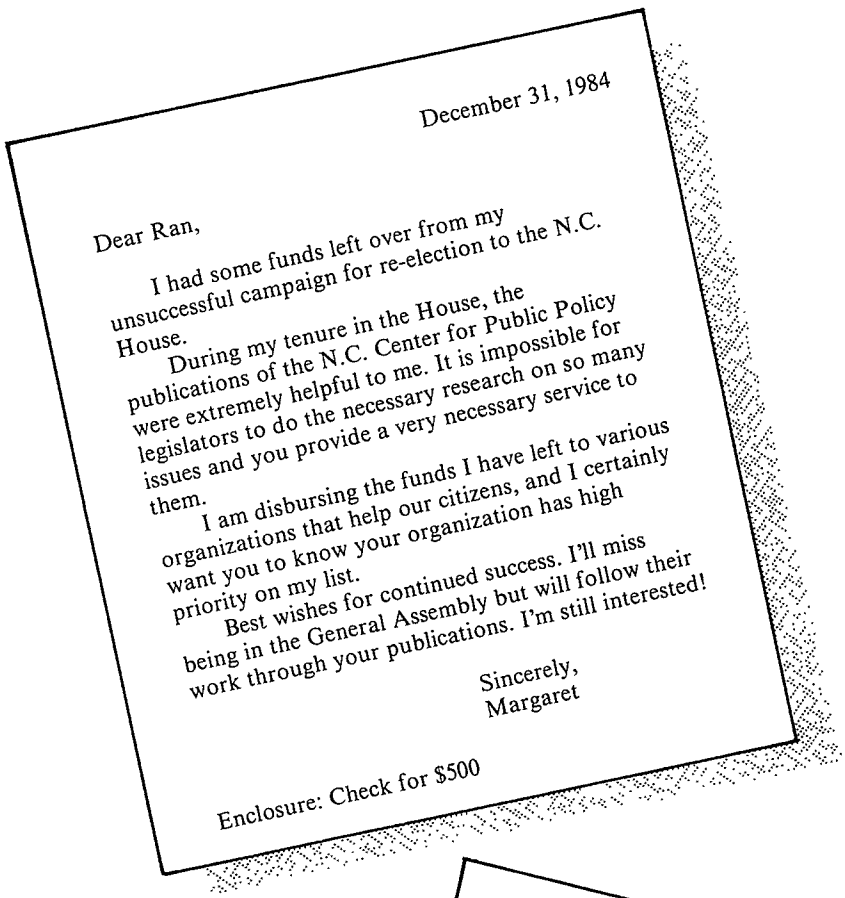
- *Giving programs and priorities of 605 foundations
- *Giving patterns of 81 North Carolina corporations
- *Details include contact persons, financial data, history, and application procedures
- *Result of 18 months of research

The complete study available in March

$35.00
Please see insert card in this issue of *Insight* to order

"Thanks, We Hope This Catches On . . ."

Two recent letters to the N.C. Center for Public Policy Research show new ways North Carolina citizens are supporting the Center's work. The letters came to Center Director Ran Coble from former N.C. Representative Margaret Tennille (D-Forsyth) and Greensboro attorney McNeill Smith. They are reprinted, with permission, below.



December 31, 1984

Dear Ran,

I had some funds left over from my unsuccessful campaign for re-election to the N.C. House.

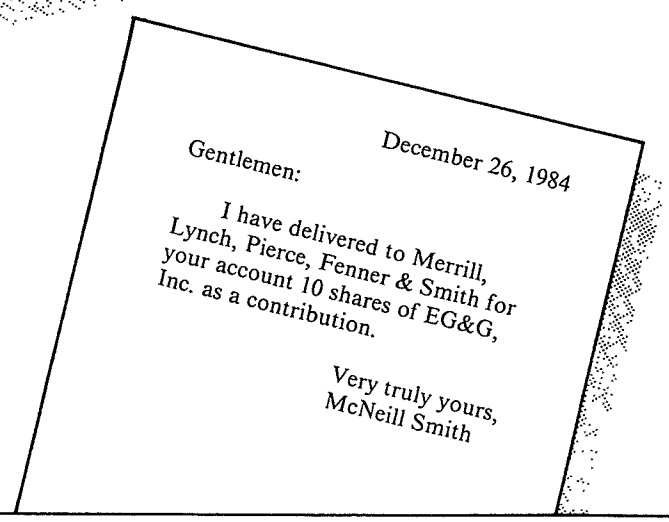
During my tenure in the House, the publications of the N.C. Center for Public Policy were extremely helpful to me. It is impossible for legislators to do the necessary research on so many issues and you provide a very necessary service to them.

I am disbursing the funds I have left to various organizations that help our citizens, and I certainly want you to know your organization has high priority on my list.

Best wishes for continued success. I'll miss being in the General Assembly but will follow their work through your publications. I'm still interested!

Sincerely,
Margaret

Enclosure: Check for $500



December 26, 1984

Gentlemen:

I have delivered to Merrill, Lynch, Pierce, Fenner & Smith for your account 10 shares of EG&G, Inc. as a contribution.

Very truly yours,
McNeill Smith

Contributors to the N.C. Center for Public Policy Research

The North Carolina Center for Public Policy Research wishes to express a special word of appreciation to the foundations and corporations that supported the Center's efforts during 1984. Their help made it possible for the Center to produce quality research on important public policy issues facing the state.

Major funding for the North Carolina Center during 1984 was provided by:

THE MARY REYNOLDS BABCOCK FOUNDATION

THE Z. SMITH REYNOLDS FOUNDATION

THE KATE B. REYNOLDS HEALTH CARE TRUST

and

THE HENRY J. KAISER FAMILY FOUNDATION

Corporate support for the Center's work was provided by:

PATRONS

Burlington Industries, Inc.
Knight Publishing Company
Universal Leaf Foundation
Carolina Power and Light Company
Southern National Bank
AT&T Technologies
Burroughs Wellcome Company
Hardee's Food Systems
Lowe's Charitable and Educational Foundation
NCNB Corporation
Stedman Corporation
Unifi, Inc.
Wachovia Bank and Trust Company
Theo. Davis Sons, Inc.

SUPPORTING CORPORATE

Ciba-Geigy Corporation
Epley Associates, Inc.
IBM Corporation
Northwestern Bank
Weyerhaeuser Company
MasterPrint

CORPORATE CONTRIBUTORS

Northern Telecom, Inc.
Carolina Telephone and Telegraph Company
Champion International
General Electric

N.C. Center for Public Policy Research
P.O. Box 430
Raleigh, North Carolina 27602

Nonprofit Org.
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1121