Consumer Federation of America
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TESTIMONY OF

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BEFORE

THE SUBCOMMITTEE ON CAPITAL MARKETS, INSURANCE,
AND GOVERNMENT SPONSORED ENTERPRISES OF
THE COMMITTEE ON FINANCIAL SERVICES
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES

REGARDING

"ADDITIONAL PERSPECTIVES ON THE NEED FOR INSURANCE REGULATORY REFORM"

OCTOBER 30, 2007

Good morning Mr. Chairman and members of the Subcommittee. My name is Bob Hunter and I am the Director of Insurance for the Consumer Federation of America (CFA). Thank you for inviting me here today to discuss the state of the property/casualty insurance industry in America and the quality of insurance regulation. CFA is a non-profit association of 300 organizations that, since 1968, has sought to advance the consumer interest through research, advocacy, and education. I am a former Federal Insurance Administrator under Presidents Ford and Carter and have also served as Texas Insurance Commissioner. I am also an actuary, a Fellow of the Casualty Actuarial Society, and a member of the American Academy of Actuaries.

America's insurance consumers, including small businesses, are vitally interested in high-quality insurance regulation. I am sad to say, however, that the quality of insurance regulation is weak and declining throughout the nation today. Therefore, your hearing is timely. We especially appreciate the fact that the Subcommittee is beginning its review with an overall examination of insurance regulation – why it exists and what are its successes and failures – rather than solely reviewing proposed legislation. In order to determine whether federal legislation is necessary and what its focus should be, it makes sense for the Committee to first conduct a thorough assessment of the current situation. If the "problems" with the present insurance regulation regime are not properly diagnosed, the "solutions" that Congress enacts will be flawed.

In this testimony, I will first discuss why regulation of the insurance industry is necessary, including a review of the key reasons regulation is required and why some current developments make meaningful oversight even more essential. I will then point out that consumers are agnostic on the question of whether regulation should be at the state or federal level but are very concerned about the quality of consumer protections that are in place, wherever the locus of regulation resides in the future. Consumer advocates have been (and are) critical of the current state-based system. However, we are not willing to accept a new regulatory structure that allows insurers to pit state and federal regulators against each other to further drive down standards or that guts consumer protections in the states and establishes one uniform but weak set of national standards. Next I will list a few of the most pressing problems, including claims practices and availability concerns, that insurance consumers are presently facing that require a regulatory response.

I will then provide a brief history of the insurance industry's desire for federal regulation in the early years of this country and the reasons why the industry switched to favoring state regulation in the latter half of the 19th century. The industry is now split on the question of whether state-based regulation should continue. I will point out that the industry has generally shifted its allegiance over the years to support oversight by the level of government that imposes the weakest regulatory regime and the fewest consumer protections. Since this balance shifts over time, some insurers now favor a new system where they can change from state to federal regulation or back again, should a regulator propose rules that they do not like.

Next I will explain why market "competition" alone cannot be relied upon to protect insurance consumers, in spite of insurer attempts to reduce or eliminate consumer protections. I will also touch on the absence of regulatory oversight of policy forms (i.e., coverages) and risk

classifications (i.e., how consumers are grouped for the purpose of charging premiums), the hollowing out of coverage offered in insurance policies, unfair discrimination, and the abdication of the insurance system's primary role in loss prevention. Industry deregulation proposals – which euphemistically claim to focus on "modernization" or "uniformity" – will likely increase the already widespread problems of insurance availability and affordability and further erode incentives for loss prevention. Furthermore, industry claims that competition is incompatible with regulation are not borne out by the facts. The experience in states like California demonstrates that appropriate regulation enhances competition, while also ensuring that insurers compete fairly and in a manner that benefits consumers. The maximization of both competitive forces and regulatory oversight in California has resulted in a generous return for these companies and high-quality protection for consumers.[1]

I then set forth the principles for a regulatory system that consumers would favor, showing ways to achieve regulatory uniformity without sacrificing consumer protections.

Finally, I briefly discuss some of the regulatory proposals put forth in recent years by insurers, including the optional federal charter approach and the SMART Act, both of which CFA strongly opposes. We do support legislation that would repeal the McCarran-Ferguson Act's broad antitrust exemption that insurers enjoy, to end the collusive pricing and other market decisions that are legal today. For example, the Senate Judiciary Committee is considering S. 618, which also has broad support from other national consumer organizations.[2]

Why is Regulation of Insurance Necessary?

The rationale behind insurance regulation is to promote beneficial competition and prevent destructive or harmful competition in various areas.

Insolvency: One of the reasons for regulation is to prevent competition that routinely causes insurers to go out of business, leaving consumers unable to collect on claims. Insolvency regulation has historically been a primary focus of insurance regulation. After several insolvencies in the 1980s, state regulators and the National Association of Insurance Commissioners (NAIC) enacted risk-based capital standards and implemented an accreditation program to help identify and prevent future insolvencies. As fewer insolvencies have occurred from the 1990s to the present, state regulators appear to be doing a better job.

Unfair and Deceptive Policies and Practices: Insurance policies, unlike most other consumer products or services, are contracts that promise to make certain payments under very specific conditions at some point in the future. Consumers can easily research the price, quality and features of a television, but it is much more difficult to make a similar evaluation of complex insurance policies and how these policies will be interpreted and serviced at some point in the future. If they did, they would never accept policies with anti-concurrent causation clauses in

[1] "Why Not the Best? The Most Effective Auto Insurance Regulation in the Nation," Consumer Federation of America, June 6, 2000.

[2] Consumer organizations that support S. 618 include CFA, the Center for Economic Justice, the Center for Insurance Research, the Center for Justice and Democracy, Consumers Union, the Foundation for Taxpayer and Consumer Rights, New Jersey Citizen Action, Public Citizen, and United Policyholders.

them. Because of the complicated nature of insurance policies, consumers rely on the representations of the seller/agent to a far greater extent than for other products. Regulation exists to prevent competition that fosters the sale of unfair and deceptive policies and claims practices.

Unfortunately, states have fared very poorly in protecting consumers from unfair and deceptive practices. Rather than acting to uncover abuses and instigate enforcement actions, states have often only reacted to lawsuits or news stories that brought harmful practices to light. For example, the common perception among regulators that "fly-by-night" insurance companies were primarily responsible for deceptive and misleading practices was shattered in the late 1980s and early 1990s by widespread allegations of such practices among companies with household names like MetLife, John Hancock, and Prudential. MetLife sold plain whole life policies to nurses as "retirement plans," and Prudential unilaterally replaced many customers' whole life policies with policies that didn't offer as much coverage. Though it is true that state regulators eventually took action through coordinated settlements, the allegations were first raised in private litigation; many consumers were defrauded before regulators acted.

The revelations and settlements resulting from investigations by New York Attorney General Eliot Spitzer show that even the most sophisticated consumers of insurance can be duped into paying too much through bid-rigging, steering, undisclosed kickback commissions to brokers and agents, and through other anticompetitive acts. A *New York Times* article on long-term care insurance claims abuses provides another example of serious problems consumers face in the current weak regulatory climate.[3] The appalling behavior of many insurers in the wake of Hurricane Katrina that resulted from the long-standing use of deceptive practices like anti-concurrent causation clauses are also a noteworthy example of the inadequacy of state oversight.

Claims abuses: Consumers pay a lot of money for insurance policies, which are promises for future protection should some unfortunate event occur. If these promises are broken, the consumer can be devastated. Many concerns have been raised about such broken promises in the poor performance of property-casualty insurers in paying legitimate claims in the wake of Hurricane Katrina. Consider this startling blog from the President of the Association of Property/Casualty Claims Professionals, James Greer, which was posted on the web site of the Editor of the National Underwriter:

James W. Greer, CPCU:

Although I live and work in Florida, my home is on the Mississippi Gulf Coast where I have family spread from one side of the state to the other. I spent six months there leading a team of over 100 CAT adjusters and handling the wind claims for the state's carrier of last resort. I personally walked through the carnage, saw the people, and felt the sorrow. I climbed the roofs, measured the slabs, and personally witnessed very visible and clear damage caused by both water AND WIND.

I also observed something else that surprised me, and, after 28 years as a claims professional who has carried "the soul" of a bygone industry in my practices and preachings, I was ashamed

[3] "Aged, Frail and Denied Care by Their Insurers," *New York Times*, March 26, 2007.

of those to whom I had vested a lifetime career: An overwhelming lack of claims adjusters on the Mississippi Gulf Coast. The industry simply did not respond.

The industry appeared as distant to the Miss. Gulf Coast as the federal government was accused of being to New Orleans. *It was as if some small group of high-level financial magnates decided that the only way to save the industry's financial fate from this mega-disaster was to take a total hand's off approach and hide beneath the waves and the flood exclusion.*

While media reps repeatedly quoted, "Each claim is different and will be handled on its own facts and merits," the carriers behaved as one...if there was evidence of water, or you were within a certain geographic boundary, adjusters were largely absent on the coast. (Emphasis added.)

(Actually, State Farm did have one of the largest CAT facilities, located centrally on the coast, but there was little evidence of other carrier presence.)

I personally observed large carriers simply refusing to respond, or even consider arguments of wind involvement...well-rationalized sets of facts, coverage and legal arguments. The silence from industry officials "far from the field" who retained the authority for claim decision-making was deafening.

In an article posted on the Association of Property & Casualty Claims Professionals' Web site shortly after Katrina hit, I described the catastrophe as "Claims Greatest Challenge," and pondered the industry would respond. Now we know.

As a member of an old Aetna family that has been widely dispersed since its demise in the '90's, I remember the day when leaders of that fine company routinely cited, and tried to honor, the social/moral contract the insurance industry had with society. It is clear that, in today's business environment, the soul of the insurance industry is missing, and despite the rhetoric of its PR machine, the industry no longer recognizes such a social/moral obligation.

As a lifetime claims professional, I will never quit writing, teaching and showing those who are interested the way things should be done to serve the best interests of the industry and its customers according to the best practices and behaviors of a bygone claims age. Perhaps someday a change in mindset will once again begin to evolve.

Clearly, for the Mississippi Gulf Coast, the Katrina catastrophe, the animosity and the litigation, it was never really about flood...nor was it about the flood exclusion. It was, and is, about the failure of the insurance industry to keep its promise...a promise that it will respond when loss occurs.

The only thing sold in insurance is peace of mind. The victims of this storm, and certainly those in Mississippi, will never again find peace of mind in insurance. Actions do speak loudest. On the Mississippi Gulf Coast, the insurance industry simply failed to act. In the end, it will pay dearly for that decision, as will all of society.

James W. Greer, CPCU, President, Association of Property & Casualty Claims Professionals[4]

There are also adverse implications for consumers because of the use of claims payment software by insurance companies. Insurers have reduced their payouts and maximized their profits by turning their claims operations into "profit centers" by using computer programs and other techniques designed to routinely underpay policyholder claims. For instance, many insurers are using programs such as "Colossus," sold by Computer Sciences Corporation (CSC.)[5] CSC sales literature touted Colossus as "the most powerful cost savings tool" and also suggested that the program will immediately reduce the size of bodily injury claims by up to 20 percent. As reported in a recent book, "…any insurer who buys a license to use Colossus is able to calibrate the amount of 'savings' it wants Colossus to generate…If Colossus does not generate sufficient 'savings' to meet the insurer's needs or goals, the insurer simply goes back and 'adjusts' the benchmark values until Colossus produces the desired results."[6] In a settlement of a class-action lawsuit, Farmers Insurance Company has agreed to stop using Colossus on uninsured and underinsured motorist claims where a duty of good faith is required and has agreed to pay class members cash benefits.[7] Other lawsuits have been filed against most of America's leading insurers for the use of these computerized claims settlement products.[8]

Programs like Colossus are designed to systematically underpay policyholders without adequately examining the validity of each individual claim. The use of these programs severs the promise of good faith that insurers owe to their policyholders. Any increase in profits that results cannot be considered to be legitimate. Moreover, the introduction of these systems could explain part of the decline in benefits that policyholders have been receiving as a percentage of premiums paid in recent years.

Colossus has been bought by most major insurance companies in response to marketing efforts by CSC promising significant savings. McKinsey & Company has also encouraged several companies to use Colossus.[9] "Before the Allstate launched a project in 1992 (called CCPR – Claims Core Process Redesign), McKinsey named its USAA project 'PACE' [Professionalism and Claims Excellence]. At State Farm, McKinsey named its project 'ACE' [Advanced Claims Excellence]."[10]

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[4] "Your Own Worst Enemy, Continued," Blog of Sam Friedman, Editor, National Underwriter Magazine, www.property-casualty.com, February 21, 2007. Posted on January 31, 2007 23:06. The blog has other interesting posts on this subject.

[5] Other programs are also available that promise similar savings to insurers, such as ISO's "Claims Outcome Advisor." These are bodily injury systems but other systems, such as Exactimate, "help" insurers control claims costs on property claims.

[6] "From Good Hands to Boxing Gloves – How Allstate Changed Casualty Insurance in America," Trial Guides, 2006, Berardinelli, Freeman and DeShaw, pages 131, 133, 135.

[7] Bad Faith Class Actions, Whitten, Reggie, PowerPoint Presentation, November 9, 2006.

[8] Ibid.

[9] "…Mc Kinsey & Co. has taught Allstate and other insurance companies how to deliver less and less." Berardinelli, Freeman and DeShaw, page 17.

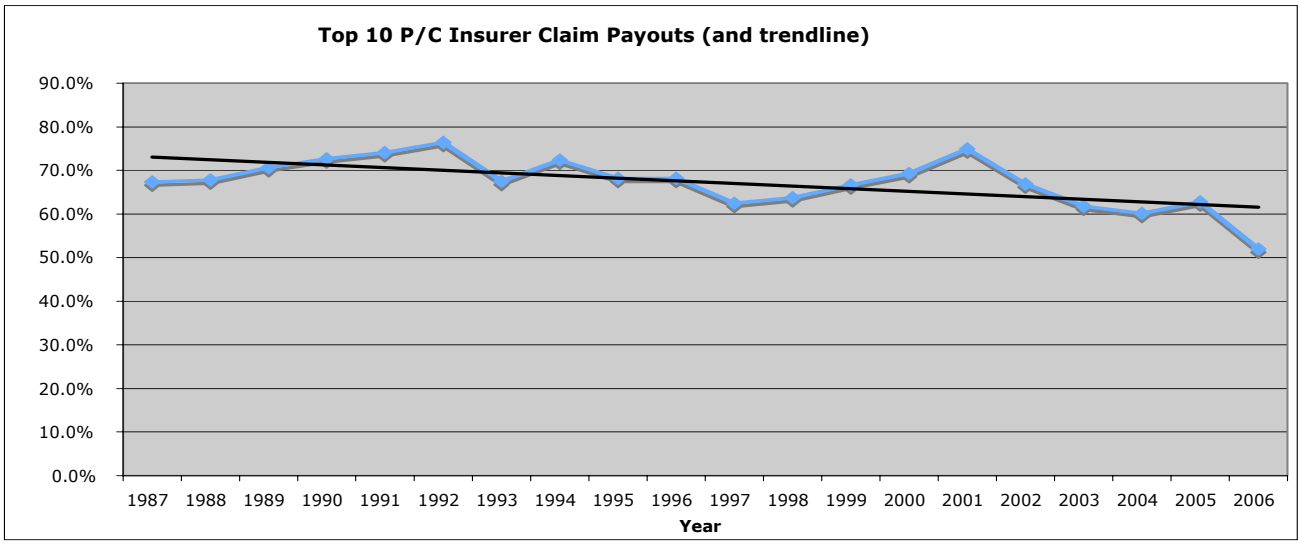
[10] Ibid. Page 57.

When McKinsey introduced Allstate to Colossus, "McKinsey already knew how Colossus worked having proved it in the field at USAA."[11] This quote was footnoted as follows: "See McKinsey at (PowerPoint slide number) 7341: "The Colossus sites have been extremely successful in reducing severities with reductions in the range of 10 percent for Colossus-evaluated claims."[12]

I have been a witness in some of the cases against insurers using the Colossus product and I am covered by a protective order in these cases. (I could go on at length about why these protective orders are bad public policy, particularly coupled with secrecy provisions in settlements, in that the abusive practice that was uncovered often continues to harm people). I am, therefore, limited in this testimony to what is in the public domain. However, as I describe above, there is public information about the use of common consultants and vendors by insurance companies that have adopted Colossus and similar systems. I strongly urge this Committee to probe the question of whether these vendors and consultants have been involved in encouraging and facilitating collusive behavior by insurance companies with these claims systems. I also urge you to investigate whether a similarity in Hurricane Katrina claims payment procedures and actions (or non-actions), as mentioned above, could indicate collusive activity by some insurers.

The use of these products to cut claims payouts may be at least part of the reason that consumers are receiving record low payouts for their premium dollars as insurers reap unprecedented profits. As is obvious in the following graph, the trend in payouts is sharply down over the last twenty years, a period during most state insurance regulators have allowed consumer protections to erode significantly and when Colossus and other claims systems were being introduced by many insurers.[13]

[11] Ibid. Page 132.
[12] Ibid.
[13] CFA tested this drop in benefits related to premiums to see if it could be attributed to a drop in investment income. Over the time frame studied, there was a three percent drop in investment income. Since insurers typically reflect about half of investment income in prices, CFA believes that the drop in investment income accounts for only 1.5 points of the 15-point drop. That is, declining investment income explains only about one-tenth of the drop in benefit payouts to consumers per dollar expended in insurance premium.



It is truly inappropriate for property/casualty insurers to be delivering only half of their premium back to policyholders as benefits.[14]

State insurance departments have been sound asleep on the issue of the negative impact that Colossus and other such products have on policyholder rights, and even on the right to good faith claims settlements. The Federal Trade Commission (FTC) should be empowered to undertake investigations and other consumer protection activities to help stop the insurers from engaging in such acts on a national basis.

Insurance Availability: Some insurance is mandated by law or required by lenders to complete financial transactions, such as mortgage loans. In a normal competitive market, participants compete by attempting to sell to all consumers seeking the product. However, in the insurance market, participants compete by attempting to "select" only the most profitable consumers. This selection competition leads to availability problems and redlining.[15] Regulation exists to limit destructive selection competition that harms consumers and society.

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[14] Insurers contend that the loss adjustment expense is a benefit to consumers. Obviously, this is a "benefit" that is not provided to the consumer or repair cars, doctor bills, etc. But even the loss and LAE ratio itself is at a record low for many decades, at under 70 percent.

[15] The industry's reliance on selection competition can have negative impacts on consumers. Insurance is a risk spreading mechanism. Insurance aggregates consumers' premiums into a common fund from which claims are paid. Insurance is a contractual social arrangement, subject to regulation by the states.

The common fund in which wealth is shifted from those without losses (claims) to those with losses (claims) is the reason that the contribution of insurance companies to the Gross National Product of the United States is measured as premiums less losses for the property-casualty lines of insurance. The U.S. government recognizes that the losses are paid from a common fund and thus are a shift in dollars from consumers without claims to those with claims, not a "product" of the insurance companies.

Competition among insurers should be focused where it has positive effects, e.g., creating efficiencies, lowering overhead. But rather than competing on the basis of the expense and profit components of rates, the industry has relied more on selection competition, which merely pushes claims from insurer to insurer or back on the person or the state. States have failed to control against the worst ravages of selection competition (e.g. redlining).

Some of the vices of selection competition that need to be addressed include zip code or other territorial selection; the potential for genetic profile selection; income (or more precisely credit report) selection; and selection

Lawsuits brought by fair housing groups and the Department of Housing and Urban Development (HUD) over the past 15 years have revealed that insurance availability problems and unfair discrimination exist and demonstrate a lack of oversight and attention by many of the states. NAIC had ample opportunity after its own studies indicated that these problems existed to move to protect consumers. It retreated, however, when, a few years ago, insurers threatened to cut off funding for its insurance information database, a primary source of NAIC income.

Serious problems with home insurance availability and affordability surfaced this spring along America's coastlines. Hundreds of thousands of people have had their homeowners' insurance policies non-renewed and rates are skyrocketing. As to the decisions to non-renew, on May 9, 2006 the Insurance Services Office (ISO) President and CEO Frank J. Coyne signaled that the market is "overexposed" along the coastline of America. In the *National Underwriter* article, "Exposures Overly Concentrated Along Storm-prone Gulf Coast" (May 15, 2006 Edition), the ISO executive "cautioned that population growth and soaring home values in vulnerable areas are boosting carrier exposures to dangerous levels." He said, "The inescapable conclusion is that the effects of exposure growth far outweigh any effects of global warming."

Insurers started major pullouts on the Gulf Coast in the wake of the ISO pronouncement. On May 12, 2006, Allstate announced it would drop 120,000 home and condominium policies and State Farm announced it would drop 39,000 policies in the wind pool areas and increase rates more than 70 percent.[16] Collusion that would be forbidden by antitrust laws in most other industries appears to be involved in the price increases that have occurred. (See section below entitled "Where Have All the Risk Takers Gone?")

One obvious solution to discrimination and availability problems is to require insurers to disclose information about policies written by geo-code, and about specific underwriting guidelines that are used to determine eligibility and rates. Such disclosure would promote competition and benefit consumers; but state regulators, for the most part, have refused to require such disclosure in the face of adamant opposition from the industry. Regulators apparently agree with insurers that such information is a "trade secret" despite the absence of legal support for such a position. In addition, though insurance companies compete with banks that must meet data disclosure and lending requirements in underserved communities under the Community Reinvestment Act ("CRA"), insurers refuse to acknowledge a similar responsibility to communities.

Reverse Competition: In certain lines of insurance,[17] insurers market their policies to a third party, such as creditors or auto dealers, who, in turn, sell the insurance to consumers on behalf of the insurer for commission and other compensation. This compensation is often not disclosed to the consumer. Absent regulation, reverse competition leads to higher -- not lower --

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based on employment. Targeted marketing based solely on information such as income, habits, and preferences, leaves out consumers in need of insurance, perhaps unfairly.

[16] "Insurers Set to Squeeze Even Tighter," *Miami Herald*, May 13, 2006.

[17] Such as credit insurance, title insurance and force-placed insurance.

prices for consumers because insurers "compete" to offer greater compensation to third party sellers, driving up the price to consumers.

The credit insurance market offers a perfect example of reverse competition. Every few years, consumer groups issue reports about the millions of dollars that consumers are overcharged for credit insurance. Despite the overwhelming evidence that insurers do not meet targeted loss ratios in most states, many regulators have not acted to protect consumers by lowering rates. Title insurance is vastly overpriced due to rampant reverse competition in that line of insurance.

The markets for low value life insurance and industrial life insurance are characterized by overpriced and inappropriately sold policies and a lack of competition. This demonstrates the need for standards that ensure substantial policy value and clear disclosure. Insurers rely on consumers' lack of sophistication to sell these overpriced policies. With some exceptions, states have not enacted standards that ensure value or provide timely, accurate disclosure. Consumers continue to pay far too much for very little coverage.[18]

Information for Consumers: True competition can only exist when purchasers are fully aware of the costs and benefits of the products and services they purchase. Because of the nature of insurance policies and pricing, consumers have had relatively little information about the quality and comparative cost of insurance policies. Regulation is needed to ensure that consumers have access to information that is necessary to make informed insurance purchase decisions and to compare prices.

While the information and outreach efforts of states have improved, states and the NAIC have a long way to go. Some states have succeeded in getting good information out to consumers, but all too often the marketplace and insurance regulators have failed to ensure adequate disclosure. Their failure affects the pocketbooks of consumers, who cannot compare adequately on the basis of price.

In many cases, insurers have stymied proposals for effective disclosure. For decades, consumer advocates pressed for more meaningful disclosure of life insurance policies, including rate-of-return disclosure, which would give consumers a simple way to determine the value of a cash-value policy. Today, even insurance experts can't determine which policy is better without running the underlying information through a computer. Regulators resisted this kind of disclosure until the insurance scandals of the 1990s, involving widespread misleading and abusive practices by insurers and agents, prompted states and the NAIC to develop model laws to address these problems. Regulators voiced strong concerns and promised tough action to correct these abuses. While early drafts held promise and included some meaningful cost-comparison requirements, the insurance industry successfully lobbied against the most important provisions of these proposals that would have made comparison-shopping possible for normal consumers. The model disclosure law that NAIC eventually adopted is inadequate for consumers trying to understand the structure and actual costs of policies.

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[18] My April 26, 2006, testimony before the House Committee on Financial Services on title insurance, detailing the reverse competition impact on that vastly overpriced product, can be found at: http://www.consumerfed.org/pdfs/Title_Insurance_Testimony042606.pdf.

California adopted a rate of return disclosure rule a few years ago for life insurance (similar to an APR in loan contracts) that would have spurred competition and helped consumers comparison-shop. Before consumers had a chance to become familiar with the disclosures, life insurance lobbyists persuaded the California legislature to scuttle it.

Are the Reasons for Insurance Regulation Still Valid?

The reasons for effective regulation of insurance are as relevant, or in some instances even more relevant, today than five or ten years ago:

- Advances in technology now provide insurers access to extraordinarily detailed data about individual customers and allow them to pursue selection competition to an extent unimaginable ten years ago.
- Insurance is being used by more Americans not just to protect against future risk, but as a tool to finance an increasing share of their future income, e.g., through annuities. We already know that many consumers have been hurt by improper claims practices by some of these insurers.
- Increased competition from other financial sectors (such as banking) for the same customers could serve as an incentive for misleading and deceptive practices and market segmentation, leaving some consumers without access to the best policies and rates. If an insurer can't compete on price with a more efficient competitor, one way to keep prices low is by offering weaker policy benefits (i.e., "competition" in the fine print).
- States and lenders still require the purchase of auto and home insurance. Combining insurer and lender functions under one roof, as allowed by the Gramm Leach Bliley Act, could increase incentives to sell insurance as an add-on to a loan (perhaps under tie-in pressure) – or to inappropriately fund insurance policies through high-cost loans.
- Insurers are gutting coverage provided by homeowners insurance policies in ways that are difficult for consumers to understand or overcome.[19]

As consumers are faced with these changes, it is more important than ever that insurance laws are updated and the consumer protection bar is raised, not lowered.

Given that Regulation is Important for Consumers, Who Should Regulate -- the States or the Federal Government?

Consumers are not concerned with who regulates insurance, but they are concerned with the ability of the regulatory system. Consumer advocates have been (and are) critical of the current state-based system, but we are not willing to accept a federal system that guts consumer protections in the states and establishes one uniform but weak set of regulatory standards.

I am one of the very few people who have served as both a state and federal insurance regulator.[20] My experience demonstrates that either a federal or state system can succeed or fail

[19] See the discussion of the anti-concurrent causation clause below.

[20] I was Texas Insurance Commissioner and Federal Insurance Administrator when the Federal Insurance Administration (FIA) was in HUD and had responsibility for the co-regulation of homeowners insurance in the

in protecting consumers. What is critical is not the locus of regulation, but the quality of the standards and the effectiveness of enforcement of those standards.

Both state and federal systems have potential advantages and disadvantages:

Item	Federal	State
Experience overseeing all aspects of insurance regulation?	No	Yes
Responsive to local needs?	No	Yes
Handle individual complaints promptly and effectively?	No	Some States
Limited impact if regulatory mistakes are made?	No	Yes
Not subject to political pressure from national insurers?	No	No
Not subject to political pressure from local insurers?	Yes	No
Efficient solvency regulation?	Yes	Yes
Effective guarantee in event of insolvency?	Yes	No
Adequately restricts revolving door between regulators and industry?	Maybe	No
More uniform regulatory approach?	Yes	No
Can easily respond to micro-trends impacting only a region or a state?	No	Yes
Can easily respond to macro-trends that cross state borders?	Yes	No
Has greater resources, like date processing capacity?	Yes	No

Despite many weaknesses that exist in state regulation, a number of states do have high-quality consumer protections. States also have extensive experience regulating insurer safety and soundness and an established system to address and respond to consumer complaints. The burden of proof is on those who for opportunistic reasons now want to shift away from 150 years of state insurance regulation to show that they are not asking federal regulators and American consumers to accept a dangerous "pig in a poke" that will harm consumers.

CFA agrees that better coordination and more consistent standards for licensing and examinations are desirable and necessary – as long as the standards are of the highest – and not of the lowest – quality. We also agree that efficient regulation is important, because consumers pay for inefficiencies. CFA participated in NAIC meetings over many months helping to find ways to eliminate inefficient regulatory practices and delays, even helping to put together a 30-day total product approval package. Our concern is not with cutting fat, but with removing regulatory muscle when consumers are vulnerable.

Top Six Problems Facing Insurance Consumers Today:

1. Insurers Are Increasingly Privatizing Profit, Socializing Risk and Creating Defective Insurance Products by Hollowing out Insurance Coverage and Cherry Picking Locations in Which They Will Underwrite.

FAIR Plans, as well as flood and crime insurance duties. The White House had also tasked FIA with keeping abreast of all insurance issues, so we worked on auto insurance issues with DOT, health insurance with HHS, medical malpractice insurance with HHS and DOC, and many other major insurance matters.

There are two basic public policy purposes of insurance. The first is to provide individuals, businesses and communities with a financial security tool to avoid financial ruin in the event of a catastrophic event, whether that event is a traffic accident, a fire or a hurricane. Insurers provide this essential financial security tool by accepting the transfer of risk from individuals and by spreading the individual risks through the pooling of very large numbers of individual risks. The pool of risks is diversified over many types of perils and many geographic locations.

The second essential purpose of insurance is to promote loss prevention. Insurance is the fundamental tool for providing economic incentives for less risky behavior and economic disincentives for more risky behavior. The insurance system is not just about paying claims; it is about reducing the loss of life and property from preventable events. Historically, insurers were at the forefront of loss prevention and loss mitigation.[21] At one point, fire was a major cause of loss. This is no longer true, in large part due to the actions of insurers in the 20th century.

Left to a "competitive" or deregulated market, insurers are undermining these two core purposes of insurance. They have hollowed out the benefits offered in many insurance policies so they no longer represent the essential financial security tool required by consumers and have pushed the risk of loss onto taxpayers through federal or state programs. The most glaring example of these two actions is demonstrated by insurer actions in the wake of Hurricane Katrina. Losses covered by insurance companies were a minority fraction of the losses sustained by consumers because insurers had succeeded in shifting exposure onto the federal government through the flood insurance program,[22] onto states through state catastrophe funds and onto consumers with higher deductibles and sharply reduced coverage inside of the homeowners insurance policy. Despite the worst catastrophe year ever in terms of dollars paid by the private insurance industry, the property-casualty industry realized record profits in 2005.[23] The trend toward shifting risk away from the primary insurance market has clearly gone too far when the property-casualty insurance industry experiences record profits in the same year as it experiences record catastrophe losses.

The critical conclusion here is that what the insurance industry calls "competition," which is essentially a completely or virtually deregulated market in which price collusion is not prevented by the application of antitrust law, will not protect consumers from unfair or unreasonable classification, policy form or coverage decisions by insurers. The overwhelming

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[21] Through such innovations as the creation of Underwriter's Laboratory.

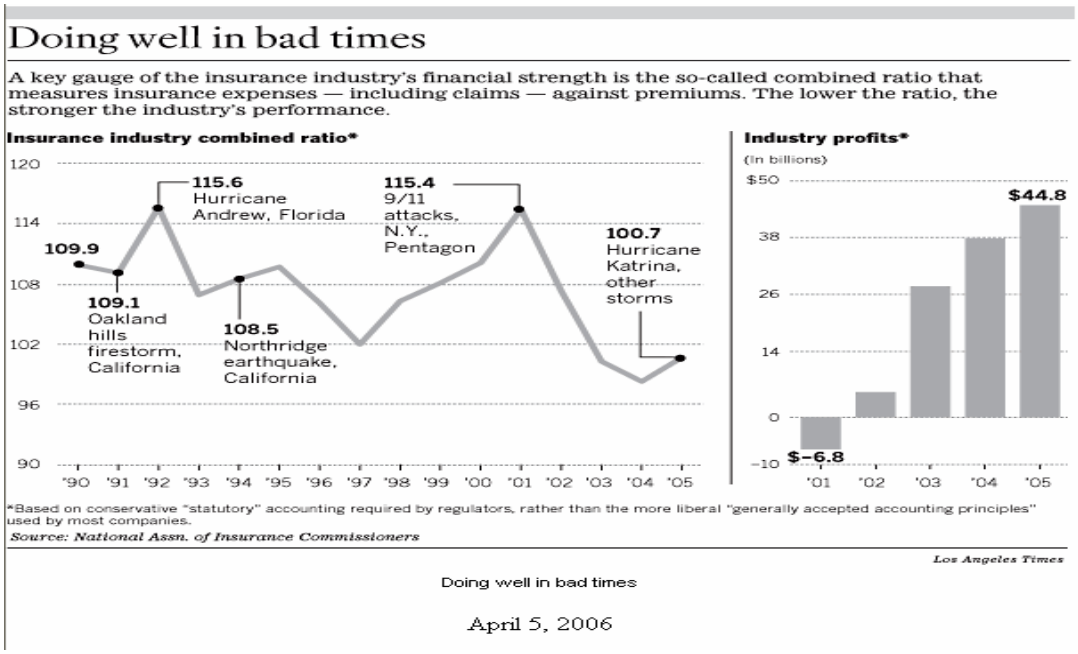
[22] The National flood Insurance Program has been in place since 1968 because insurers could not price or underwrite the risk. Insurers have since developed the technological capacity to create the data necessary for such pricing and underwriting. Consideration should be given by Congress to returning some of this risk to private insurance control. The federal program has had excessive subsidies and has been ineffective in mitigating risk in coastal areas as well as private insurers could.

[23] Indeed, they enjoyed record profits in 2004 ($38.5 billion), 2005 ($44.2 billion), and 2006 ($63.7 billion). That three-year net income of $146.4 billion represents profits of almost $500 per person in America, an astonishing sum. (See "Property/Casualty Insurance in 2007: Overpriced Insurance, Underpaid Claims, Declining Losses and Unjustified Profits," Americans for Insurance Reform, Center for Insurance Research, Center for Economic Justice, Center for Justice and Democracy, Consumer Federation of America, Consumers Union, Foundation for Taxpayer and Consumer Rights and United Policyholders, January 8, 2007 at http://www.consumerfed.org/pdfs/2007Insurance_White_Paper.pdf.

evidence is that a market failure regarding policy forms and coverage has triggered a need for greater regulatory oversight of these factors to protect consumers.

Where Have All the Risk Takers Gone? Unaffordable Home Insurance Covers Less and Less Risk

In 2004, four major hurricanes hit Florida, but the property-casualty insurance industry enjoyed record profits of $38.5 billion. In 2005, Hurricane Katrina resulted in the highest hurricane losses ever, but the insurance industry also had another record year of profits, which reached $44.2 billion. Below is a chart from a *Los Angeles Times* article on the subject:[24]



Since the article was published, the property-casualty industry has reported the largest annual profit in its history in 2006, as cited above.

[24]Gosselin, Peter, "Insurers Show Record Gains in Year of Catastrophic Losses," *Los Angeles Times*, April 5, 2006.

Insurers often contend that such large returns are justified given the enormous financial risks undertaken by the insurance industry. Although it may be true that reinsurance is a high-risk industry,[25] it is certainly not true for the primary market. In fact, primary insurers have succeeded in eliminating much risk. This is not an opinion, but a simple fact.

If one purchases a property-casualty insurance company's stock, with few exceptions, one has bought into a business that is lower in risk than the market in general, hurricanes notwithstanding. This is shown in any Value Line publication, which tests the risk of a stock. One key measure is the stock's Beta, which is the sensitivity of a stock's returns to the returns on some market index, such as the Standard & Poor's 500. A Beta between 0 and 1, such as utility stocks, is a low-volatility investment. A Beta equal to 1 matches the index. A Beta greater than 1 is anything more volatile than the index, such as a "small cap" fund.

Another measure of a shareholder's risk is the Financial Safety Index, with 1 being the safest investment and 5 being least safe. A third measure of risk is the Stock Price Stability reported in five percentile intervals with 5 marking the least stability and 100 marking the highest.

Consider Allstate. At the same time the company has taken draconian steps to sharply raise premiums and/or reduce coverage for many homeowners in coastal areas, it has presented shareholders with very low risk: Beta = 0.90; Financial Safety = 1, and Stock Price Stability = 95.[26]

ValueLine posts results for 26 property/casualty insurers.[27] The simple averages for these carriers are: Beta = 0.97; Financial Safety = 2.4; and Stock Price Stability = 83.

By all three measures, property/casualty insurance stocks are of below-average risk, safer than buying an S&P 500 index fund. Therefore, long-term below-average returns for insurers should be expected given the low-risk nature of this investment. The low returns demonstrate that the capital market is performing efficiently by awarding below-average returns to a below-average risk industry.

Another measure of how property/casualty insurers have insulated themselves from risk is the extraordinary profits they have earned in recent years. In 2004, insurers posted their largest dollar net (after tax) profit in history ($38.5 billion) despite the fact that four major hurricanes caused significant damage in Florida. Insurers achieved another record of $44.2 billion in 2005, despite the unprecedented losses caused by hurricanes Katrina, Rita, and Wilma. In 2006, profits were the highest ($63.7 billion) yet because of low hurricane activity, excessive rates, the use of programs to systematically keep payments to policyholders low and other reasons discussed in this testimony.

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[25] CFA is still researching this question.

[26] ValueLine, December 22, 2006 edition.

[27] The stocks are ACE Ltd., Alleghany Corp., Allstate Corp., American Financial Group, W.R. Berkley Corp., Berkshire Hathaway, Inc., CAN Financial, Chubb Corp., Cincinnati Financial, Everest Re Group, HCC Insurance, Hanover Insurance Group, Markel Corp., Mercury General, Ohio Casualty Corp., Old Republic International Corp., PMI Group, Inc., Partner Re, Ltd., Progressive Corp., PLI Corp., Safeco Corp., St. Paul/Travelers Group, Selective Insurance, Transatlantic Holdings, 21st Century Insurance Group and XL Group, Ltd.

How did insurers do it? Some of the answers are clear:

First, insurers did make intelligent use of reinsurance, securitization, and other risk spreading techniques. That is the good news.

Second, after Hurricane Andrew, insurers modernized ratemaking by using computer models. This development was a mixed blessing for consumers. While this caused huge price increases for consumers, CFA and other consumer leaders supported the change because we saw insurers as genuinely shocked by the scope of losses caused by Hurricane Andrew. Insurers promised that the model, by projecting either 1,000 or 10,000 years of experience, would bring stability to prices. The model contained projections of huge hurricanes (and earthquakes) as well as periods of intense activity and periods of little or no activity.

In the last two years, however, Risk Management Solutions (RMS) and other modelers have moved from using a 10,000-year projection to a five-year projection, which has caused a 40 percent increase in loss projections in Florida and the Gulf Coast, and a 25-30 percent jump in the Mid-Atlantic and Northeast. As a result, the hurricane component of insurance rates has sharply increased, resulting in overall double-digit rate increases along America's coastline from Maine to Texas. The RMS action interjects politics into a process that should be based solely on sound science. It is truly outrageous that insurers would renege on the promises made in the mid 1990s. CFA has called on regulators in coastal states to reject these rate hikes.

It is clear that insurance companies sought this move to higher rates. RMS's press release of March 23, 2006 states:

> 'Coming off back-to-back, extraordinarily active hurricane seasons, the market is looking for leadership. At RMS, we are taking a clear, unambiguous position that our clients should manage their risks in a manner consistent with elevated levels of hurricane activity and severity,' stated Hemant Shah, president and CEO of RMS. 'We live in a dynamic world, and there is now a critical mass of data and science that point to this being the prudent course of action.'

The "market" (the insurers) sought leadership (higher rates), so RMS was in a competitive bind. If it did not raise rates, the market would likely go to modelers who did. So RMS acted and other modelers are following suit.[28] It is simply unethical that scientists at these modeling firms, under pressure from insurers, appear to have completely changed their minds at the same time despite having used models for over a decade that they assured the public were scientifically sound. RMS has become the vehicle for collusive pricing.

Almost two years after CFA warned the coastal states and the NAIC about the problems with RMS new methods, little protection for consumers has been put in place. Consumers and

[28] According to the *National Underwriter's* Online Service on March 23, 2006, "Two other modeling vendors—Boston-based AIR Worldwide and Oakland, Calif.-based Eqecat—are also in the process of reworking their hurricane models."

businesses in coastal areas have suffered significant harm in the form of unjustified rate increases because the NAIC took no action to end collusion and the retreat from science by the modelers. In fact, the sum total of NAIC's response on an issue that is vital to millions of Americans who live and work near the nation's coastlines was to hold a hearing on whether modeling companies should be regulated. Florida, Georgia, and Louisiana, to their credit, did not allow the new model to be used by primary insurers. New York and Massachusetts have also taken some steps to prevent unjustified rate hikes or policy non-renewals. In the meantime, residents in the other states along the coast have been paying rates up to 50 percent higher solely because of the changes adopted by RMS and other modelers. At the same time, it has become more and more obvious that those who questioned the scientific legitimacy of the modeling changes were correct.

Consider the series of investigative articles on this topic that ran in the *Tampa Tribune* earlier this year indicating that the scientists consulted by RMS on their model no longer support the methodology that was used. "On Saturday, one of the scientists whom Risk Management Solutions consulted, Jim Elsner, a professor of geography at Florida State University, told the Tribune that the company's five-year model 'points to a problem with the way these modeling groups are operating' and that the results contain assumptions that are 'actually unscientific.'… Thomas R. Knutson, a research meteorologist with the National Oceanic and Atmospheric Administration in Princeton, N.J., and another Risk Management expert panelist, said Saturday the five-year timeline didn't come from the experts. 'I think that question was driven more by the needs of the insurance industry as opposed to the science,' he said."[29]

Scientists not employed by RMS are also speaking out: " 'It's ridiculous from a scientific point of view. It just doesn't wash well in the context of the way science is conducted,' said Mark S. Frankel, director of the Scientific Freedom, Responsibility & Law Program at the American Association for the Advancement of Science, in Washington… Charles Watson, an engineer who specializes in numerical hazard models, said RMS acted irresponsibly. 'Especially for something with trillions of dollars in property value, and peoples' lives and livelihood are literally at stake in these decisions. It is irresponsible to implement before peer review. There are tremendous policy implications.'"[30]

Even RMS's competitors are stating that the methodology for the 5-year model does not represent good science. In an article in *Contingencies*, the magazine of the American Academy of Actuaries,[31]AIR's Senior Vice President, David A. LaLonde, said, "We [AIR] continue to believe, given the current state of the science, that the standard base model based on over 100 years of historical data and over 20 years of research and development remains the most credible model." AIR's entire premise in the article is that short-term projections, like five years, are not appropriate. Since AIR followed RMS's lead in using the 5-year model despite their misgivings, LaLonde acknowledged that policyholders have experienced rate increases of "as much as 40 % higher than the long-term average in some regions." AIR also seems to confirm the possibility of collusion between modelers and insurers, stating that, "...many in the industry challenged catastrophe models and called for a change."

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[29] New Speaker Challenges Insurance Risk Projections, *Tampa Tribune*, January 10, 2007.
[30] Ethicist Questions Insurance Rate Data; *Tampa Tribune*, January 12, 2007.
[31] What Happened in 2006? *Contingencies*, March/April 2007.

In a third major development, insurers have not only passed along gigantic price increases to homeowners in coastal areas, but they have also sharply gutted coverage. Hurricane deductibles of two to five percent were introduced. Caps on home replacement costs were also added. State Farm has a 20 percent cap. Other insurers refuse to pay for any increased replacement costs at all, even though demand for home rebuilding usually surges in the wake of a hurricane driving replacement costs up sharply. Insurers also excluded coverage for laws and ordinances, so that if a home has to be elevated to meet flood insurance standards or rewired to meet local building codes, insurers no longer have to pay.

But the most egregious change was the introduction into homeowners' insurance policies of the anti-concurrent causation ("ACC") clause. It removes all coverage for wind damage if another, non-covered event (usually a flood) also occurs, regardless of the timing of the events. Under this anti-consumer measure, if a hurricane of 125-miles-per-hour rips a house apart but hours later a storm surge floods the property, the consumer would receive no reimbursement for wind losses incurred. The use of ACC clauses is intellectually ambiguous, even if the language is found by the courts to be clear.

At a hearing held by the House Financial Services Oversight Subcommittee on February 28th, 2007, Mississippi Attorney General Jim Hood testified that a number of insurance companies operating on the Gulf Coast had tried to escape paying legitimate homeowners' claims after Hurricane Katrina through the use of ACC clauses. Although the ACC clauses were invalidated by a Mississippi judge, insurers intended to refuse to pay wind damage caused by the hurricane if flooding occurred at about the same time, even if the flood hit hours after a home was damaged by wind. The court ruling only affected insurers in Mississippi, so insurers may still be using ACC clauses in other states in the region.

In some cases, particularly those involving the complete destruction of a home down to a slab, insurers did not even seriously study or "adjust" the claim, instead declaring the wind coverage to be trumped by the flood. Such cases often lead to the payment of full flood coverage by the NFIP, even if all or some of the losses paid were really caused by wind damage that should have been paid by insurers under a homeowner's policy.

Consider a $200,000 home that is covered by just a homeowners' policy, with no flood insurance protection. Assume that hurricane winds strike the home for several hours, causing $150,000 worth of damage. Two hours later a flood hits, causing an additional $25,000 in damage for a total damage of $175,000. If the insurer of the home has an ACC, the policyholder would get nothing. If the policyholder had, in addition to the homeowners policy, a flood policy for $200,000, the wind claim would be denied and taxpayers would likely pay $175,000 when they should only pay $25,000. Insurers who get paid handsomely to service the flood insurance program, the Write Your Own ("WYO") companies, should be prohibited from having policy language that has the effect, as ACC does, of shifting insurer losses onto the taxpayers. Congress must make sure that the flood program is not being used by private insurers as a place to lay off their obligations.

Finally, insurers have simply dumped a great deal of risk by not renewing the policies of tens of thousands of homeowner and business properties. Allstate, the leading culprit after

Hurricane Andrew, is emerging as the "heavy" once more in the wake of Katrina[32]. After Hurricane Andrew, Allstate threatened to not renew the policies of 300,000 South Floridians, provoking a state moratorium on such action. Today, Allstate is not renewing policies even in places like Long Island and not writing in entire states, like Connecticut. Yes, you heard me right, all of Connecticut, even in places many miles from the coast!

These actions present a serious credibility problem for insurers. They told us, and we believed, that Hurricane Andrew was their "wake up" call because its size and intensity surprised them. This caused them to make massive adjustments in price, coverage, and portfolio of risk. What is their excuse now for engaging in another round of massive and precipitous actions?

Insurers surely knew that forecasters had predicted for decades that an increased period of hurricane activity and intensity would occur from the 1990s to about 2010. They also surely knew a storm of Hurricane Katrina's size, location, and intensity was possible. The *New Orleans Times-Picayune* predicted exactly the sort of damage that occurred in a series of articles more than three years before Katrina hit.[33]

Take Allstate's pullout from part of New York and their refusal to write any new business in the entire state of Connecticut. It is very hard to look at this move as a legitimate step today when no pullout occurred after Hurricane Andrew. Why isn't the probability of a dangerous storm hitting Long Island or Connecticut already accounted for in the modeling – and rate structure – that were instituted after Hurricane Andrew? This type of precipitous action raises the question of whether Allstate is using the threat of hurricane damage as an excuse to drop customers they have had but do not want to retain for other reasons, such as clients in highly congested areas with poorer credit scores. Whether it was mismanagement that started a decade ago or the clever use of an opportunity today, consumers are being unjustifiably harmed. Insurance is supposed to bring stability, not turmoil, into peoples' lives.

2. The Revolution in Risk Classification has Created Many Questionable Risk Characteristics, Generated New Forms of Redlining and Undermined the Loss Prevention Role of the Insurance System.

As discussed above, one of the primary purposes of the insurance system is to promote loss prevention. The basic tool for loss prevention is price. By providing discounts for characteristics associated with less risky behavior and surcharges for characteristics associated with more risky behavior, the insurance system provides essential economic signals to consumers about how to lower their insurance costs and reduce the likelihood of events that claim lives or damage property.

Over the past fifteen years, insurers have become more "sophisticated" about rating and risk classification. Through the use of data mining and third party databases, like consumer credit reports, insurers have dramatically increased the number of rating characteristics and rate levels used.

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[32] See "The 'Good Hands Company' or a Leader in Anti-Consumer Practices?," Consumer Federation of America, July 18, 2007 at http://www.consumerfed.org/pdfs/Allstate_Report_07_18_07.pdf.

[33] McQuaid, John; Schleifstein, Mark, "Washing Away," *New Orleans Times Picayune.* June 23-27, 2002.

We are certainly not against insurers using sophisticated analytic tools and various databases to identify the causes of accidents and losses. We would applaud these actions if the results were employed to promote loss prevention by helping consumers better understand the behaviors associated with accidents and by providing price signals to encourage consumers to avoid the risky behaviors surfaced by this sophisticated research.

Unfortunately, insurers have generally not used the new risk classification research to promote loss prevention. Rather, insurers have used new risk classifications to undermine the loss prevention role of insurance by placing much greater emphasis on risk factors unrelated to loss prevention and almost wholly related to the economic status of potential policyholders. The industry's new approach to risk classification is a form of redlining, where a host of factors are employed that are proxies for economic status and sometimes race.

For example, although federal oversight of the impact of credit scores in insurance underwriting and rating decisions has been quite poor,[34] it is well-documented in studies by the Texas and Missouri Departments of Insurance that credit scoring has a disproportionately harmful effect on low income and minority consumers.[35] And recently, GEICO's use of data about occupation and educational status has garnered the attention of New Jersey legislators.[36] But other factors have not received similar visibility. Several auto insurers use prior liability limits as a major rating factor. This means that for two consumers who are otherwise identical and who are both seeking the same coverage, the consumer who previously had coverage of only the minimum required under law will be charged more than the consumer who previously was able to afford a policy with higher limits. As with credit scoring and occupation/educational status information, this risk classification system clearly penalized lower income consumers.

Once again, deregulated "competition" alone will not protect consumers from unfair risk classification and unfair discrimination. Once again, this market failure demands close regulatory scrutiny of the use of risk classification factors when underwriting, coverage and rating decisions are made.

Let me present one more example of the illegitimate use of risk classification factors to illustrate our concern. Insurers have developed loss history databases – databases in which insurers report claims filed by their policyholders that are then made available to other insurers. Insurers initially used the claims history databases –Comprehensive Loss Underwriting Exchange (CLUE) reports, for example – to verify the loss history reported by consumers when

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[34] Federal agencies with potential oversight authority paid virtually no attention to the possible disparate impact of the use of credit scoring in insurance until Congress mandated a study on this matter as part of the Fair Access to Credit Transactions (FACT) Act (Section 215). Unfortunately, the agency charged with completing this study, the Federal Trade Commission, has chosen to use data for this analysis from an industry-sponsored study that cannot be independently verified for bias or accuracy, resulting in a study that offers an unreliable and incomplete description of insurance credit scoring and its alternatives.

[35] "Report to the 79th Legislature: Use of Credit Information by Insurers in Texas," Texas Department of Insurance, December 30, 2004; "Insurance-Based Credit Scores: Impact on Minority and Low Income Populations in Missouri," Missouri Department of Insurance, January 2004.

[36] Letter from Consumer Federation of America and NJ CURE to NAIC President Alessandro Iuppa regarding GEICO rating methods and underwriting guidelines, March 14, 2006.

applying for new policies. However, in recent years, insurers started data mining these loss history databases and decided that consumers who merely made an inquiry about their coverage – didn't file a claim, but simply inquired about their coverage – would be treated as if they had made a claim. Penalizing a consumer for making an inquiry on his or her policy is not just glaringly inequitable; it undermines loss prevention by discouraging consumers from interacting with insurers about potentially risky situations.

Although insurers and the purveyors of the claims databases – including ChoicePoint – have largely stopped this practice after much criticism, simple competitive market forces without adequate oversight harmed consumers over a long period and undermined the loss prevention role of the insurance system. Moreover, as with the use of many questionable risk classification factors, competitive forces without regulatory oversight can actually exacerbate problems for consumers as insurers compete in risk selection and price poor people out of markets.

3. Insurance Cartels – Back to the Future

The insurance industry arose from cartel roots. For centuries, property-casualty insurers have used so-called "rating bureaus" to make rates for insurance companies to use jointly. Not many years ago, these bureaus required that insurers charge rates developed by the bureaus. (The last vestiges of this practice persisted into the 1990s).

In recent years, the rate bureaus have stopped requiring the use of their rates or even calculating full rates because of lawsuits by state attorneys general. State attorneys general charged in court that the last liability insurance crisis was caused in great part by insurers sharply raising their prices to return to Insurance Services Office (ISO) rate levels in the mid-1980s. As a result of a settlement with these states, ISO agreed to move away from requiring final prices. ISO is an insurance rate bureau or advisory organization. Historically, ISO was a means of controlling competition. It still serves to restrain competition since it makes "loss costs" (the part of the rate that covers expected claims and the costs of adjusting claims) which represent about 60-70 percent of the rate.[37] ISO also makes available expense data to which insurers can compare their costs in setting their final rates. ISO sets classes of risk that are adopted by many insurers. ISO diminishes competition significantly through all of these activities. There are other such organizations that also set pure premiums or do other activities that result in joint insurance company decisions. These include the National Council on Compensation Insurance (NCCI) and National Insurance Services Organization (NISS). Examples of ISO's many anticompetitive activities are attached.

Today the rate bureaus still produce joint price guidance for the large preponderance of the rate. The rating bureaus start with historic data for these costs and then actuarially manipulate the data (through processes such as "trending" and "loss development") to determine an estimate of the projected cost of claims and adjustment expenses in the future period when the costs they are calculating will be used in setting the rates for many insurers. Rate bureaus, of course, must bias their projections to the high side to be sure that the resulting rates or loss costs are high enough to cover the needs of the least efficient, worst underwriting insurer member or subscriber to the service.

[37] A list of activities of ISO is attached as Attachment 3.

Legal experts testifying before the House Judiciary Committee in 1993 concluded that, absent McCarran-Ferguson's antitrust exemption, manipulation of historic loss data to project losses into the future would be illegal (whereas the simple collection and distribution of historic data itself would be legal since that would be a pro-competitive activity). This is why there are no similar rate bureaus in other industries. For instance, there is no CSO (Contractor Services Office) predicting the cost of labor and materials for construction of buildings in the construction trades for the next year (to which contractors could add a factor to cover their overhead and profit). The CSO participants would go to jail for such audacity.

Further, rate organizations like ISO file "multipliers" for insurers to convert the loss costs into final rates. The insurer merely has to tell ISO what overhead expense load and profit load they want and a multiplier will be filed. The loss cost times the multiplier is the rate the insurer will use. An insurer can, as ISO once did, use an average expense of higher cost insurers for the expense load if it so chooses plus the traditional ISO profit factor of five percent and replicate the old "bureau" rate quite readily.

It is clear that the rate bureaus[38] still have a significant anti-competitive influence on insurance prices in America.

- The rate bureaus guide pricing with their loss cost/multiplier methods.

- The rate bureaus manipulate historic data in ways that would not be legal absent the McCarran-Ferguson antitrust exemption.

- The rate bureaus also signal to the market that it is OK to raise rates. The periodic "hard" markets are a return to rate bureau pricing levels after falling below such pricing during the "soft" market phase.

- The rate bureaus signal other market activities, such as when it is time for a market to be abandoned and consumers left, possibly, with no insurance.

More recently, insurers have begun to utilize new third party organizations (like RMS and Fair Isaac) to provide information (often from "black boxes" beyond state insurance department regulatory reach) for key insurance pricing and underwriting decisions, which helps insurers to avoid scrutiny for their actions. These organizations are not regulated by the state insurance departments and have a huge impact on rates and underwriting decisions with no state oversight. Indeed RMS's action, since it is not a regulated entity, may be a violation of current antitrust laws.

The Senate Judiciary Committee is in the midst of a review of the antitrust exemption. The Chairman and bipartisan members of the Committee have introduced S.618, which would

[38] By "rate bureaus" here I include the traditional bureaus (such as ISO) but also the new bureaus that have a significant impact on insurance pricing such as the catastrophe modelers (including RMS) and other non-regulated organizations that impact insurance pricing and other decisions across many insurers (credit scoring organizations like Fair Isaac are one example).

repeal the antitrust exemption and provide the FTC with antitrust enforcement authority if insurers engage in anticompetitive behavior not immunized by the state action doctrine. CFA and a number of other national consumer organizations support passage of S.618.[39]

4. Reverse Competition in Some Lines of Insurance

As indicated above, some lines of insurance, such as credit insurance (including mortgage life insurance), title insurance and forced placed insurance, suffer from "reverse competition." Reverse competition occurs when competition acts to drive prices up, not down. This happens when the entity that selects the insurer is not the ultimate consumer but a third party that receives some sort of kickback (in the form of commissions, below–cost services, affiliate income, sham reinsurance, etc.).

An example is credit insurance added to a car loan. The third-party selecting the insurer is the car dealer who is offered commissions for the deal. The dealer will often select the insurer with the biggest kickback, not with the lower rate. This causes the price of the insurance to rise and the consumer to pay higher rates.

Other examples of reverse competition occur in the title and mortgage guaranty lines, where the product is required by a third party and not the consumer paying for the coverage. In these two cases, the insurer markets its product not to the consumer paying for the product, but to the third party who is in the position to steer the ultimate consumer to the insurer. This competition for the referrers of business drives up the cost of insurance – hence, reverse competition.

We know from the investigations and settlements by New York Attorney General Eliot Spitzer that even sophisticated buyers can suffer from bid rigging and other negative consequences of "reverse-competition". Even when unsophisticated consumers purchase insurance lines that don't typically have reverse competition, these buyers can suffer similar consequences if they do not shop carefully. Independent agents represent several insurance companies. At times, this can be helpful, but not always. If a buyer is not diligent, an agent could place the consumer into a higher priced insurer with a bigger commission rate for the agent. Unfortunately, this happens too often since regulators have not imposed suitability or lowest cost requirements on the agents.

5. Claims Problems

Many consumers face a variety of claims problems. Often, their only recourse is to retain an attorney, an option that is not affordable for consumers in many situations. For example, many Gulf Coast residents are in litigation over handling of homeowners claims by insurers after Hurricane Katrina. We have seen many reports from consumers of situations that appear to involve bad claims handling practices, particularly related to policy forms that appear ambiguous.[40]

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[39] My testimony on this bill at the Senate Judiciary Committee hearing of March 7, 2007, can be found at http://judiciary.senate.gov/pdf/03-07-07McCarran-FergusonHearing-HunterTestimony.pdf.

[40] Reviews of calls to the Americans for Insurance Reform hotline are available at www.insurance-reform.org.

Some insurers have also adopted practices that routinely "low-ball" claims offers through the use of computerized claims processing and other techniques that have sought to cut claims costs arbitrarily.

See the more detailed discussion of claims problems earlier in this testimony.

6. The Revolving Door between Regulators and the Insurance Industry Results in Undue Industry Influence at the National Association of Insurance Commissioners

Consider this list of recent NAIC Presidents and their current place of employment:

2006: Al Iuppa – moved in mid-term as NAIC President to become chief lobbyist for the insurer Zurich Financial Services Group

2005: Diane Koken – recently resigned as Pennsylvania's commissioner to, as an AP story put it: "Koken… said she has accepted a nomination to the board of a national insurance company. She declined to identify the company but said she expects to be elected in April and decided to step down effective Feb. 19 to avoid potential conflicts of interest."[41]

2004: Ernest Csiszar – moved in mid-term as NAIC President to lobby on behalf of the property-casualty insurers as President of the Property Casualty Insurers Association

2003: Mike Pickens – currently lobbies on behalf of insurers as a private attorney

2002: Terrie Vaughn – currently lobbies on behalf of life insurers as a Board Member of Principal Financial Group

2001: Kathleen Sebelius – currently Governor of Kansas

2000: George Nichols – currently works for New York Life

The revolving door of regulators to industry and of industry to regulators is particularly troubling given the role of the NAIC in state insurance regulation.[42] The NAIC plays a major role in guiding state insurance oversight, yet it is organized as a non-profit trade association of regulators and, consequently, lacks the public accountability of a government agency, like an insurance department. For example, it is not subject to Freedom of Information statutes. In addition, policy decisions are made at the NAIC by allowing each state one vote, not matter the population of the state. This means that the Commissioner of Insurance in South Dakota has equal influence as the California or New York regulator. The result is that regulators in states comprising a minority of the country's population can determine national policy for the entire

[41] "Diane Koken Resigns After Ten Years as PA Insurance Chief," *The Associated Press*, Feb. 13, 2007. *See* http://www.yorkdispatch.com/pennsylvania/ci_5225171?source=sb-google.

[42] Studies over they years show that about half of all commissioners come from and return to the insurance industry. Studies also show that about 20 percent of state legislators serving on insurance committees in state legislatures are actively employed directly or indirectly by the insurance industry.

country. This problem is exacerbated by the inappropriate industry influence resulting from the revolving door between regulators and industry.

Why Have Insurers Recently Embraced Federal Regulation (Again)?

The recent "conversion" of some insurers to the concept of federal regulation is based solely on the notion that such regulation would be weaker. Insurers have, on occasion, sought federal regulation when the states increased regulatory control and the federal regulatory attitude was more laissez-faire. Thus, in the 1800s, the industry argued in favor of a federal role before the Supreme Court in *Paul v. Virginia*, but the court ruled that the states controlled because insurance was intrastate commerce.

Later, in the 1943 *SEUA* case, the Court reversed itself, declaring that insurance was interstate commerce and that federal antitrust and other laws applied to insurance. By this time, Franklin Roosevelt was in office and the federal government was a tougher regulator than were the states. The industry sought, and obtained, the McCarran-Ferguson Act. This law delegated excusive authority for insurance regulation to the states, with no routine Congressional review. The Act also granted insurers a virtually unheard of exemption from antitrust laws, which allowed insurance companies to collude in setting rates and to pursue other anticompetitive practices without fear of federal prosecution.

From 1943 until recently, the insurance industry has violently opposed any federal role in insurance regulation. In 1980, insurers successfully lobbied to stop the Federal Trade Commission from investigating deceptive acts and practices of any kind in the insurance industry. They also convinced the White House that year to eliminate the Federal Insurance Administration's work on insurance matters other than flood insurance. Since that time, the industry has successfully scuttled any attempt to require insurers to comply with federal antitrust laws and has even tried to avoid complying with federal civil rights laws.

Notice that the insurance industry is very pragmatic in their selection of a preferred regulator. They always favor the least regulation. It is not surprising that, today, the industry would again seek a federal role at a time they perceive little regulatory interest at the federal level. But, rather than going for full federal control, they have learned that there are ebbs and flows in regulatory oversight at the federal and state levels, so they seek the ability to switch back and forth at will.

Further, the insurance industry has used the possibility of an increased federal role to pressure NAIC and the states into gutting consumer protections over the last seven years. Insurers have repeatedly warned states that the only way to preserve their control over insurance regulation is to weaken consumer protections.[43] They have been assisted in this effort by a series

[43] The clearest attempt to inappropriately pressure the NAIC occurred at their spring 2001 meeting in Nashville, which I witnessed. There, speaking on behalf of the entire industry, Paul Mattera of Liberty Mutual Insurance Company told the NAIC that they were losing insurance companies every day to political support for the federal option and that their huge effort in 2000 to deregulate and speed product approval was too little, too late. He called for an immediate step-up of deregulation and measurable "victories" of deregulation to stem the tide. In a July 9, 2001, *Wall Street Journal* article by Chris Oster, Mattera admitted his intent was to get a "headline or two to get

of House hearings under the previous Committee leadership. Rather than focusing on the need for improved consumer protection, the hearings served as a platform for a few Representatives to issue ominous statements calling on the states to further deregulate insurance oversight, "or else."

This strategy of "whipsawing" state regulators to lower standards benefits all elements of the insurance industry, even those that do not support any federal regulatory approach. Even if Congress does nothing, the threat of federal intervention is enough to scare state regulators into acceding to insurer demands to weaken consumer protections.

Unfortunately for consumers, the strategy has already paid off, before the first insurance bill is ever marked up in Congress. In the last few years, the NAIC has moved suddenly to cut consumer protections adopted over a period of decades. The NAIC is terrified of Congressional action and sees reducing state consumer protections as the way to "save" state regulation by placating insurance companies and encouraging them to stay in the fold. This strategy of saving the village by burning it has made state regulation more, not less vulnerable to a federal takeover.

The NAIC has also failed to act in the face of a number of serious problems facing consumers in the insurance market.

NAIC Failures to Act

1. Failure to do anything about abuses in the small face life market. Instead, NAIC adopted an incomprehensible disclosure on premiums exceeding benefits, but did nothing on overcharges, multiple policies, or unfair sales practices.

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people refocused." His remarks were so offensive that I went up to several top commissioners immediately afterward and said that Materra's speech was the most embarrassing thing I had witnessed in 40 years of attending NAIC meetings. I was particularly embarrassed since no commissioner challenged Mattera and many commissioners had almost begged the industry to grant them more time to deliver whatever the industry wanted.

Jane Bryant Quinn, in her speech to the NAIC on October 3, 2000, said: "Now the industry is pressing state regulators to be even more hands-off with the threat that otherwise they'll go to the feds." As a result, other observers of the NAIC see this pressure as potentially damaging to consumers.

Larry Forrester, President of the National Association of Mutual Insurance Companies (NAMIC), wrote an article in the *National Underwriter* of June 4, 2000. In it he said, "…how long will Congress and our own industry watch and wait while our competitors continue to operate in a more uniform and less burdensome regulatory environment? Momentum for federal regulation appears to be building in Washington and state officials should be as aware of it as any of the rest of us who have lobbyists in the nation's capital…NAIC's ideas for speed to market, complete with deadlines for action, are especially important. Congress and the industry will be watching closely…The long knives for state regulation are already out…"

In a press release entitled "Alliance Advocates Simplification of Personal Lines Regulation at NCOIL Meeting; Sees it as Key to Fighting Federal Control" dated March 2, 2001, John Lobert, Senior VP of the Alliance of American Insurers, said, "Absent prompt and rapid progress (in deregulation) … others in the financial services industry – including insurers – will aggressively pursue federal regulation of our business…"

In the NAIC meeting of June 2006, Neil Alldredge of the National Association of Mutual Insurance Companies pointed out that "states are making progress with rate deregulation reforms. In the past four years, 16 states have enacted various price deregulation reforms…(but) change is not happening quickly enough…He concluded that the U.S. Congress is interested in insurance regulatory modernization and the insurance industry will continue to educate Congress about the slow pace of change in the states (Minutes of the NAIC/Industry Liaison Committee, June 10, 2006)."

2. Failure to do anything meaningful about unsuitable sales in any line of insurance. Suitability requirements still do not exist for life insurance sales even in the wake of the remarkable market conduct scandals of the late 1980s and early 1990s. A senior annuities protection model was finally adopted (after years of debate) that is so limited as to do nothing to protect consumers.

3. Failure to call for collection and public disclosure of market performance data after years of requests for regulators to enhance market data, as NAIC weakened consumer protections. How does one test whether a market is workably competitive without data on market shares by zip code and other tests?

4. Failure to call for repeal of the antitrust exemption in the McCarran-Ferguson Act as they push forward deregulation model bills. Indeed, the NAIC still opposes repeal of the antitrust exemption even as they deregulate…effectively seeking to deregulate cartel-like organizations.

5. Failure to do anything as an organization on the use of credit scoring for insurance purposes. In the absence of NAIC action, industry misinformation about credit scoring has dominated state legislative debates. NAIC's failure to analyze the issue and perform any studies on consumer impact, especially on lower income consumers and minorities, has been a remarkable dereliction of duty.

6. Failure to end use of occupation and education in underwriting and pricing of auto insurance.[44]

7. Failure to address problems with risk selection. There has not even been a discussion of insurers' explosive use of underwriting and rating factors targeted at socio-economic characteristics: credit scoring, check writing, prior bodily injury coverage limits purchased by the applicant, prior insurer, prior non-standard insurer, not-at-fault claims, not to mention use of genetic information, where Congress has had to recently act to fill the regulatory void.

8. Failure to heed calls from consumer leaders to do something about contingency commissions for decades until Attorney General Spitzer finally acted.

9. Failure to even discover, much less deal with, the claims abuses relating to the use of systems designed to systematically underpay claims for millions of Americans.

10. Failure to do anything on single premium credit insurance abuses.

11. Failure to take recent steps on redlining or insurance availability or affordability. Many states no longer even look at these issues, 30 years after the federal government issued studies documenting the abusive practices of insurers in this regard. Yet,

[44] Florida has held hearings on the practice.

ongoing lawsuits continue to reveal that redlining practices harm the most vulnerable consumers.

12. Failure to take meaningful action on conflict-of-interest restrictions even after Ernest Csiszar left his post as South Carolina regulator and President of the NAIC in September 2004 to become President of the Property Casualty Insurers Association of America after negotiating deregulation provisions in the SMART Act desired by PCIAA members.

13. Failure to act to create regional catastrophic pools to spread hurricane risks or to effectively deal with inappropriate short-term, unscientific models which have sharply raised consumers' home insurance prices along the coasts.

NAIC Rollbacks of Consumer Protections

1. The NAIC pushed through small business property-casualty deregulation, without doing anything to reflect consumer concerns (indeed, even refusing to tell consumer groups why they rejected their specific proposals) or to upgrade "back-end" market conduct quality, despite promises to do so. As a result, many states adopted the approach and have rolled back their regulatory protections for small businesses.

2. States are rolling back consumer protections in auto insurance as well. New Jersey, Texas, Louisiana, and New Hampshire have done so in the last three years.

3. NAIC has terminated free access for consumers to the annual statements of insurance companies at a time when the need for enhanced disclosure is needed if price regulation is to be reduced.

4. NAIC is currently actively considering adoption of personal lines (auto and home insurance) regulatory framework guidance to the states that would severely reduce consumer protections.

Can Competition Alone Guarantee a Fair, Competitive Insurance Market?

Consumers, who over the last 30 years have been the victims of vanishing premiums, churning, race-based pricing, creaming, and consumer credit insurance policies that pay pennies in claims per dollar in premium, are not clamoring for such policies to be brought to market with even less regulatory oversight than in the past. The fact that "speed-to-market" has been identified as a vital issue in modernizing insurance regulation demonstrates that some policymakers have bought into insurers' claims that less regulation benefits consumers. We disagree. We think smarter, more efficient regulation benefits both consumers and insurers and leads to more beneficial competition. Mindless deregulation, on the other hand, will harm consumers.

The need for better regulation that benefits both consumers and insurers is being exploited by some in the insurance industry to eliminate the most effective aspects of state

insurance regulation such as rate regulation, in favor of a model based on the premise that competition alone will protect consumers.[45] We question the entire foundation behind the assumption that virtually no front-end regulation of insurance rates and terms coupled with more back-end (market conduct) regulation is better for consumers. First of all, there are many reasons why competition in insurance is weak (see a list of these reasons attached as Attachment 2). The track record of market conduct regulation has been extremely poor. As noted above, insurance regulators rarely are the first to identify major problems in the marketplace.

Given this track record, market conduct standards and examinations by regulators must be dramatically improved to enable regulators to become the first to identify and fix problems in the marketplace and to address market conduct problems on a national basis. From an efficiency and consumer protection perspective, it makes no sense to lessen efforts to prevent the introduction of unfair and inappropriate policies in the marketplace. It takes far less effort to prevent an inappropriate insurance policy or market practice from being introduced than to examine the practice, stop a company from doing it and provide proper restitution to consumers after the fact.

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[45] If America moves to a "competitive" model, certain steps must first be taken to ensure "true competition" and prevent consumer harm. First, insurance lines must be assessed to determine whether a competitive model, e.g., the alleviation of rate regulation, is even appropriate. This assessment must have as its focus how the market works for consumers. For example, states cannot do away with rate regulation of consumer credit insurance and other types of insurance subject to reverse competition. The need for relative cost information and the complexity of the line/policy are factors that must be considered.

However, if certain lines are identified as appropriate for a "competitive" system, the following must be in place before such a system can be implemented,:

- Policies must be transparent: Disclosure, policy forms, and other laws must create transparent policies. Consumers must be able to comprehend the policy's value, coverage, actual costs, including commissions and fees. If consumers cannot adequately compare actual costs and value, and if consumers are not given the best rate for which they qualify, there can be no true competition.
- Policies should be standardized to promote comparison-shopping.
- Antitrust laws must apply.
- Anti-rebate, anti-group, and other anti-competitive state laws must be repealed.
- Strong market conduct and enforcement rules must be in place with adequate penalties to serve as an incentive to compete fairly and honestly.
- Consumers must be able to hold companies legally accountable through strong private remedies for losses suffered as a result of company wrongdoing.
- Consumers must have knowledge of and control over flow and access of data about their insurance history through strong privacy rules.
- There must be an independent consumer advocate to review and assess the market, assure the public that the market is workably competitive, and determine if policies are transparent.

Safeguards to protect against competition based solely on risk selection must also be in place to prevent redlining and other problems, particularly with policies that are subject to either a public or private mandate. If a competitive system is implemented, the market must be tested on a regular basis to make sure that the system is working and to identify any market dislocations. Standby rate regulation should be available in the event the "competitive model" becomes dysfunctional.

If the industry will not agree to disclose actual costs (including all fees and commissions, ensuring transparency of policies, strong market conduct rules, and enforcement) then it is not advocating true competition, only deregulation.

The unique nature of insurance policies and insurance companies requires more extensive front-end regulation than other consumer commodities. And while insurance markets can be structured to promote beneficial price competition, deregulation does not lead to, let alone guarantee, such beneficial price competition.

Front-end regulation should be designed to prevent market conduct problems from occurring instead of inviting those problems to occur. It should also promote beneficial competition, such as price competition and loss mitigation efforts, and deter destructive competition, such as selection competition, and unfair sales and claims settlement practices. Simply stated, strong, smart, efficient and consistent front-end regulation is critical for meaningful consumer protection and absolutely necessary to any meaningful modernization of insurance regulation.

Is Regulation Incompatible With Competition?

The insurance industry promotes a myth: that regulation and competition are incompatible. This is demonstrably untrue. Regulation and competition both seek the same goal: the lowest possible price that is consistent with a reasonable return for the seller. There is no reason that these systems cannot coexist and even compliment each other.

The proof that competition and regulation can work together to benefit consumers and the industry is the manner in which California regulates auto insurance under Proposition 103. Indeed, that was the theory of the drafters (including myself) of Proposition 103. Before Proposition 103, Californians had experienced significant price increases under a system of "open competition" of the sort the insurers now seek at the federal level. (No regulation of price is permitted but rate collusion by rating bureaus is allowed, while consumers receive very little help in getting information.) Proposition 103 sought to maximize competition by eliminating the state antitrust exemption, laws that forbade agents to compete, laws that prohibited buying groups from forming, and so on. It also imposed the best system of prior approval of insurance rates and forms in the nation, with very clear rules on how rates would be judged.

As our in-depth study of regulation by the states revealed,[46] California's regulatory transformation -- to rely on both maximum regulation and competition -- has produced remarkable results for auto insurance consumers and for the insurance companies doing business there. The study reported that insurers realized very nice profits, above the national average, while consumers saw the average price for auto insurance drop from $747.97 in 1989, the year Proposition 103 was implemented, to $717.98 in 1998. Meanwhile, the average premium rose nationally from $551.95 in 1989 to $704.32 in 1998. California's rank dropped from the third costliest state to the 20th.

As of 2005, the average annual premium in California was $844.50 (ranked 18th) vs. $829.17 for the nation.[47] Since California transitioned from relying simply on competition -- as promoted by insurers -- to full competition and regulation, the average auto rate went up by 12.9

[46] "Why Not the Best? The Most Effective Auto Insurance Regulation in the Nation," Consumer Federation of America, June 6, 2000.

[47] State Average Expenditures & Premiums for Personal Automobile Insurance in 2001, NAIC, July 2005.

percent while the national average rose by 50.2 percent -- a powerhouse result for California's consumers! [48] In 1989, California consumers were paying 36 percent more that the national average, while today they pay a mere 2 percent more than the national average price.

How Can Uniformity be Achieved Without Loss of Consumer Protections?

CFA would endorse a more uniform national or multi-state approach if certain rigorous conditions were met. The attached fact sheet, *Consumer Principles and Standards for Insurance Regulation,*[49] provides detailed standards that regulators should meet to properly protect consumers, whether at the state, multi-state or national level. It should be noted that none of recent proposals offered by insurers or on behalf of insurers to Congress come close to meeting these standards.

One obvious vehicle for multi-state enforcement of insurance standards is the NAIC. The NAIC Commission of the Interstate Insurance Product Regulation Compact began operation with a small staff on June 13th of this year. We have favored empowering the NAIC to implement such a multi-state approach only if the NAIC's decision-making procedures are overhauled to make it a more transparent, accountable body with meaningful regulatory powers. These steps would include public access to insurer filings during the review process and formal, funded consumer participation. To date, regulators have refused to take these steps. Moreover, the Commission will be unlikely to carry out its role as a truly independent regulator due to inadequate funding. The Commission will be receiving and reviewing life, annuity and long term care filings for at least 27 states, but its current budget only allows for a total staff of three people. As stated above, recent NAIC failures demonstrate that it is not an impartial regulatory body that can be counted on to adequately consider consumer needs.

Because of its historical domination by the insurance industry, consumer organizations are extremely skeptical about its ability to confer national treatment in a fair and democratic way. It is essential that any federal legislation to empower the NAIC include standards to prevent undue industry influence and ensure the NAIC can operate as an effective regulatory entity, including:

- Democratic processes/accountability to the public, which must include: notice and comment rulemaking; on the record voting; accurate minutes; rules against ex-parte communication; public meeting/disclosure/sunshine rules/FOIA applicability.
- A decision-making process subject to an excellent Administrative Procedures Act.
- Strong conflict of interest and revolving door statutes similar to those of the federal government to prevent undue insurance industry influence. If decision-making members of the NAIC have connections, past or present, to certain companies, the process will not be perceived as fair.

[48] Insurers have posted excellent profits as well. Over the decade ending in 2004, California insurers enjoyed a return on equity for private passenger auto insurance of 11.1 percent vs. 8.5 percent for the nation (Report on Profitability by Line by State 2004, NAIC).

[49] See Attachment 1.

- Independent funding. The NAIC cannot serve as a regulatory entity if it relies on the industry for its funding. The bill should establish a system of state funding to the NAIC at a set percentage of premium so that all states and insured entities equally fund the NAIC.
- National Independent Advocate. To offset industry domination, an independent, national, public insurance counsel/ombudsman with necessary funding is needed. Consumers must be adequately represented in the process for the process to be accountable and credible.

Regulation by Domiciliary States Will Lead to Unacceptably Weak Standards

When I was Texas Insurance Commissioner, I had to go into another state to seek a court order to declare an insurer, domiciled in the other state, insolvent. The commissioner of that state refused to do so because of local politics (several ex-governors were on the Board of the failed insurer).

CFA opposes allowing a domiciliary state to essentially act as a national regulator by allowing domiciled companies to comply only with that state's standards. This approach has several potential problems, including the following:

- It promotes forum shopping. Companies would move from state to state to secure regulation from the state that has the least capacity to regulate, provoking a "race to the bottom."
- The state of domicile is often under the greatest political and economic pressure not to act to end harmful business practices by a powerful in-state company.
- The resources of states to properly regulate insurance vary widely.
- It is antithetical to states' rights to apply laws from other states to any business operating within their borders. If such a move is made, however, it is imperative that consumers have a national, independent advocate.
- It promotes a lack of consistency in regulation because companies could change domiciliary state status.
- Residents of one state cannot be adequately represented by the legislature/executive of another. If a resident's state consumer protections did not apply, the resident would be subject to laws of a state in which they have no representation. How can a consumer living in Colorado influence decisions made in Connecticut?
- Rather than focusing on protecting consumers, this system would change the focus to protecting itself and its regulatory turf, as has happened in the bank regulatory system. State and federal banking regulators have competed to lower their consumer protections to lure banks to their system.
- We would be particularly concerned with proposals to give exclusive control of market conduct exams to a domiciliary state. Unscheduled exams by a state are very important for that state's ability to protect its consumers from abuse. States must retain the ability to act quickly based on complaints or other information.

"One-Stop" Policy Approval Must Meet High Standards

Allowing insurers to get approval for their products from a single, unaccountable, non-state regulatory entity would also lead to extremely weak protections unless several conditions are met:

- An entity, such as the NAIC's Coordinated Advertising, Rate and Form Review Authority (CARFRA), that is not subject to authorizing legislation, due process standards, public accountability, prohibitions on ex-parte communications, and similar standards should not have the authority to determine which lines would be subject to a one-stop approval process or develop national standards. It also must have funding through the states, not directly from insurers. Independent funding ensures that the regulatory entity is not subject to unfair and detrimental industry influence.
- Any standards that apply must be high and improve the ability of consumers to understand policies and compare on the basis of price. Consumers do not want "speed—to-market" for bad policies.
- Any entity that serves as national standard setter, reviewer and/or approver needs federal authorizing legislation. An "interstate compact" or "memorandum of understanding" is unworkable and unaccountable.
- Giving the regulated insurer the option to choose which entity regulates it, is an invitation to a race to the bottom for regulatory standards.
- Standardization of forms by line has the potential to assist consumers if done in such a way to enhance understanding of terms, benefits, limitations, and actual costs of policies.
- Public/consumer input is essential if the entity makes decisions that ultimately affect information provided to and rates charged consumers.
- We support the concept of an electronic central filing repository, but the public must have access to it.
- To retain oversight of policies and rates affecting their residents, states must have the ability to reject decisions of the entity.
- Any national system must include a national, externally funded consumer-public advocate/counsel to represent consumers in standard setting, development of forms, rate approval, etc.

Recent Federal Proposals

Given the extremely sorry state of state regulation, it is hard to believe that a federal bill could be crafted that would make matters worse. Yet, insurers have managed to do it – not once, but twice! Their bills not only do not provide the basic standards of consumer protection cited above, they would undermine the extremely low standards of consumer protection now extant in many states.

Greater resistance in Congress and extremely low public opinion of insurers in the wake of their poor performance after Hurricane Katrina, which occurred as the insurers rolled to three years of record profits in a row, has led insurers to temporarily step back from regulatory "reform." As one insurance lobbyist told me, "We are not pushing in this atmosphere – we do not want to risk having a bill that actually might enhance regulation, our goal all along has been deregulation, not uniformity." Nonetheless, it is important to reflect on how harmful to consumers these proposals would be.

<u>Insurer Dream Bill #1: Optional Federal Insurance Charter</u>

The bills that have been drafted by trade associations like the American Bankers Association and the American Council of Life Insurers would create a federal regulator that would have little, if any, authority to regulate price or product, regardless of how non-competitive the market for a particular line of insurance might be. (This bill has been introduced in the House as H.R. 3200 by Representatives Bean and Royce and in the Senate as S. 40 by Senators Johnson and Sununu.) The bills also offer little improvement in consumer protection or information systems to address the major problems cited above. Insurers would be able to choose whether to be regulated by this weak federal regulator or by state regulators.

Consumer organizations strongly oppose an optional federal charter that allows the regulated company, at its sole discretion, to pick its regulator. This is a prescription for regulatory arbitrage that can only undermine needed consumer protections. Indeed the industry drafters of such proposals have openly stated that this is their goal. If elements of the insurance industry truly want to obtain uniformity of regulation, "speed to market" and other advantages through a federal regulator, let them propose a federal approach that does not allow insurers to run back to the states when regulation gets tougher than they want. We could all debate the merits of that approach. CFA and the entire consumer community stand ready to fight optional charters with all the strength we can muster.

Insurer Dream Bill #2: SMART Act

The State Modernization and Regulatory Transformation (SMART) Act was proposed by former House Financial Services Chairman Michael Oxley and Representative Richard Baker as a discussion draft in 2005. Rather than increase insurance consumer protections for individuals and small businesses while spurring states to increase the uniformity of insurance regulation, this sweeping proposal would override important state consumer protection laws, sanction anticompetitive practices by insurance companies and incite state regulators into a competition to further weaken insurance oversight. It is quite simply one of the most grievously flawed and one-sided pieces of legislation that we have ever seen, with absolutely no protections for consumers. The consumers who will be harmed by it are our nation's most vulnerable: the oldest, the poorest, and the sickest.

For example, the discussion draft would have preempted state regulation of insurance rates. Imagine the impact on the Gulf Coast of that "brilliant" idea! This would leave millions of consumers vulnerable to price gouging, as well as abusive and discriminatory insurance classification practices. It would also encourage a return to insurance redlining, as deregulation of prices would include the lifting of state controls on territorial line drawing. States would be helpless to stop the misuse of risk classification information, such as credit scores, territorial data, and the details of consumers' prior insurance history, for pricing purposes. The draft approach goes so far as to deregulate cartel-like organizations such as the Insurance Services Office and the National Council on Compensation Insurance, while leaving the federal antitrust exemption fully intact.

What the draft does not do is as revealing as what it does require. It does not create a federal office to represent consumer interests, although the draft creates two positions to represent insurer interests. It takes no steps to spur increased competition in the insurance

industry, such as providing assistance or information to the millions of consumers who find it extremely difficult to comparison shop for this complex and expensive product, or eliminating the antitrust exemption that insurers currently enjoy under the McCarran-Ferguson Act. Insurers are not required to meet community reinvestment requirements, as banks are, to guarantee that insurance is available in underserved communities. Nothing is done to prevent insurers from using inappropriate information, such as credit scores or a person's income, to develop insurance rates.

CFA supports the goals outlined in several sections of this draft. As stated above, we are not opposed to increasing uniformity in insurance regulation. Unfortunately, however, in almost every circumstance in which the draft attempts to ensure uniformity, it chooses the weakest consumer protection approach possible. Like the OFC, this approach has no chance in the current Congress, given the outrage over insurer practices and profits.

Insurer Dream #3: Non-admitted Insurance/Reinsurance Regulation

This bill, which was initially only one of 17 titles in the SMART Act, preempts states only in the regulation of surplus lines of insurance and reinsurance. This legislation (H.R. 1065) has passed the House of Representatives this year and has been introduced this year by Senators Martinez and Nelson as S. 929. It provides for a method of collecting state premium taxes for surplus lines and allocating this income to the states. CFA has several concerns with this legislation:

1. Contrary to the stated intent of the authors of this legislation, this bill (Section 107(3)) appears to open the door to the increased sale of poorly regulated, non-admitted personal lines of insurance to individual consumers, not just commercial insurance sold to sophisticated corporations. Moreover, the bill does not exclude non-admitted personal lines of insurance from its provisions. If the bill fosters a sharp growth in under-regulated, non-admitted insurance – as it is intended to do – it could seriously harm consumers.

2. Great regulatory confusion and ineptitude would likely result when the state of domicile for an insured party regulates all parts of that entity's insurance transaction. (Section 103 prohibits any state from overseeing surplus lines of transactions other than the home state of an insured party.) Consider how Michigan might regulate a transaction in which General Motors or another large company based in the state, has purchased a commercial automobile policy for its cars on the West and Gulf Coasts from non-admitted insurers. In all likelihood, Michigan regulators know very little about dealing with earthquake risk in California or hurricane risk in Florida in pricing insurance policies, or in handling claims resulting from such weather events if GM's cars are damaged. Moreover, since Michigan is a no-fault state for auto insurance, regulators there would likely know very little about tort laws in other states and how pricing and claims should be handled. How can 50 regulators each become experts in the laws of all 50 states? This is regulatory super-complexity, not regulatory simplification.

3. The bill is based on the incorrect assumption that the domiciled state of an insured party or reinsurance company will provide adequate oversight. The bill handcuffs states that would have a legitimate interest in acting to protect residents harmed by clearly abusive insurance practices (Section 102). For example, suppose a non-admitted insurer for a

company like GM acts in bad faith and refuses to pay legitimate claims regarding unsafe automobiles that harmed drivers in other states? These states would have no ability to investigate or sanction that insurance company while the State of Michigan, with limited resources and very little in-state impact, would have much less of an incentive to get to the bottom of the problem.

Moreover, a "home state" regulator has the greatest interest in pleasing a large insured party – and employer – based in that state. This could lead the regulator to lower insurance standards that protect residents and consumers who use that company's products and services across the country.

The bill (Section 105) would also allow large commercial insured parties to seek coverage from non-admitted insurers without determining whether the same coverage is available from an admitted carrier, which most states now require. It is not in the public interest to foster the growth of a segment of the market that does not have to meet state standards – unless admitted insurance is truly not available. For example, guaranty associations in all states do not cover claims for surplus lines insurers from other states when an insured entity and its insurer become insolvent. This may be a minor problem for the defunct policyholder and the defunct insurer, but it certainly is not minor for the people that the policyholder may have injured who are left without guarantee association protection.

Similarly, the bill (Section 202(a)) only allows the domiciled state of a reinsurance company to regulate that company's solvency. What if insured entities in the state of domicile are covered by only one percent of the reinsurance written by a particular company but entities in another state are covered by seventy-five percent of the reinsurance? Moreover, allowing a domiciliary state to essentially act as a national regulator promotes forum shopping by insurers to secure the most favorable regulatory environment. The state of domicile is often under the greatest political and economic pressure not to act to end harmful business practices by a powerful in-state insurer. As stated above, when I was Insurance Commissioner of Texas, I had to investigate an insolvent insurer in another state because the commissioner of that state refused to do so.

4. Several deregulatory provisions of the bill are based on the faulty assumption that large buyers of insurance do not need protections that would normally be provided in an insurance transaction, such as prohibitions on deceptive practices and mandated verification of the legality of policy forms. (For example, Section 103 prohibits any state from overseeing surplus lines transactions other than the home state of an insured party.) The investigations and settlements pursued by New York Attorney General Eliot Spitzer refute this assumption. Large, sophisticated corporations were victimized by insurers and brokers through bid-rigging, kickbacks, hidden commissions, and blatant conflicts of interest.

A Pro-Consumer Bill: The Insurance Consumer Protection Act of 2003

Only one recent bill considers the consumer perspective in its design, adopting many of the consumer protection standards cited in this testimony. That was S. 1373 of 2003 introduced by Senator Hollings. The bill would adopt a unitary federal regulatory system under which all

interstate insurers would be regulated. Intrastate insurers would continue to be regulated by the states.

The bill's regulatory structure requires federal prior approval of prices to protect consumers, including some of the approval procedures (such as hearing requirements when prices change significantly) being used so effectively in California. It requires annual market conduct exams. It creates an office of consumer protection. It enhances competition by removing the antitrust protection insurers hide behind in ratemaking. It improves consumer information and creates a system of consumer feedback.

If federal regulation is to be considered, S.1373 should be the baseline for any debate on the subject.

A Pro-Consumer Bill Whose Time has Come: Amending the McCarran- Ferguson Act to Remove the Antitrust Exemption

Insurers say they want competition alone to determine rates. The best way for Congress to help spur competition in the insurance industry would be to repeal the McCarran Ferguson Act, as proposed by S. 618. This would test the industry's desire to compete under the same rules as virtually all other American businesses.

Wisely, S. 618 also unleashes the Federal Trade Commission to perform oversight of anticompetitive insurer behavior, a key step necessary for effective and efficient consumer protection. We strongly support passage of this legislation.

Another Pro-Consumer Bill: Improving Disclosure to Consumers

One cause of the problems we have witnessed in the settlement of Hurricane Katrina claims is that consumers cannot understand complex insurance policy language. Senator Lott's Bill, S.1061, the "Homeowner's Insurance Noncoverage Disclosure Act," is an essential step to help people know what will not be covered if some calamity occurs to a home. The use of the FTC, an agency too long restrained from helping Americans with insurance problems, is also welcome. CFA supports passage of S.1061.

Conclusion

CFA looks forward to working with the Subcommittee to strengthen consumer protections for insurance, Mr. Chairman. I will be happy to respond to questions at the appropriate time.

ATTACHMENT 1

Consumer Principles and Standards for Insurance Regulation

1. Consumers should have access to timely and meaningful information about the costs, terms, risks and benefits of insurance policies.

- Meaningful disclosure prior to sale tailored for particular policies and written at the education level of the average consumer sufficient to educate and enable consumers to assess a particular policy and its value should be required for all insurance; it should be standardized by line to facilitate comparison shopping; it should include comparative prices, terms, conditions, limitations, exclusions, loss ratio expected, commissions/fees and information on seller (service and solvency); it should address non-English speaking or ESL populations.
- Insurance departments should identify, based on inquiries and market conduct exams, populations that may need directed education efforts, e.g., seniors, low-income, low education.
- Disclosure should be made appropriate for medium in which product is sold, e.g., in person, by telephone, on-line.
- Loss ratios should be disclosed in such a way that consumers can compare them for similar policies in the market, e.g., a scale based on insurer filings developed by insurance regulators or an independent third party.
- Non-term life insurance policies, e.g., those that build cash values, should include rate of return disclosure. This would provide consumers with a tool, analogous to the APR required in loan contracts, with which they could compare competing cash value policies. It would also help them in deciding whether to buy cash value policies.
- A free look period should be required; with meaningful state guidelines to assess the appropriateness of a policy and value based on standards the state creates from data for similar policies.
- Comparative data on insurers' complaint records, length of time to settle claims by size of claim, solvency information, and coverage ratings (e.g., policies should be ranked based on actuarial value so a consumer knows if comparing apples to apples) should be available to the public.
- Significant changes at renewal must be clearly presented as warnings to consumers, e.g., changes in deductibles for wind loss.
- Information on claims policy and filing process should be readily available to all consumers and included in policy information.
- Sellers should determine and consumers should be informed of whether insurance coverage replaces or supplements already existing coverage to protect against over-insuring, e.g., life and credit.
- Consumer Bill of Rights, tailored for each line, should accompany every policy.
- Consumer feedback to the insurance department should be sought after every transaction (e.g., after policy sale, renewal, termination, claim denial). The insurer should give the consumer notice of feedback procedure at the end of the transaction, e.g., form on-line or toll-free telephone number.

2. **Insurance policies should be designed to promote competition, facilitate comparison-shopping, and provide meaningful and needed protection against loss.**

   - Disclosure requirements above apply here as well and should be included in the design of policy and in the policy form approval process.
   - Policies must be transparent and standardized so that true price competition can prevail. Components of the insurance policy must be clear to the consumer, e.g., the actual current and future cost, including commissions and penalties.
   - Suitability or appropriateness rules should be in place and strictly enforced, particularly for investment/cash value policies. Companies must have clear standards for determining suitability and compliance mechanism. For example, sellers of variable life insurance are required to find that the sales that their representatives make are suitable for the buyers. Such a requirement should apply to all life insurance policies, particularly when replacement of a policy is at issue.
   - "Junk" policies, including those that do not meet a minimum loss ratio, should be identified and prohibited. Low-value policies should be clearly identified and subject to a set of strictly enforced standards that ensure minimum value for consumers.
   - Where policies are subject to reverse competition, special protections are needed against tie-ins, overpricing, e.g., action to limit credit insurance rates.

3. **All consumers should have access to adequate coverage and not be subject to unfair discrimination.**

   - Where coverage is mandated by the state or required as part of another transaction/purchase by the private market (e.g., mortgage), regulatory intervention is appropriate to assure reasonable affordability and guarantee availability.
   - Market reforms in the area of health insurance should include guaranteed issue and community rating and, where needed, subsidies to assure health care is affordable for all.
   - Information sufficient to allow public determination of unfair discrimination must be available. For example, geo-code data, rating classifications, and underwriting guidelines should be reported to regulatory authorities for review and made public.
   - Regulatory entities should conduct ongoing, aggressive market conduct reviews to assess whether unfair discrimination is present and to punish and remedy it if found, e.g., redlining reviews (analysis of market shares by census tracts or zip codes, analysis of questionable rating criteria such as credit rating), reviews of pricing methods, and reviews of all forms of underwriting instructions, including oral instructions to producers.
   - Insurance companies should be required to invest in communities and market and sell policies to prevent or remedy availability problems in communities.
   - Clear anti-discrimination standards must be enforced so that underwriting and pricing are not unfairly discriminatory. Prohibited criteria should include race, national origin, gender, marital status, sexual preference, income, language, religion, credit history, domestic violence, and, as feasible, age and disabilities. Underwriting and rating classes should be demonstrably related to risk and backed by a public, credible statistical analysis that proves the risk-related result.

4. **All consumers should reap the benefits of technological changes in the marketplace that decrease prices and promote efficiency and convenience.**

   - Rules should be in place to protect against redlining and other forms of unfair discrimination via certain technologies, e.g., if companies only offer better rates, etc. online.
   - Regulators should take steps to certify that online sellers of insurance are genuine, licensed entities and tailor consumer protection, UTPA, etc. to the technology to ensure consumers are protected to the same degree regardless of how and where they purchase policies.
   - Regulators should develop rules/principles for e-commerce (or use those developed for other financial firms if appropriate and applicable).
   - In order to keep pace with changes and determine whether any specific regulatory action is needed, regulators should assess whether and to what extent technological changes are decreasing costs and what, if any, harm or benefits accrue to consumers.
   - A regulatory entity, on its own or through delegation to an independent third party, should become the portal through which consumers go to find acceptable sites on the web. The standards for linking to acceptable insurer sites via the entity and the records of the insurers should be public; the sites should be verified/reviewed frequently and the data from the reviews also made public.

5. **Consumers should have control over whether their personal information is shared with affiliates or third parties.**

   - Personal financial information should not be disclosed for purposes other than the one for which it is given unless the consumer provides prior written or other form of verifiable consent.
   - Consumers should have access to the information held by the insurance company to make sure it is timely, accurate, and complete. They should be periodically notified how they can obtain such information and how to correct errors.
   - Consumers should not be denied policies or services because they refuse to share information (unless information is needed to complete the transaction).
   - Consumers should have meaningful and timely notice of the company's privacy policy and their rights and how the company plans to use, collect, and or disclose information about the consumer.
   - Insurance companies should have a clear set of standards for maintaining the security of information and have methods to ensure compliance.
   - Health information is particularly sensitive and, in addition to a strong opt-in, requires particularly tight control and use only by persons who need to see the information for the purpose for which the consumer has agreed to the sharing of the data.
   - Protections should not be denied to beneficiaries and claimants because a policy is purchased by a commercial entity rather than by an individual (e.g., a worker should get privacy protection under workers' compensation).

6. **Consumers should have access to a meaningful redress mechanism when they suffer losses from fraud, deceptive practices or other violations; wrongdoers should be held accountable directly to consumers.**

   - Aggrieved consumers must have the ability to hold insurers directly accountable for losses suffered due to their actions. UTPAs should provide private cause of action.
   - Alternative Dispute Resolution clauses should be permitted and enforceable in consumer insurance contracts only if the ADR process is: 1) contractually mandated with non-binding results, 2) at the option of the insured/beneficiary with binding results, or 3) at the option of the insured/beneficiary with non-binding results.
   - Bad faith causes of action must be available to consumers.
   - When regulators engage in settlements on behalf of consumers, there should be an external, consumer advisory committee or other mechanism to assess fairness of settlement and any redress mechanism developed should be an independent, fair, and neutral decision-maker.
   - Private attorney general provisions should be included in insurance laws.
   - There should be an independent agency that has as its mission to investigate and enforce deceptive and fraudulent practices by insurers, e.g., the reauthorization of FTC.

7. **Consumers should enjoy a regulatory structure that is accountable to the public, promotes competition, remedies market failures and abusive practices, preserves the financial soundness of the industry and protects policyholders' funds, and is responsive to the needs of consumers.**

   - Insurance regulators must have a clear mission statement that includes as a primary goal the protection of consumers:
     - The mission statement must declare basic fundamentals by line of insurance (such as whether the state relies on rate regulation or competition for pricing). Whichever approach is used, the statement must explain how it is accomplished. For instance, if competition is used, the state must post the review of competition (e.g., market shares, concentration by zone, etc.) to show that the market for the line is workably competitive, apply anti-trust laws, allow groups to form for the sole purpose of buying insurance, allow rebates so agents will compete, assure that price information is available from an independent source, etc. If regulation is used, the process must be described, including access to proposed rates and other proposals for the public, intervention opportunities, etc.
     - Consumer bills of rights should be crafted for each line of insurance and consumers should have easily accessible information about their rights.
     - Regulators should focus on online monitoring and certification to protect against fraudulent companies.
     - A department or division within the regulatory body should be established for education and outreach to consumers, including providing:
       - Interactive websites to collect from and disseminate information to consumers, including information about complaints, complaint ratios, and consumer rights with regard to policies and claims.
       - Access to information sources should be user friendly.

        - Counseling services to assist consumers, e.g., with health insurance purchases, claims, etc. where needed should be established.
    - Consumers should have access to a national, publicly available database on complaints against companies/sellers, i.e., the NAIC database. (NAIC is implementing this.)
    - To promote efficiency, centralized electronic filing and use of centralized filing data for information on rates for organizations making rate information available to consumers, e.g., help develop the information brokering business.
    - Regulatory system should be subject to sunshine laws that require all regulatory actions to take place in public unless clearly warranted and specified criteria apply. Any insurer claim of trade secret status of data supplied to the regulatory entity must be subject to judicial review with the burden of proof on the insurer.
    - Strong conflict of interest, code of ethics, and anti-revolving door statutes are essential to protect the public.
    - Election of insurance commissioners must be accompanied by a prohibition against industry financial support in such elections.
    - Adequate and enforceable standards for training and education of sellers should be in place.
    - The regulatory role should in no way, directly or indirectly, be delegated to the industry or its organizations.
    - The guaranty fund system should be a prefunded, national fund that protects policyholders against loss due to insolvency. It is recognized that a phase-in program is essential to implement this recommendation.
    - Solvency regulation/investment rules should promote a safe and sound insurance system and protect policyholder funds, e.g., providing a rapid response to insolvency to protect against loss of assets/value.
    - Laws and regulations should be up to date with and applicable to e-commerce.
    - Antitrust laws should apply to the industry.
    - A priority for insurance regulators should be to coordinate with other financial regulators to ensure consumer protection laws are in place and adequately enforced regardless of corporate structure or ownership of insurance entity. Insurance regulators should err on side of providing consumer protection even if regulatory jurisdiction is at issue. This should be stated mission/goal of recent changes brought about by GLB law.
        - Obtain information/complaints about insurance sellers from other agencies and include in databases.
    - A national system of "Consumer Alerts" should be established by the regulators, e.g., companies directed to inform consumers of significant trends of abuse such as race-based rates or life insurance churning.
    - Market conduct exams should have standards that ensure compliance with consumer protection laws and be responsive to consumer complaints; exam standards should include agent licensing, training and sales/replacement activity; companies should be held responsible for training agents and monitoring agents with ultimate review/authority with the regulator. Market conduct standards should be part of an accreditation process.

- The regulatory structure must ensure accountability to the public it serves. For example, if consumers in state X have been harmed by an entity that is regulated by state Y, consumers would not be able to hold their regulators/legislators accountable to their needs and interests. To help ensure accountability a national consumer advocate office, with the ability to represent consumers before each insurance department, is needed when national approaches to insurance regulation or "one-stop" approval processes are implemented.
- Insurance regulator should have standards in place to ensure mergers and acquisitions by insurance companies of other insurers or financial firms, or changes in the status of insurance companies (e.g., demutualization, non-profit to for-profit), meet the needs of consumers and communities.
- Penalties for violations must be updated to ensure they serve as incentives against violating consumer protections and should be indexed to inflation.

8. Consumers should be adequately represented in the regulatory process.

- Consumers should have representation before regulatory entities that are independent, external to regulatory structure, and are empowered to represent consumers before any administrative or legislative bodies. To the extent that there is national treatment of companies, a national partnership, or "one-stop" approval, there must be a national consumer advocate's office created to represent the consumers of all states before the national treatment state, the one-stop state or any other approving entity.
- Insurance departments should support public counsel or other external, independent, consumer representation mechanisms before legislative, regulatory, and NAIC bodies.
- Regulatory entities should have a well-established structure for ongoing dialogue with and meaningful input from consumers in the state, e.g., a consumer advisory committee. This is particularly important to ensure that the needs of certain populations in the state and the needs of changing technologies are met.

ATTACHMENT 2

WHY INSURANCE IS AN ESSENTIAL PUBLIC GOOD AND IS NOT A NORMAL PRODUCT THAT CAN BE REGULATED SOLELY THROUGH COMPETITION

1. ***Complex Legal Document***. Most products are able to be viewed, tested, "tires kicked" and so on. Insurance policies, however, are difficult for consumers to read and understand -- even more difficult than documents for most other financial products. For example, consumers often think they are buying insurance, only to find they bought a list of exclusions.

2. ***Comparison Shopping is Difficult***. Consumers must first understand what is in the policy to compare prices.

3. ***Policy Lag Time***. Consumers pay a significant amount for a piece of paper that contains specific promises regarding actions that might be taken far into the future. The test of an insurance policy's usefulness may not arise for decades, when a claim arises.

4. ***Determining Service Quality is Very Difficult***. Consumers must determine service quality at the time of purchase, but the level of service offered by insurers is usually unknown at the time a policy is bought. Some states have complaint ratio data that help consumers make purchase decisions, and the NAIC has made a national database available that should help, but service is not an easy factor to assess.

5. ***Financial Soundness is Hard to Assess***. Consumers must determine the financial solidity of the insurance company. One can get information from A.M. Best and other rating agencies, but this is also complex information to obtain and decipher.

6. ***Pricing is Dismayingly Complex***. Some insurers have many tiers of prices for similar consumers—as many as 25 tiers in some cases. Consumers also face an array of classifications that can number in the thousands of slots. Online assistance may help consumers understand some of these distinctions, but the final price is determined only when the consumer actually applies and full underwriting is conducted. At that point, the consumer might be quoted a much different rate than he or she expected. Frequently, consumers receive a higher rate, even after accepting a quote from an agent.

7. ***Underwriting Denial***. After all that, underwriting may result in the consumer being turned away.

8. ***Mandated Purchase***. Government or lending institutions often require insurance. Consumers who must buy insurance do not constitute a "free-market", but a captive market ripe for arbitrary insurance pricing. The demand is inelastic.

9. ***Incentives for Rampant Adverse Selection***. Insurer profit can be maximized by refusing to insure classes of business (e.g., redlining) or by charging regressive prices.

10. ***Antitrust Exemption***. Insurance is largely exempt from antitrust law under the provisions of the McCarran-Ferguson Act.

Compare shopping for insurance with shopping for a can of peas. When you shop for peas, you see the product and the unit price. All the choices are before you on the same shelf. At the checkout counter, no one asks where you live and then denies you the right to make a purchase. You can taste the quality as soon as you get home and it does not matter if the pea company goes broke or provides poor service. If you don't like peas at all, you need not buy any. By contrast, the complexity of insurance products and pricing structures makes it difficult for consumers to comparison shop. Unlike peas, which are a discretionary product, consumers absolutely require insurance products, whether as a condition of a mortgage, as a result of mandatory insurance laws, or simply to protect their home or health.

ATTACHMENT 3

COLLUSIVE ACTIVITY BY THE INSURANCE SERVICES ORGANIZATION THAT IS ALLOWED BY THE MCCARRAN-FERGUSON ANTITRUST EXEMPTION

The ISO website has extensive information on the range of services they offer insurance companies. The website illustrates the deep involvement that this organization has in helping to set insurer rates, establishing policy forms, underwriting policies, and in setting other rules.

Some examples:

- The page "The State Filing Handbook," promises 24/7 access to "procedures for adopting or modifying ISO's filings as the basis for your own rates, rules and forms."

- The page "ISO MarketWatch Cube" is a "powerful new tool for analyzing renewal price changes in the major commercial lines of insurance…the only source of insurance premium-change information based on a large number of actual policies." This price information is available "in various levels of detail – major coverage, state, county and class groupings – for specific time periods, either month or quarter…"

- "MarketWatch" supplies reports "that measure the change in voluntary-market premiums (adjusted for exposure changes) for policies renewed by the same insurer group…a valuable tool for…strategically planning business expansion, supporting your underwriting and actuarial functions…"

- "ISO's Actuarial Service" gives an insurer "timely, accurate information on such topics as loss and premium trend, risk classifications, loss development, increased limits factors, catastrophe and excess loss, and expenses." Explaining trend, ISO points out that the insurer can "estimate future costs using ISO's analyses of how inflation and other factors affect cost levels and whether claim frequency is rising or falling." Explaining "expenses" ISO lets an insurer "compare your underwriting expenses against aggregate results to gauge your productivity and efficiency relative to the average…" NOTE: These items, predicting the future for cost movement and supplying data on expenses sufficient for turning ISO's loss cost filings into final rates, are particularly anti-competitive and likely, absent McCarran-Ferguson antitrust exemption protection, illegal.

- "ISO's Actuarial Services" web page goes on to state that insurers using these services will get minutes and agendas of "ISO's line actuarial panels to help you keep abreast of ratemaking research and product development."

- The "Guide to ISO Products and Services" is a long list of ways ISO can assist insurers with rating, underwriting, policy forms, manuals, rate quotes, statistics, actuarial help, loss reserves, policy writing, catastrophe pricing, information on specific locations for property insurance pricing, claims handling, information on homeowner claims, credit

scoring, making filings for rates, rules and policy forms with the states and other services.

Finally, ISO has a page describing "Advisory Prospective Loss Costs," which lays out the massive manipulations ISO makes to the historic data. A lengthy excerpt follows:

> "Advisory Prospective Loss Costs are accurate projections of average future claim costs and loss-adjustment expenses — overall and by coverage, class, territory, and other categories.
> Your company can use ISO's estimates of future loss costs in making independent decisions about the prices you charge for your policies. For most property/casualty insurers, in most lines of business, ISO loss costs are an essential piece of information. You can consider our loss data — together with other information and your own judgment — in determining your competitive pricing strategies.
>
> "**The insurance pricing problem –**Unlike companies in other industries, you as a property/casualty insurer don't know the ultimate cost of the product you sell — the insurance policy — at the time of sale. At that time, losses under the policy have not yet occurred. It may take months or years after the policy expires before you learn about, settle, and pay all the claims. Firms in other industries can base their prices largely on known or controllable costs. For example, manufacturing companies know at the time of sale how much they have spent on labor, raw materials, equipment, transportation, and other goods and services. But your company has to *predict* the major part of your costs — losses and related expenses — based on historical data gathered from policies written in the past and from claims paid or incurred on those policies. As in all forms of statistical analysis, a large and consistent sample allows more accurate predictions than a smaller sample. That's where ISO comes in. The ISO database of insurance premium and loss data is the world's largest collection of that information. And ISO quality checks the data to make sure it's valid, reliable, and accurate. But before we can use the data for estimating future loss costs, ISO must make a number of adjustments, including loss development, loss-adjustment expenses, and trend.
>
> **"Loss development …**because it takes time to learn about, settle, and pay claims, the most recent data is always incomplete. Therefore, ISO uses a process called *loss development* to adjust insurers' early estimates of losses to their ultimate level. We look at historical patterns of the changes in loss estimates from an early evaluation date — shortly after the end of a given policy or accident year — to the time, several or many years later, when the insurers have settled and paid all the losses. ISO calculates *loss development factors* that allow us to adjust the data from a number of recent policy or accident years to the ultimate settlement level. We use the adjusted — or developed — data as the basis for the rest of our calculations.
>
> **"Loss-adjustment expenses –** In addition to paying claims, your company must also pay a variety of expenses related to settling the claims. Those include legal-defense costs, the cost of operating a claims department, and others. Your company allocates some of those costs — mainly legal defense — to particular claims. Other costs appear

as overhead. ISO collects data on allocated and unallocated loss-adjustment expenses, and we adjust the claim costs to reflect those expenses.

"Trend –Losses adjusted by loss-development factors and loaded to include loss-adjustment expenses give the best estimates of the costs insurers will ultimately pay for past policies. But you need estimates of losses in the future — when your new policies will be in effect. To produce those estimates, ISO looks separately at two components of the loss cost — claim *frequency* and claim *severity*. We examine recent historical patterns in the number of claims per unit of exposure (the frequency) and in the average cost per claim (the severity). We also consider changes in external conditions. For example, for auto insurance, we look at changes in speed limits, road conditions, traffic density, gasoline prices, the extent of driver education, and patterns of drunk driving. For just three lines of insurance — commercial auto, personal auto, and homeowners — ISO performs 3,000 separate reviews per year to estimate loss trends. Through this kind of analysis, we develop *trend factors* that we use to adjust the developed losses and loss-adjustment expenses to the future period for which you need cost information.

"What you get – With ISO's advisory prospective loss costs, you get solid data that you can use in determining your prices by coverage, state, territory, class, policy limit, deductible, and many other categories. You get estimates based on the largest, most credible set of insurance statistics in the world. And you get the benefit of ISO's renowned team of actuaries and other insurance professionals. ISO has a staff of more than 200 actuarial personnel — including about 50 members of the Casualty Actuarial Society. And no organization anywhere has more experience and expertise in collecting and managing data and estimating future losses."

ISO's activities extensively interfere with the competitive market, a situation allowed by the provisions of the McCarran-Ferguson Act's extensive antitrust exemption.