Approved 3-26-87
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Dale Sprague at
Chairperson

3:30 ~~a~~.m./p.m. on March 25, 1987 in room 531-N of the Capitol.

All members were present except:

Rep. King

Committee staff present:

Chris Courtwright, Research Department
Bill Edds, Revisor's Office
Deanna Willard, Committee Secretary

Conferees appearing before the committee:

Dick Brock, Kansas Insurance Department
Jerel Wright, Kansas Credit Union League
Ed Hund, Kansas Trial Lawyers Association

The meeting was called to order by the Chairman.

The minutes of the March 19, 1987, meeting were approved.

Hearing on: SB 99 - Life insurance; interest payable on death proceeds

Staff explained that the bill would amend K.S.A. 40-447 to clarify that interest is payable on the proceeds of a life insurance policy beginning ten days after receipt of due proof of the death of the policyholder.

Mr. Dick Brock explained that the bill is to clarify a conflict between subsections (a) and (c). (Att. 1.)

Hearing on: SB 103 - Health care provider insurance availability act; eliminating sunset

Staff explained that the bill would delete the July 1, 1987, sunset provision for the medical malpractice joint underwriting authority from K.S.A. 3414. It was stated that all liability coverage writers in the state are required to underwrite those policies for which health care providers are not able to obtain coverage in the normal marketplace.

Mr. Dick Brock said that there were 259 participants in the plan in 1985; he gave the breakdown of the number in each field, i.e. clinics, hospitals, physicians, osteopaths, chiropractors, etc. The rationale for the sunset was that the medical malpractice crisis was hoped to be temporary; however, Mr. Brock stated that as long as there is a mandatory insurance requirement, there will be some risk that can't be covered in the normal market. His explanation of the bill is attached. (Att. 2.)

He continued in response to questioning. There are various reasons why coverage would not be available, i.e. high risk category like ob-gyn, or financial insolvency of the company which wrote a particular risk. Subsection (f) of the statute gives the laundry list of those categories which are eligible to

participate. Statute provides the JUA be "no profit, no loss." Excess losses are paid by the Health Care Stabilization Fund; profits go to the fund. Coverage can be obtained through the plan in some cases cheaper than in the normal market. If the mandatory requirement were struck, health care providers would have to be self-insured if they couldn't obtain coverage. The plan wasn't set up to distinguish between those who should and shouldn't be practicing.

A member stated that the sunset provision sends a message that the JUA is still being looked at, whereas striking the sunset creates a vehicle whereby everyone can buy insurance endlessly. The Chairman noted that the medical society hasn't appeared on the bill, perhaps assuming that the sunset will be eliminated and the insurance pool will continue to be available.

Hearing on: SB 133 - Group life insurance; policy requirements

Staff explained that the bill would allow group credit life insurance to be sold in an amount not to exceed the greater of the scheduled or actual amount of the debt or $100,000, whichever is less. It closely parallels HB 2128 recommended favorably by this committee.

Mr. Jerel Wright, Kansas Credit Union League, presented testimony in support of the bill. He said the repeal of the $25,000 ceiling would provide equal treatment for all credit life insurance, whether individual or group. (Att. 3.)

He said the Senate does not plan hearings on HB 2128. An amendment on the Senate floor added a $100,000 ceiling, rather than no limit. The Senate committee chair said they would concur with amendments to the bill to reflect earlier action of this committee.

Hearing on: SB 247 - Insurance; recording and reporting of loss and expense experience

Staff explained that the bill would amend two statutes which would authorize the Commissioner to develop statistical plans requiring property and casualty insurance companies to record and report loss and expense experience on specific classifications of insurance. It was introduced following the adverse reporting of SB 23 which would have mandated specific gathering of information.

Mr. Brock explained that the bill would allow the Commissioner to require an insurer to report its loss experience on a classification basis different from the insurer's rating system. It would allow gathering of data on a specific classification, i.e. day care centers, rather than the rate class which includes foster homes. The major changes are contained in lines 49-53 and lines 88-99.

He stated that it makes little sense for information to be

collected just for the sake of the information; it should have a planned function. He mentioned that some information has been reported as required since 1975 but that it has only been used once and said it is an expensive process for the department and for others involved. Information he distributed is attached. (Att. 4.)

He said the Insurance Department likes SB 247; some of the desired information could have been obtained through SB 23 on a selective basis through rules and regulations. He said the department does not formally adopt regulations but rather reviews statistical plans developed by statistical agents. Sometimes changes are made; the department adopts the plans by approval. Information obtained through SB 247 would be available to the public.

Written testimony was distributed from Mr. Ron Smith, Kansas Bar Association, expressing support for SB 247 as it would allow the Commissioner to require property/casualty companies to file statistical information plans to support rate increases. (Att. 5.)

Mr. Ed Hund, KTLA, said he has no objection to the bill but it doesn't go far enough. He spoke of the controversy of "tort reform versus insurance reform" and said there isn't evidence of what the insurance companies have been doing except what they are willing to provide. He said evidence should be available for future policymaking, i.e. premium earned, number of claims and payouts, investment returns, expenses. He offered amendments that mirror SB 23 and the interim committee suggestions. (Att. 6.)

Several committee members expressed concern that the insurance industry doesn't provide needed statistics. There was discussion as to whether amending the bill would cause it to be defeated; the opinion was expressed that the committee should take a look at SB 23 and amend this bill if the consensus is that it should be.

The meeting was adjourned at 4:45 p.m.

Date: 3-25-87

GUEST REGISTER

HOUSE
COMMITTEE ON INSURANCE

NAME	ORGANIZATION	ADDRESS	PHONE
R.E. Wilson	Alliance Ins Co	McPherson	241-2200
Jarel Wright	Ks Credit Union	Topeka	273-4343
Richard Harmon	Domestic insurance companies	Topeka	232-0545
JACK ROBERTS	BC-BS	TOPEKA	295-4695
Dee Ann Bernhard	alliance of American Insurers	Schaumburg, IL	312-490-8635
Edward Hund	Ks Trial Lawyers	Wichita	316-269-9055
Anne McGarity	KTLA	Topeka	232-7756
Dick Block	Ins Dept	"	

Explanatory Memorandum For
House Bill No. 99
(Legislative Proposal No. 3)

K.S.A. 40-447 was enacted by the 1977 Session of the Kansas Legislature. The purpose and intent of this legislation was quite clear in that it was designed to provide life insurers an incentive to pay death claims quickly and to require the payment of interest if they didn't. However, there is an inconsistency contained within this law which requires clarification. Specifically, subsection (a) of this bill provides that, if interest on death proceeds becomes payable, it shall be computed from the date due proof of death is received whereas subsection (c) requires the beneficiary to be notified that interest is payable from the date of death.

Since subsection (a) is the operative section that imposes the actual obligation on the insurer, since subsection (c) simply requires the beneficiary to be notified of the insurer's obligation; and since the legislative sponsor of the bill has confirmed it was his intent that interest be computed from the date of receipt of due proof of death; it has generally been assumed the language of subsection (a) controls the manner in which the interest is computed. Despite several previous efforts, the inconsistency between the two subsections has not been changed and House Bill No. 99 will address the problem.

The Senate amendment is simply for clarification and has no effect on the original intent of the bill.

Explanatory Memorandum For
House Bill No. 103
(Legislative Proposal No. 5)

The Health Care Provider Insurance Act provides for the establishment of a mechanism which enables health care providers to obtain required medical malpractice insurance if they are unable to do so from the voluntary insurance market. From the inception of the act in 1976, these particular provisions have been subject to a sunset provision whereby the requirements pertaining to the residual market mechanism or medical malpractice JUA as it is often called would expire as of a given date. Current law provides for an expiration date of July 1, 1987. This means if there is no amendment enacted into law by this session of the legislature, health care providers will still be subject to a compulsory insurance requirement but may not be able to obtain the required coverage.

House Bill No. 103 addresses this problem by suggesting that the sunset provision be totally removed from the law. An alternative would, of course, be to simply amend "1987" to some later year. However, as long as there is a compulsory insurance requirement, an availability mechanism will be necessary. Therefore, the proposal would simply eliminate the provisions relating to expiration of the plan and, by so doing eliminate periodically requiring the legislature to extend its life.

TESTIMONY ON

SENATE BILL 133

HOUSE INSURANCE COMMITTEE

MARCH 25, 1987

House Insurance Committee
March 25, 1987
Att. 3

I am Jerel Wright, legislative representative for the Kansas Credit Union League (KCUL) which is the financial trade association for credit unions in Kansas. Approximately 96% of all Kansas credit unions, state and federally chartered, are members of KCUL.

One of the many services offered to credit union members is credit life insurance. Most credit unions allow each member the option to establish credit life insurance on each loan received through the credit union. This insurance is offered through a group credit life insurance policy issued to the credit union making the loan. We are here today to request an amendment to K.S.A. 40-433(2)(d) to remove the $25,000 ceiling on credit life insurance offered through a group credit life insurance policy.

Current Law

Kansas law permits group credit life insurance to be written in an amount not exceeding the amount of indebtedness or $25,000, whichever is less. Individual credit life insurance can be written in an amount not exceeding the indebtedness. The repeal of the $25,000 ceiling would provide equal treatment for all credit life insurance, whether individual or group.

Purpose of Limits

The original purpose of dollar amount limits on group insurance policies was to insure the safety and soundness of insurers by

imposing statutory underwriting restrictions when group insurance was a revolutionary and untested insurance product. Such dollar amount limits have long since been demonstrated to be unnecessary. The Model Group Life Insurance Bill of the National Association of Insurance Commissioners, on which the Kansas statute is patterned, contained similar limitations for all group life insurance policies when it was initially adopted in 1956. This Model was substantially amended by the National Association of Insurance Commissioners in 1980 and all reference to dollar amount limits was deleted. In Kansas, dollar amount limits no longer apply to any kind of group insurance except group credit life insurance.

Other States

In other states, the updating of group life insurance laws has occurred in a piecemeal, but rather steady, fashion over approximately the last 20 years. Currently, only 20 other states have any group credit life insurance dollar amount limits and only 6 have dollar amount limits as low as $25,000. Of the 4 states adjoining Kansas, only Oklahoma has a dollar amount limit for group credit life insurance and the Oklahoma limit is $100,000. Clearly, the $25,000 limit in Kansas is outdated and should be repealed.

Credit insurance may be written using either group forms or individual forms. Group forms and individual forms are subject to identical or parallel statutes and regulations, except for the

current $25,000 statutory limit on the amount that can be written under a group form. Use of group forms for credit life insurance is significantly more efficient than is the use of individual policy forms and existence of an amount limit for group forms deprives Kansas insurers, creditors and consumers alike of the benefits derived from greater efficiency.

The current Kansas dollar amount limits can be avoided by some larger groups having multi-state operations by use of a group policy issued in another state. Thus, the statutory amount limits also unfairly discriminate against smaller, local creditors (including all or virtually all credit unions located in Kansas) and the people they were designed to serve.

Many credit unions, in fact, provide group credit life insurance on all eligible loans without a specific charge to the borrowers. The statutory limit effectively prevents these credit unions from insuring that part of any loan balance exceeding $25,000, even though there would be no charge to the debtor for such coverage.

Mr. Chairman, these problems can be eliminated by approving our proposed amendments to this law. For these reasons, we urge the favorable consideration of our proposal.

M E M O R A N D U M

COPY

TO: Gary Stotts
Acting Director of the Budget

FROM: Fletcher Bell
Commissioner of Insurance

SUBJECT: Senate Bill No. 247

DATE: February 27, 1987

Senate Bill No. 247 proposes to amend K.S.A. 40-937 and 40-1118 which concern loss and expense reporting requirements for property and casualty insurance companies. Specifically, this bill would eliminate the statutory requirement which prohibits the Insurance Department from requiring an insurer to report its loss experience on a classification basis that is inconsistent with the insurer's rating system. In effect, the Commissioner of Insurance would be authorized to develop statistical plans and require insurers to submit annual reports that are consistent with those plans.

During the 1986 session, this legislation (Senate Bill No. 729) was passed by the Senate; however, it died in the House Insurance Committee. Our fiscal note for Senate Bill No. 729 indicated the need for 3 new positions to implement and maintain uniform statistical plans and reporting requirements. Much of the work we envisioned doing with regard to Senate Bill No. 729 will now be performed by the National Association of Insurance Commissioners (NAIC) in the near future. Specifically, the NAIC has adopted an action plan to:

1. Explore new mechanisms for obtaining classification detail for commercial lines;

2. Review the current Fast Track report and recommend improvements to assist in the identification of emerging trends or problems in commercial liability lines of insurance;

3. Recommend changes to the NAIC Statistical Handbook to implement any changes that have been identified during this review;

4. Explore the possibility of using the State Computing Network to speed distribution of fast track and other information;

5. Develop appropriate guidelines for use by the states to implement the procedures and measures associated with the NAIC Statistical Handbook;

6. Promptly convey to state regulators the recommendations and urge the states to review and adopt the reporting requirements of the NAIC Statistical Handbook as modified; and

7. Establish an appropriate standing statistical task force to review and ensure that mechanisms for collecting and reporting insurance data are current.

As a result of the NAIC's activity in this area, enactment of Senate Bill No. 247 could be accomplished without any fiscal impact on the Insurance Department.

Respectfully submitted,

Fletcher Bell
Commissioner of Insurance

FB:bf
cc: Carolyn Rampey
Legislative Research Department

0317

PRIMARY INSURERS—AVAILABLE DATA

The property and casualty insurance industry currently collects more useful information and provides more important statistics than any other industry in the United States.

Property and casualty insurers collect and analyze vast amounts of data to meet their responsibilities to government, to provide a basis for business decisions, and to share relevant information with investors and consumers.

Although each of these three interests—regulator, company, and customer—may need or want data for different purposes, all insurance data comes from just one source: fundamental, everyday business transactions. Each time a premium is collected, a claim is paid, an expense incurred, or an investment is made, an insurance company data reporting system captures and compiles information. The sum of these individual transactions forms the pool of data available for the industry to fulfill its public and corporate obligations.

The data pool is a collection of information about individual company financial operations and insurance programs. It is structured to be cost-effective and operated efficiently so that insurer expenses and, ultimately, the premiums charged to policyholders can be kept as low as possible.

The data pool is also sufficiently flexible to allow for detailed analysis by accountants, actuaries, economists, regulators, statisticians, securities analysts, stockholders, underwriters and others. Whatever their purpose—solvency, profitability, ratemaking—these groups have access to insurance data that are timely, accurate, and complete.

This report demonstrates that data from basic insurance business transactions—collecting premiums, paying losses, managing investments—form the basis of all analyses, simple or complex. It identifies the kinds of data that are available and explains their uses. From this report, it will be apparent that the recent federal legislative proposals and many of the state initiatives for additional data collection have their foundation in a misunderstanding of the value and amount of data currently produced.

Although the descriptions, procedures, data and reports mentioned throughout this document are generally applicable to most of the property and casualty lines of insurance, the Advisory Committee has directed its comments to the major commercial lines, excluding Workers' Compensation.

All insurance data come from the same source—the individual business transactions of an insurance company. The manner in which the data are compiled is a function of the purpose for which they will be used. Two basic types of data are compiled: financial and statistical.

Financial data are needed to measure the overall solvency and profitability of insurance companies. Solvency is a basic goal of insurance public policy: an insurer must be financially able to satisfy its future obligations to protect customers and compensate injured victims. Profitability is also important: sufficient capital must be attracted to meet the current and future demands for insurance by America's businesses and individuals.

Insurance financial data focus on quarterly or annual performance. They are useful only as a one-time "snap shot" view of a financial picture that is both larger in scope and longer in duration. They are not intended, nor are they sufficient to be a fully accurate measure of the long-term insurer stability that sound public policy and economics require. To achieve their basic objective—measuring solvency and profitability—insurance financial data must also take into account the long-term liabilities assumed by insurance companies as part of their unique risk-taking function. The methods for this analysis are prescribed by law and regulation and are known collectively as "Statutory Accounting Principles."

"Statutory Accounting Principles" are purposefully different from the accounting methods ("GAAP" accounting, or Generally Accepted Accounting Principles) used by other, non-insurance businesses. "Commentary I" compares the differences in greater detail.

Still, the regulatory specifications for reporting financial data encompass the information necessary to convert to a GAAP basis. In fact, many analyses of insurance data are conducted on a GAAP basis, particularly when the analysis includes a comparison to other industries.

By requiring insurers to report specific types of financial data, state insurance regulators, the Internal Revenue Service, the Securities and Exchange Commission, and others have direct access to insurers' most important financial information. Indeed, comprehensive financial information exists as a matter of public information to permit the performance of even the most complex analyses. During the public debates of the past year, critics of the industry would have been unable to prepare their commentaries had not such a degree of financial data been available for public consumption.

The "Report on Liability Insurance" is an example of the type of analysis that can be performed using financial data. It is included later in this section. Data in that report, when compared to other industries, has been adjusted to a GAAP basis.

COMMENTARY I

Statutory Accounting Principles (SAP) and Generally Accepted Accounting Principles (GAAP) are different accounting methods for measuring assets and liabilities. Insurers are required to report their financial information on a SAP basis. Its focus is solvency on a liquidation basis. Thus, it measures an insurer's ability to fulfill its financial responsibilities to the public. Other businesses report on a GAAP basis, which emphasizes profitability on the transactions conducted over a given period of time.

There are two philosophical differences between SAP and GAAP. First, SAP are designed to demonstrate an insurance company's ability to meet all of its obligations to its policyholders and claimants in the event that it were to be liquidated. GAAP are designed to demonstrate profitability over a given period of time. Second, SAP stresses the importance of surplus adequacy, whereas GAAP contemplates the deferral of certain costs to accounting periods, where related revenues are earned. It is recognized that SAP is conservative in order to protect the interests of policyholders, while GAAP relates more to economic reality by matching earned revenue with those expenses incurred in producing that revenue.

The principal specific differences between SAP and GAAP are:

1. Under SAP, certain acquisition costs that are related to written premiums, such as premium taxes and agents' commissions, are charged against current income. In the case of liquidation, dollars expended up-front would not be available to pay policyholder claims. Under GAAP, these amounts are capitalized as an asset and then amortized by periodic charges to earnings over the terms of the applicable insurance policies.

2. Under SAP, some assets are excluded from the statutory balance sheet, since their value is not readily convertible into cash to pay claims. These "non-admitted" assets include certain furniture and equipment and leasehold improvements, whose value under forced-sale conditions is likely to be substantially less than book value; premium balances over ninety days due, which are considered uncollectible for Annual Statement purposes; and reinsurance recoverable from unauthorized companies. Under GAAP, these amounts are restored to the balance sheet.

3. Under SAP, certain loss reserves are required to be established by conservative statutory formulae. Under GAAP, actual ultimate reserve estimates are used.

4. Under SAP, dividends to policyholders are not recorded as liabilities until declared; up until then, the dollars are available for claim costs. GAAP requires that all undeclared policyholder dividends be accrued at the balance sheet date, using the best estimates available.

5. GAAP requires that a liability be established for future federal income taxes applicable to prepaid acquisition costs, to unrealized appreciation on equity-type securities, and to other timing differences. Under SAP, insurance companies are generally not allowed to provide for deferred federal income taxes; they are entered at such time as the dollars are payable and hence no longer available to pay policy claims.

The Annual Statement is the primary source document for insurer financial information. It is a "living" document, developed and reviewed continually by the National Association of Insurance Commissioners (NAIC). Because it provides a uniform data reporting format and is required by all states, the Annual Statement facilitates the analysis of financial information from insurers throughout the country.

The Annual Statement is designed to assist state regulators in evaluating individual insurer's solvency and solidity. It is the prime data source for estimating individual insurer and overall industry profitability. All companies, regardless of their size or market share, are required to submit Annual Statements. The Annual Statement is illustrated in Exhibit 1.

Generally, the Annual Statement provides detailed information about assets and liabilities including data on premiums, losses, reserves, expenses, dividends, taxes and investments. When possible, Annual Statement financial data are separately identified by line of business, by state, or both. The lines of business reported on the Annual Statement are listed in Exhibit 2.

The Annual Statement is much more comprehensive than a balance sheet. Typically, it provides over 60 pages of important financial information and, depending upon the complexity of an insurer's investments, may exceed several hundred pages. In addition to its basic financial presentation, the Annual Statement includes numerous special schedules and supplements that contain more detailed information about particular lines of business (e.g., medical malpractice) or certain line items (e.g., expenses). The schedules and supplements included in the Annual Statement are listed in Exhibit 3.

Exhibit 1

The Annual Statement is designed to assist state regulators in evaluating individual insurer's solvency and solidity. All companies are required to file these statements annually with the insurance regulator in each state in which they are licensed.

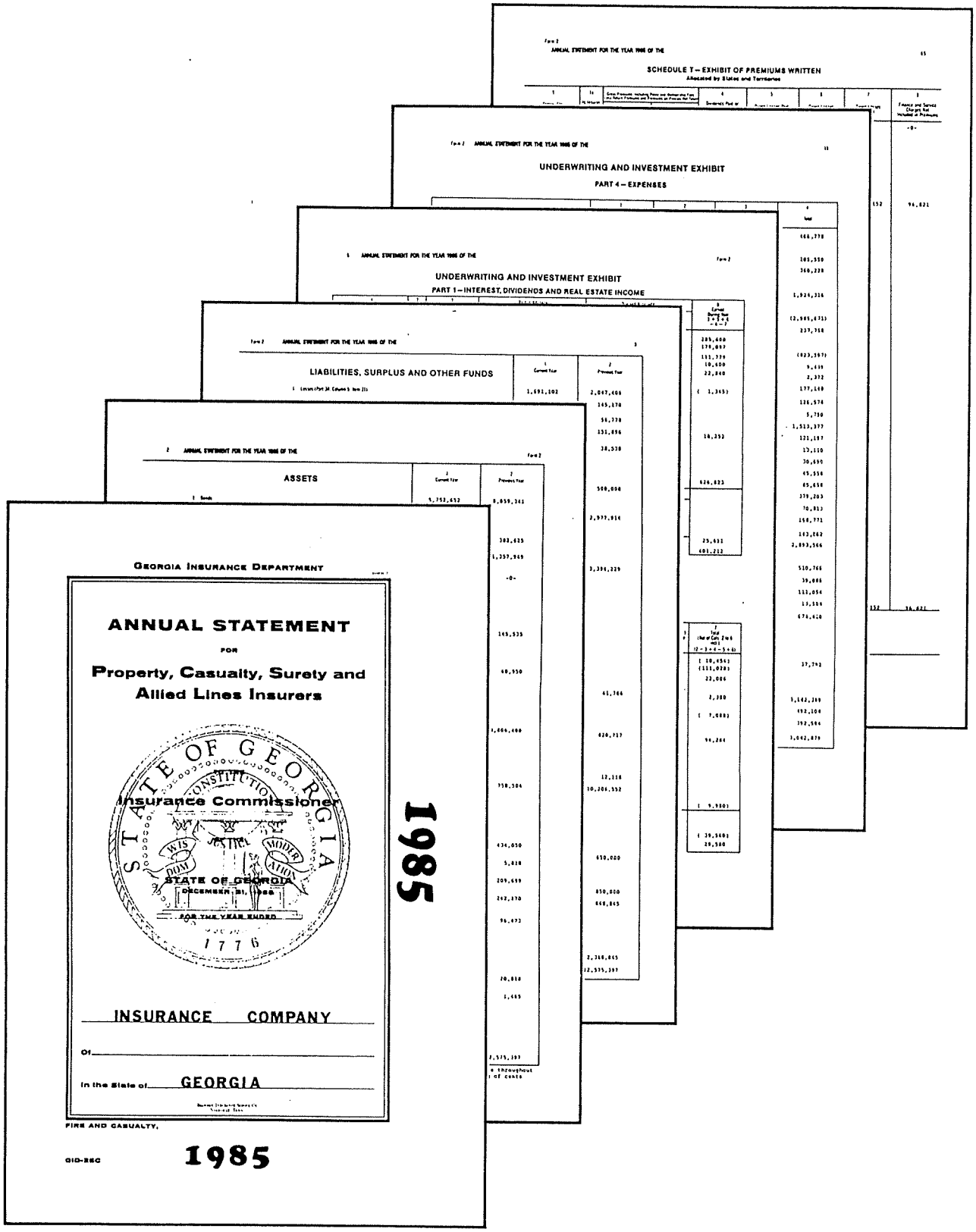


Exhibit 2

Financial data by state for each of these 32 lines are contained in the Annual Statement, e.g., written and earned premiums; dividends paid to policyholders; paid, incurred, and unpaid losses.

Detailed expense information for these same lines is provided in the Insurance Expense Exhibit (see Exhibit 8).

LINES OF BUSINESS

Fire
Allied Lines
Farmowners Multiple Peril
Homeowners Multiple Peril
Commercial Multiple Peril
Ocean Marine
Inland Marine
Medical Malpractice
Earthquake
Group Accident and Health
Credit Accident and Health (Group and Individual)
Collectively Renewable Accident and Health
Non-Cancellable Accident and Health
Guaranteed Renewable Accident and Health
Non-Renewable for Stated Reasons Only
Other Accident Only
All Other Accident and Health
Workers' Compensation
Other Liability (General Liability)
Private Passenger Auto No-Fault (Personal Injury Protection)
Other Private Passenger Auto Liability
Commercial Auto No-Fault (Personal Injury Protection)
Other Commercial Auto Liability
Private Passenger Auto Physical Damage
Commercial Auto Physical Damage
Aircraft (All Perils)
Fidelity
Surety
Glass
Burglary
Boiler and Machinery
Credit

Exhibit 3

ANNUAL STATEMENT EXHIBITS AND SCHEDULES

Balance Sheet
Statement of Income, including analysis of changes in surplus
Cash Flow
Underwriting and Investment Exhibit

Part 1	Interest Dividends and Real Estate Income
Part 1A	Capital Gains and Loss on Investments
Part 2	Premiums Earned
Part 2A	Premiums in Force
Part 2B	Recapitulation of All Premiums
Part 2C	Premiums Written
Part 3	Losses Paid and Incurred
Part 3A	Unpaid Losses and Loss Adjustment Expenses
Part 4	Expenses

Exhibit 1—Analysis of Assets
Exhibit 2—Analysis of Non-Admitted Assets
Exhibit 3—Reconciliation of Ledger Assets
Exhibit of Premiums and Losses in the State of _____, also known as "Page 14"—this state specific exhibit includes a summary by line of the direct underwriting experience in each state where the insurer is licensed.
General Interrogatories—data on dividends, shares outstanding, loans to officers, accounting and reinsurance, etc.
Notes to Financial Statements—descriptive information in support of the balance sheet valuations.
Special Deposit Schedule, Schedule of all Other Deposits
Schedule of Examination Fees and Expenses
Five-Year Historical Data
Schedule A —Real Estate Owned, Acquired or Sold
Schedule B —All Long-Term Mortgages held during year
Schedule BA —Other Long-Term Invested Assets
Schedule C —Collateral Loans
Schedule D —Stocks and Bonds
Schedule DA —Short-Term Investments
Schedule DB —Financial Options and Futures
Schedule F —Reinsurance
Schedule G —Fidelity and Surety Experience
Schedule K —Credit Reserves
Schedule H —Accident and Health Exhibit
Schedule M —Payments to regulators, agents, lawyers, trade groups
Schedule N —Bank Accounts
Schedule O —Loss and loss expense development for non-liability coverages
Schedule P —Loss and loss expense development for liability coverages
Schedule X —Unlisted Assets
Schedule Y —Organizational Chart
Schedule T —Exhibit of Premiums written by state

SUPPLEMENTS FILED WITH INSURANCE DEPARTMENTS

Insurance Expense Exhibit
Medical Malpractice Supplement to Schedule T
Stockholder Information Supplement
Statement of Opinion Relating to Loss and Loss Adjustment Expense Reserves
Product Liability Supplement
Accident and Health Policiy Experience Exhibit
Credit Life and Accident and Health Policy Exhibit
Medicare Supplement Insurance Experience Exhibit

The **Underwriting and Investment Exhibit**, the **Page 14 Exhibit of Premiums and Losses**, and the display of **Five-Year Historical Data** are frequently referenced examples of the basic financial data that are required as part of the Annual Statement. From these portions of the Annual Statement, detailed profit and loss information by line, market share information by line and state, and historic performance profiles can be calculated.

It is important to note that information from these sources can only be accurately evaluated as long as the analysis appropriately recognizes the long-term obligations assumed by insurance companies. The use of "Statutory Accounting Principles," as discussed earlier, provides the necessary accounting information but is itself insufficient unless the analysis also includes the proper financial statement line items. For example, the basis for a proper analysis of insurer profitability goes beyond the compilation of written premiums and paid loss data. This concept is explained in more detail in "Commentary II."

The Underwriting and Investment Exhibit, Annual Statement Page 14 and the Five-Year Historical Data exhibit are illustrated in Exhibits 4, 5, and 6, respectively.

COMMENTARY II

Comparing written premiums and paid losses is not an accurate measure of insurer profitability. It does not account for the long-term contractual obligations assumed by insurers as part of their unique risk-taking function. And like other loss ratio analyses, it does not recognize the fixed and variable expenses that any business must incur to generate its revenue.

The "pyramid" scheme is a classic financial sham. In a "pyramid," ever-increasing numbers of participants make investments that are used immediately to compensate their predecessors. This sustains the "pyramid" on the attractive notion that its obligations need never be satisfied, just transferred again and again to future groups of participants. In theory at least, the "pyramid" is successful until, for whatever reason, its obligations can no longer be transferred. When that happens, the "pyramid" collapses.

No one benefits if insurance companies are only as stable as "pyramid" schemes. That's why insurance regulators and stockholders insist upon strict adherence to the fundamental accounting principle that revenue must be matched with the expenses that were incurred to generate it. Unlike other businesses, where revenue and payout sequences follow one another closely, insurers accept premium in exchange for a more long-term obligation. For some lines of coverage, notably liability coverages, many losses are paid years after the policy period in which they were incurred. Thus, to be used in an analysis of insurer profitability, the premiums paid for a given set of insurance policies must be compared to all the losses—paid and outstanding—that the policies will ultimately be called on to pay.

Measuring insurer profitability on a cash flow or a written premium/paid loss basis has the characteristics of a "pyramid" approach. The written premium/paid loss analysis does not recognize the existence of long-term obligations assumed under insurance contracts—instead, it presumes that these obligations can be effectively transferred to succeeding business years. Indeed, as long as future premiums are generated in sufficient quantity to sustain a continuous transfer of obligations, an insurer will undoubtedly appear to be in a better financial position than it actually is. Unfortunately, once growth slows or stops—or the potential liabilities are realized to be larger than first thought—the insurer, like the "pyramid," will be unable to meet its obligations and will collapse.

Positive cash flow does not assure that an insurer is solvent, much less does it indicate that the company is profitable. Almost any insurer with an expanding book of business will show a positive cash flow, notwithstanding its lack of profitability or its weak financial condition. Some illustrations might be helpful. Ambassador Insurance Company, with over $160 million in assets in 1982, had total positive cash flow of $62.8 million from 1979 to 1982 and yet was declared insolvent in 1984. Mission Insurance Group, with almost $900 million in assets in 1983, and positive cash flow of $362.2 million from 1979–1984 has been placed in rehabilitation.

Like all loss ratio analyses, the written premium/paid loss comparison also fails on another, more obvious account. It completely ignores the fixed and variable expenses that every business incurs in order to produce its products. Certainly, if the final cost of a product reflected only the cost of the raw materials needed to make the product, there would never be enough income to pay for related expenses—salaries, fixed plant, utilities, research, advertising, distribution, sales, and taxes, to name a few. Insurer expenses must still be included in any analysis that intends to accurately evaluate insurer profitability.

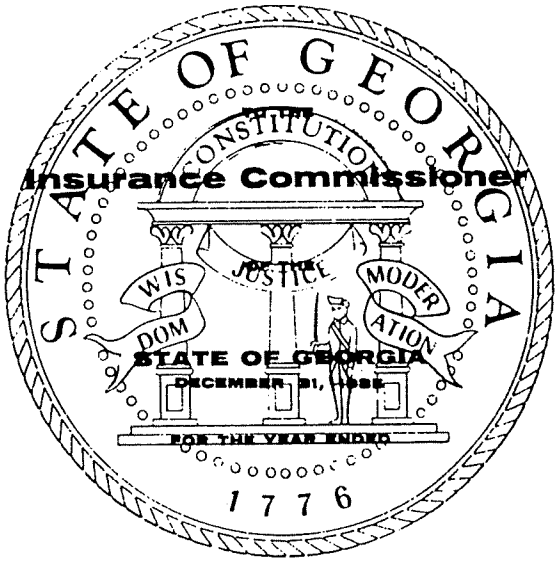
GEORGIA INSURANCE DEPARTMENT

FORM 2

ANNUAL STATEMENT

FOR

Property, Casualty, Surety and Allied Lines Insurers



Insurance Commissioner

1985

INSURANCE COMPANY

Of

In the State of GEORGIA

BRANDON INSURANCE SERVICE CO
NASHVILLE, TENN.

FIRE AND CASUALTY,

OID-25C

1985

Exhibit 4

This Annual Statement exhibit provides a summary of a company's overall investment results as well as its underwriting results for each line of insurance.

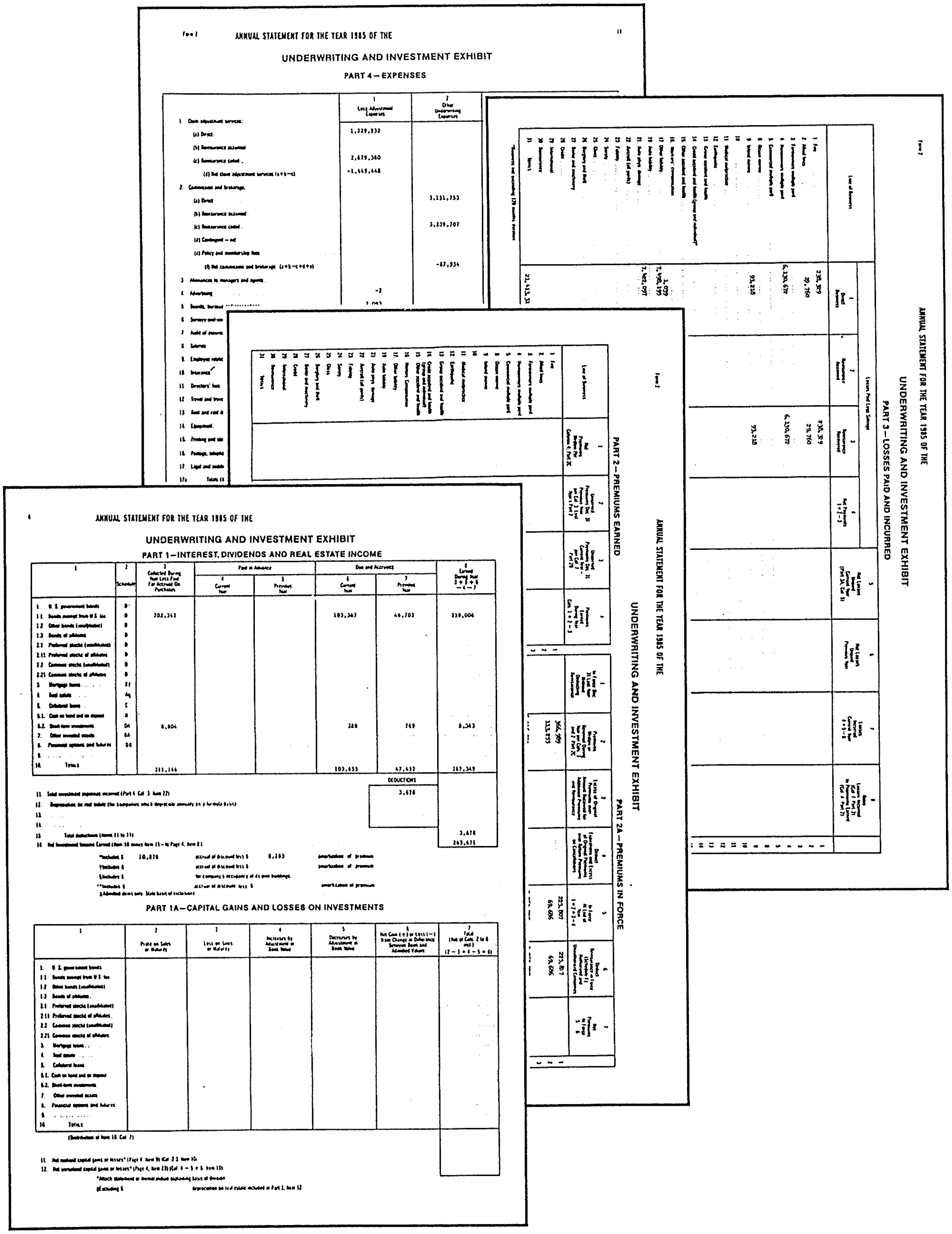


Exhibit 5

This exhibit for each state, known as Page 14, provides a summary of written and earned premium and paid, unpaid and incurred losses and dividends paid to policyholders for each of the 32 lines of insurance.

14

ANNUAL STATEMENT FOR THE YEAR 1985 OF THE

EXHIBIT OF PREMIUMS AND LOSSES

Form 2

BUSINESS IN THE STATE OF Ohio DURING THE YEAR 1985

1 Line of Business	Gross Premiums Including Policy and Membership Fees Less Return Premiums and Premiums on Policies Not Taken		4 Dividends Paid or Credited to Policyholders on Direct Business	5 Direct Losses Paid (deducting salvage)	6 Direct Losses Incurred [1]	7 Direct Losses Unpaid
	2 Direct Premiums Written	3 Direct Premiums Earned*				
1 Fire	366,989	176,333		238,329	414,193	175,863
2 Allied lines	113,255	55,008		29,760	62,772	33,012
3 Farmowners multiple peril						
4 Homeowners multiple peril	6,116,930	2,690,219		6,130,672	8,993,920	2,863,248
5 Commercial multiple peril	1,508	1,508				
8 Ocean marine						
9 Inland marine	137,586	52,830		93,218	143,396	50,178
10						
11 Medical malpractice						
12 Earthquake	7,098	2,518				
13 Group accident and health 14 Credit A & H (Group and Individual)						
15.1 Collectively renewable A & H						
15.2 Non-cancellable A & H						
15.3 Guaranteed renewable A & H 15.4 Non-renewable for stated reasons only						
15.5 Other accident only						
15.6 All other A & H						
16 Workers' compensation						
17 Other liability 19.1 Private passenger auto no fault (personal injury protection)	12,664	5,242		1,039	3,234	5,886
19.2 Other private passenger auto liability 19.3 Commercial auto no fault (personal injury protection)	12,302,322	11,843,433		7,498,195	9,370,521	9,414,353
19.4 Other commercial auto liability 21.1 Private passenger auto physical damage 21.2 Commercial auto physical damage	10,207,486	9,748,656		7,422,097	7,801,365	1,788,473
22 Aircraft (all perils)						
23 Fidelity						
24 Surety						
25 Glass	43	(10)			3	3
26 Burglary and theft						
27 Boiler and machinery						
28 Credit						
31 TOTALS	29,266,061	24,578,737		21,413,310	26,789,404	14,331,016

Finance and service charges not included in Lines 1 to 31 $

*Direct premiums earned may be estimated by formula on the basis of country-wide ratios for the respective lines of business except where adjustments are required to recognize special situations

1. Column 6, Direct Losses Incurred, reflects a change in allocation method of 12-31-84 and 12-31-85 IBNR by state for private passenger to buses.

CREDIT ACCIDENT AND HEALTH INSURANCE
(Included in the Above Exhibit)

1	2 Direct Premiums (Excluding Reinsurance Accepted and without Deduction of Reinsurance Ceded)	3 Direct Premiums Earned (prior to Dividends and Retrospective Rate Credits Paid or Credited)	4 Dividends Paid or Credited on Direct Business	5 Direct Losses Paid	6 Direct Losses Incurred	7 Direct Losses Unpaid
32.1 Group A & H Policies – Loans of 60 or LESS months' duration 32.2 Group A & H Policies – Loans of GREATER THAN 60 MONTHS DURATION BUT NOT GREATER THAN 120 MONTHS						
33 Other A & H Policies						
34 TOTALS (Items 32.1 + 32.2 + 33						

Exhibit 6

This exhibit provides five years of data taken from or developed from Annual Statements for corresponding years for 69 separate items.

Form 2 ANNUAL STATEMENT FOR THE YEAR 1985 OF THE 21

FIVE-YEAR HISTORICAL DATA

(Continued)

	1 1985	2 1984	3 1983	4 1982	5 1981
Capital and Surplus Accounts (Page 4)					
39. Net Unrealized Capital Gains or Losses (Item 23)					
40. Dividends to Stockholders (Cash) (Item					
41. Change in Surplus as Regards Policyhol for the Year (Item 39)					
Gross Losses Paid (Page 9, Part 3, Cols					
42. Liability Lines (Items 11, 16, 17 & 19)					
43. Property Lines (Items 1, 2, 9, 12, 21, 2					
44. Property and Liability Combined Lines (Items 3, 4, 5, 8, 22 & 27)					
45. All Other Lines (Items 10, 13, 14, 15, 2					
46. Total (Item 31)					
Net Losses Paid (Page 9, Part 3, Col. 4)					
47. Liability Lines (Items 11, 16, 17 & 19)					
48. Property Lines (Items 1, 2, 9, 12, 21, 2					
49. Property and Liability Combined Lines (Items 3, 4, 5, 8, 22 & 27)					
50. All Other Lines (Items 10, 13, 14, 15, 2 24, 28, 29 & 30)					
51. Total (Item 31)					
Operating Ratios (Page 4) (Item divided by Page 4, Item 1) x 100					
52. Premiums Earned (Item 1)					
53. Losses Incurred (Item 2)					
54. Loss Expenses Incurred (Item 3)					
55. Other Underwriting Expenses Incurred					
56. Net Underwriting Gain or (Loss) (Item 7					
Other Ratios					
57. Other Underwriting Expenses to Net Pre (Page 4, Items 4+5−17 divided by Pag Col. 4, Item 31 x 100.0)					
58. Losses and Loss Expenses Incurred to (Page 4, Items 2+3 divided by Page 4, I					
59. Net Premiums Written to Policyholders' Part 2C, Col. 4, Item 31, divided by Pag Col. 1 x 100.0)					
One Year Loss Development (000 omitt Schedule "O", Page 54					
60. Development in estimated liability on un incurred prior to current year (Part 1, It					
61. Development in estimated liability for lo on losses incurred prior to current yea					
Schedule "P", Page 59					
62. Development in estimated losses and lo incurred prior to current year (Part 2, It Col. 7 less Col. 6)					
63. Total of above Items 60, 61 & 62					
64. Ratio of development of loss and loss e to policyholders' surplus of previous ye above divided by Page 4, Item 21, Col.					
Two Year Loss Development (000 omitt Schedule "O", Page 54					
65. Development in estimated liability on un losses incurred 2 years before the curr and prior (Part 1, Item 31, Col. 19)					
66. Development in estimated liability for lo expenses on losses incurred 2 years be current year and prior (Part 2, Item 31,					
Schedule "P", Page 59					
67. Development in estimated losses and lo incurred 2 years before the current yea (Part 2, Item 9, Col. 7 less Col. 5)					
68. Total of above Items 65, 66 & 67					
69. Ratio of development of loss and loss expe to reported policyholders' surplus of secon year end (Item 68 above divided by Page 4 Col. 2 x 100.0)					

20 Form 2

ANNUAL STATEMENT FOR THE YEAR 1985 OF THE

FIVE-YEAR HISTORICAL DATA

All Figures Taken From or Developed From Annual Statements of Corresponding Years
Show amounts in whole dollars only, no cents; show ratios and percentages to one decimal place, i.e. 17.6.

	1 1985	2 1984	3 1983	4 1982	5 1981
Gross Premiums Written (Page 8, Part 2C, Cols 1 & 2)					
1. Liability Lines (Items 11, 16, 17 & 19)	12,315,186	10,402,214	8,283,480	6,024,477	3,042,159
2. Property Lines (Items 1, 2, 9, 12, 21, 25 & 26)	10,832,457	8,634,746	7,123,719	4,660,523	2,226,642
3. Property and Liability Combined Lines (Item 3, 4, 5, 8, 22 & 27)	6,118,438	-0-	-0-	-0-	-0-
4. All Other Lines (Items 10, 13, 14, 15, 23, 24, 28, 29 & 30)					
5. Total (Item 33)	29,266,081	19,036,960	15,407,199	10,685,000	5,268,801
Net Premiums Written (Page 8, Part 2C, Col)					
6. Liability Lines (Items 11, 16, 17 & 19)					
7. Property Lines (Items 1, 2, 9, 12, 21, 25 & 26)					
8. Property and Liability Combined Lines (Item 3, 4, 5, 8, 22 & 27)					
9. All Other Lines (Items 10, 13, 14, 15, 23, 24 28, 29 & 30)					
10. Total (Item 31)					
Statement of Income (Page 4)					
11. Net Underwriting Gain or Loss (Item 7)	-1,773	-2,583	-2,860	-3,272	-1,890
12. Net Investment Gain or Loss (Item 9A)	263,671	245,757	235,940	225,631	211,328
13. Total Other Income (Item 17)					
14. Dividends to Policyholders (Item 18A)					
15. Federal and Foreign Income Taxes Incurred (Item 19)	1,229	3,564	14,363	35,928	15,838
16. Net Income (Item 20)	260,669	239,610	218,717	186,431	193,600
Balance Sheet Items (Pages 2 and 3)					
17. Total Admitted Assets (Page 2, Item 22)	3,963,346	3,674,414	3,433,933	3,210,098	3,018,817
18. Agents' Balances or Uncollected Premiums (Page 2)					
18.1 In Course of Collection (Item 8.1)					
18.2 Deferred and Not Yet Due (Item 8.2)					
19. Total Liabilities (Page 3, Item 23)	52,376	24,113	23,831	20,976	19,537
20. Losses (Page 3, Item 1)					
21. Loss Adjustment Expenses (Page 3, Item 2)					
22. Unearned Premiums (Page 3, Item 10)					
23. Capital Paid Up (Page 3, Items 25A and 25B)	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
24. Surplus as Regards Policyholders (Page 3, Item 27)	3,910,970	3,650,301	3,410,102	3,189,122	2,999,280
Percentage Distribution of Cash and Invested Assets (Page 2) (Item divided by Page 2, Item 7a) x 100.0					
25. Bonds (Item 1)	98.0	96.7	96.5	98.6	99.6
26. Stocks (Items 2.1 and 2.2)					
27. Mortgage Loans on Real Estate (Item 3)					
28. Real Estate (Items 4.1 and 4.2)					
29. Collateral Loans (Item 5)					
30. Cash and short-term investments (Items 5.1 and 6.2) (1981, Item 6)	2.0	3.3	3.5	1.4	.4
31. Other Invested Assets (Item 7)					
32. Cash and Invested Assets (Item 7a)	100.0	100.0	100.0	100.0	100.0
Investments in Parent, Subsidiaries and Affiliates					
33. Affiliated Bonds (Page 29, Item 29, Col. 6)					
34. Affiliated Preferred Stocks (Page 29, Item 47, Col. 3)					
35. Affiliated Common Stocks (Page 29, Item 65, Col. 3)					
36. Affiliated Short-Term Investments (Schedule DA, Part 1, Col. 10)					
37. Total of above Items 33, 34, 35 & 36					
38. Percentage of Investments in Parents, Subsidiaries and Affiliates to Surplus as Regards Policyholders (Item 37 above divided by Page 3, Col. 1, Item 27 x 100.0)					

Schedule P of the Annual Statement is a representative example of the necessary analytical information that insurers report in addition to their basic "bottom line" financial data. Generally, Schedule P provides an analysis of reserve development for the so-called "long tail" lines—those characterized by a time lag between the occurrence that gives rise to the claim, the report of the claim, and the ultimate settlement. Examples of these long-tail lines include automobile liability, other liability, medical malpractice and the multiple-peril coverages. Using Schedule P, the adequacy of historic loss reserve levels can be evaluated. The information required by Schedule P is illustrated in Exhibit 7.

The **Insurance Expense Exhibit** is the most prominent of the supplements required in conjunction with the Annual Statement. It allocates expenses (e.g., loss adjustment expenses, acquisition expenses, taxes) to each Annual Statement line of business. The Insurance Expense Exhibit is illustrated in Exhibit 8.

The **Quarterly Statement** is a streamlined version of the Annual Statement. It contains a balance sheet, income statement and statement of changes in financial position, but with less supporting detail than the Annual Statement provides. While the Quarterly Statement is not universally required, many states have established criteria for its use. In some states, all licensed companies are required to file a Quarterly Statement. In others, only newly organized companies or companies identified as being in potential financial difficulty are required to file.

Exhibit 7

Schedule P can be used to evaluate the adequacy of historic loss reserve levels by an analysis of their development over time. Information is provided for the lines of insurance, which are characterized by a lag in claim reporting and settlement, i.e., the "longer-tail" lines like auto liability, other liability, medical malpractice, and multiple-peril lines.

SCHEDULE P

SCHEDULE P—PART 1B—OTHER LIABILITY†

1	Prior to 1976	215,292	88,024	12,989	14.8	8,409	9.6	109,422	50.8				109,422	50.8	1
2	1976	84,611	15,212	715	4.7	895	5.9	16,822	19.3				16,822	19.9	2
3	1977	91,676	18,758	1,732	9.6	1,832	9.8	22,322	24.3				22,322	24.3	3
4	1978	88,786	20,342	8,719	42.9	1,600	7.9	30,661	34.5				30,661	34.5	4
5	1979	110,683	25,573	4,864	19.0	4,796	18.8	35,233	31.8				35,233	31.8	5
6	1980	110,376	12,251	6,746	55.1	2,003	16.3	21,000	19.0				21,000	19.0	6
7	1981	81,150	18,666	1,370	7.3	6,427	34.4	26,463	32.6				26,463	32.6	7
8	1982	76,805	16,860	352	2.1	18,692	110.9	35,904	46.7				35,904	46.7	8
9	1983	110,768	17,790	2,599	14.6	25,571	143.7	45,950	41.5	1	100	5	46,065	41.6	9
10	1984	73,332	14,581	368	2.5	17,132	117.5	32,081	43.7	1	100	24	32,205	43.9	10
11	1985	68,832	6,208	1,897	30.6	11,390	183.5	19,495	28.3	1	3,450	844	23,789	34.6	11
12	TOTALS	1,112,311	254,265	42,351	16.7	98,747	38.8	395,363	35.5	3	3,650	873	399,886	36.0	12

COMPUTATION OF EXCESS OF STATUTORY RESERVE OVER STATEMENT RESERVES—OTHER LIABILITY

1985 $ 17,483 1984 $ 11,806 1983 $ 14,132 [illegible] $ 43,421 [illegible] 60.0

See Schedule P- Part 1F for footnotes

SCHEDULE P—PART 2B—OTHER LIABILITY

1	Prior to 1980	231	232	221	215	214	215	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
2	1980	23	20	23	24	24	21	20.9	18.2	20.9	21.8	21.8	19.1	
3	Cumulative Total	254	252	244	239	238	236	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
4	1981	XXXX	45	26	27	26	26	XXXX	55.6	32.1	33.3	32.1	32.1	
5	Cumulative Total	XXXX	297	270	266	264	262	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
6	1982	XXXX	XXXX	44	37	36	36	XXXX	XXXX	57.1	48.1	46.8	46.8	
7	Cumulative Total	XXXX	XXXX	314	303	300	298	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
8	1983	XXXX	XXXX	XXXX	54	47	46	XXXX	XXXX	XXXX	48.6	42.3	41.4	
9	Cumulative Total	XXXX	XXXX	XXXX	357	347	344	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
10	1984	XXXX	XXXX	XXXX	XXXX	34	32	XXXX	XXXX	XXXX	XXXX	46.6	43.8	
11	Cumulative Total	XXXX	XXXX	XXXX	XXXX	381	376	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	
12	1985	XXXX	XXXX	XXXX	XXXX	XXXX	24	XXXX						

SCHEDULE P—PART 3B—OTHER LIABILITY

Calendar Year Premiums Earned, Accident Year Loss and Loss Expense Incurred

	Dollars (000 omitted)							Percentages						
	1 1979	2 1980	3 1981	4 1982	5 1983	6 1984	7 1985	8 1979	9 1980	10 1981	11 1982	12 1983	13 1984	14 1985
Summary Data from Schedule P Part 1B														
1 Premiums Earned	111	110	81	77	111	73	69	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2 Loss & Loss Exp Incd	35	21	26	36	46	32	24	31.5	19.1	32.1	46.8	41.4	43.8	34.8
Loss & Loss Expense through 1 year														
3 Paid	22	10	8	33	38	28	19	19.8	9.1	9.9	42.8	34.2	38.3	27.5
4 Reserve (2)– (3)	13	11	18	3	8	4	5	11.7	10.0	22.2	3.9	7.2	5.5	7.2
Loss & Loss Expense through 2 years														
5 Paid	24	12	26	36	46	32	XX	21.6	10.9	32.1	46.7	41.4	43.8	XX
6 Reserve (2) – (5)	11	9	0	0	0	0	XX	9.9	8.2	0	0	0	0	XX
Loss & Loss Expense through 3 years														
7 Paid	25	20	27	36	46	XX	XX	22.5	18.2	33.3	46.7	41.4	XX	XX
8 Reserve (2) – (7)	10	1	(1)	0	0	XX	XX	9.0	.9	(1.2)	0	0	XX	XX
Loss & Loss Expense through 4 years														
9 Paid	32	21	26	36	XX	XX	XX	28.8	19.1	32.1	46.7	XX	XX	XX
10 Reserve (2) – (9)	3	0	0	0	XX	XX	XX	2.7	0	0	0	XX	XX	XX
Loss & Loss Expense through 5 years														
11 Paid	35	21	26	XX	XX	XX	XX	31.5	19.1	32.1	XX	XX	XX	XX
12 Reserve (2) – (11)	0	0	0	XX	XX	XX	XX	0	0	0	XX	XX	XX	XX

Exhibit 8

This exhibit provides an allocation of expenses such as loss adjustment expense, commissions and other acquisition expense, general expenses and taxes, licenses and fees to each of the 32 Annual Statement lines of business listed on Exhibit 2.

INSURANCE EXPENSE EXHIBIT – 1986

FOR THE YEAR ENDED DECEMBER 31, 1986

OF THE ..... INSURANCE COMPANY

ADDRESS (City, State and Zip Code)

NAIC Group Code ..... NAIC Company Code .....

REPORT TO THE STATE OF

GENERAL INSTRUCTIONS **(To Be Filed Not Later Than April 1, 1987)**

(1) Refer to Instructions for Uniform Classifications of Expenses for definitions of Expense Groups and instructions for allocation of expenses to lines of business.
(2) Compute all ratios to nearest third place and express as percentages, e.g., 48.3
(3) There should be submitted with this exhibit a detailed statement or footnote with respect to any item or items requiring special comment or explanation.
(4) Report all amounts to the nearer thousand or through truncation of digits below a thousand. (Example: $602,503 may be reported as $603 by rounding or as $602 by truncation.)
(5) An individual company expense exhibit must be submitted. Pooled expense exhibits will not be accepted. The individual expense exhibit must reconcile to the individual company's annual statement

PART I – ALLOCATION TO EXPENSE GROUPS

Operating Expense Classifications	1	Other Underwriting Expenses			5	6
	Loss Adjustment Expenses	2 Acquisition, Field Supervision and Collection Expenses	3 General Expenses	4 Taxes, Licenses and Fees	Investment Expenses	Total Expenses
1. Claim adjustment services:						
a. Direct						
b. Reinsurance assumed						
c. Reinsurance ceded						
d. Net claim adjustment services (a + b – c)						
2. Commission and brokerage:						
a. Direct						
b. Reinsurance assumed						
c. Reinsurance ceded						
d. Contingent – net						
e. Policy and membership fees						
f. Net commission and brokerage (a + b – c + d + e)						
3. Allowances to managers and agents						
4. Advertising						
5. Boards, bureaus and associations						
6. Surveys and underwriting reports						
7. Audit of assureds' records						
8. Salaries						
9. Employee relations and welfare						
10. Insurance						
11. Directors' fees						
12. Travel and travel items						
13. Rent and rent items						
14. Equipment						
15. Printing and stationery						
16. Postage, telephone and telegraph, exchange and express						
17. Legal and auditing						
17a. Totals (Items 3 to 17)						
18. Taxes, licenses and fees:						
a. State and local insurance taxes						
b. Insurance department licenses and fees						
c. Payroll taxes						
d. All other (excl. Fed. and foreign income and real estate)						
e. Total taxes, licenses and fees (a + b + c + d)						
19. Real estate expenses						
20. Real estate taxes						
21. Miscellaneous (itemize)						
a.						
b.						
c.						
22. TOTAL EXPENSES INCURRED						

AFFIDAVIT

STATE OF }
COUNTY OF } ss.

(Name) (Title) , and (Name) (Title)

of (Hereinafter called the Insurer), being duly sworn, each for himself declares

1. That he is familiar with the matters to which the within exhibits, the answers, and the information, if any, refer
2. That he is duly authorized to make, and does make, the following declaration on behalf of the Insurer.
3. That the within exhibits, the answers, and the information, if any, are full and true statements of the matters respectively described herein, according to his best knowledge, information and belief

Subscribed and sworn to before me this

..... day of ....., 1987

Annual statements alone do not satisfy all of the financial data reporting obligations placed upon insurers. Because insurance companies are businesses, they must also comply with the requirements of government agencies that monitor the activities of the general business community.

The Securities and Exchange Commission (SEC) requires corporations with securities, either listed on national exchanges or registered under the Securities Act of 1933, to furnish shareholders with periodic information. Generally, such corporations must register their securities if their assets exceed three million dollars, and the number of their shareholders for any one class of equity securities exceeds five hundred. Many insurance companies fall within these categories, and thus are subject to the requirements of the SEC.

Form 10-K is customarily used to fulfill SEC annual reporting requirements. Companies filing the form have the option of incorporating, by reference, certain information included in the annual report to shareholders, or publishing the same information again in Form 10-K. Form 10-K contains a number of insurance supplements, which include information on premium revenue, investment income, losses and loss expenses, operating expenses, and reserves.

The **Internal Revenue Service (IRS)** also specifies a detailed level of financial data reporting for all businesses, especially insurance companies. The data requirements of the IRS fall into the same basic categories as those required by other public agencies. IRS activity thus represents one more level of government review of insurer financial data.

Regulators specify the financial data that must be reported. Review by insurance professionals, financial analysts, and regulatory examiners assure the accuracy of these reports.

General requirements for reporting financial data have their basis in statute. Reporting details—frequency, format, data elements—are more often specified by regulations or related administrative bulletins.

The documents themselves, and the number and kinds of schedules and supplements, are adequate testimony to the fact that the statutory and regulatory reporting requirements are not static. They are the product of continuous review and revision, like that conducted by the NAIC Blanks Committee. This dynamic regulatory environment assures that the reported financial data keep pace with ever-changing business demands and social expectations. Regulators expect the industry to provide useful, timely reports that can be substantiated.

To ensure the integrity of the information provided in the Annual Statement, some states require independent verification by a certified public accountant (CPA). Because the overwhelming majority of insurance business is written by interstate writers of property/casualty insurance, the mandatory CPA verification effectively covers more than 90% of the business. In addition to the CPA verification, many states require that loss reserves be certified by actuaries or other designated loss reserve specialists.

Because financial data must ultimately be reconciled to statistical data (as will be discussed later), another degree of verification is achieved.

Insurers are also subject to financial examinations by state regulators and reviews by the SEC and IRS. Generally, state financial examinations of insurers occur at three- to five-year intervals. Regulators also have the responsibility and legal authority to examine an insurer any time they have reason to believe its financial condition may be in jeopardy.

State regulators and private service organizations compile the Annual Statements filed by individual companies into computerized financial data bases. These data bases facilitate analysis of individual companies and the industry as a whole. In particular, the NAIC Data Base helps identify companies that may be financially troubled. Information from the NAIC Data Base assists regulators in discharging their responsibility to protect policyholders and claimants from insurer insolvency.

The **NAIC Support Services Office** compiles key financial data from the Annual Statements of all licensed insurers doing business in the United States. This compilation is accomplished through the NAIC's own data base, linked via the NAIC State Telecommunications Network, to terminals in the office of every state regulator. As soon as the data enter the NAIC Data Base—usually within a week of the time Annual Statement filings are required to be submitted to the states and the NAIC—individual states may directly access key information to perform solvency/solidity analyses. Important information regarding market share rankings and profitability is also made routinely available for the states. With appropriate lead time, customized reports about particular states, companies, or insurance lines can also be produced. Samples of the reports available through the NAIC State Telecommunications Network are contained in Exhibit 9.

The **Insurance Regulatory Information System (IRIS)**, generally known as the Early Warning System, is a valuable feature of the NAIC Data Base. Under IRIS, the NAIC calculates a series of financial ratios (e.g., ratio of written premium to policyholder's surplus) for each insurance company. These ratios serve as preliminary tests of the company's financial condition. The tests measure solvency, liquidity, profitability, and other aspects of insurance company operations. Exhibit 10 contains a list of the IRIS tests and a sample IRIS report.

If a company's IRIS results do not meet established criteria, the information is presented to an NAIC examiner team. The examiner team is composed of fifteen select regulatory professionals, who meet to review the IRIS information and possibly identify causes for the results. They determine the level of regulatory attention that may be required. If immediate attention is necessary, the team notifies the regulator in the state of domicile, and the NAIC zone examination coordinators, who then become responsible for undertaking specific remedial action. The NAIC examiner team reconvenes at a later date to review the remedial steps, and to recommend additional measures if necessary.

The **NAIC Report on Profitability By Line and By State** was created to establish a standard format for estimating profitability. Since this report requires the allocation of line items that are not actually separable by line and state (e.g., surplus, investment income) the report has recognized limitations. An illustration of the NAIC Profitability Report is contained in Exhibit 11.

The staff of the state insurance departments can access information via the NAIC State Telecommunications Network, which includes written and earned premium; paid, incurred, and unpaid losses; market share; dividends; guaranty fund assessments.

DATE: 06/25/86

PENNSYLVANIA INSURANCE DEPARTMENT
1984 AGGREGATE PROPERTY COMPANIES LOSS RATIO

PAGE: 1
LICENSED COMPANIES

LINE OF BUSINESS	DIRECT PREMIUMS WRITTEN	MARKET SHARE	CUMULATIVE MARKET SHARE	DIRECT PREMIUM EARNED	DIRECT LOSSES INCURRED	LOSS RATIO EXCLUDING ALL LAE
FIRE	150,098,860	2.44	2.44	156,207,692	74,933,129	.4797
ALLIED LINES	120,968,756	3.21	3.21	132,356,789	30,990,158	.6545
FARMOWNERS MULTIPLE PERIL	140,419,427	2.28	2.28	120,478,945	20,567,012	.7896

DATE: 06/26/86

NEW HAMPSHIRE INSURANCE DEPARTMENT
1984 AGGREGATE STATE PAGE DATA
FIRE AND CASUALTY

PAGE: 1
LICENSED COMPANIES

LINE OF BUSINESS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
FIRE	14,098,005	14,033,415	151,928	8,788,012	6,438,753	3,100,531
ALLIED LINES	11,078,432	12,033,432	138,730	1,563,793	1,540,350	1,254,655
HOMEOWNERS MULTIPLE PERIL	76,163,468	74,640,797	1,607,109	4,792,279	4,986,867	2,069,254

DATE: 06/26/86

NEW HAMPSHIRE INSURANCE DEPARTMENT
1984 STATE PAGE DATA
LINE OF BUSINESS: 11 - MEDICAL MALPRACTICE

PAGE: 1
LICENSED COMPANIES

Zero Companies Excluded.

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
20354	COMPANY A	NY	768,136	714,395		105,663	805,408	285,802
15156	COMPANY B	OH	270,367	534,897		102,586	847,902	225,179
14356	COMPANY C	GA	279,498	321,467		231,678	946,321	421,356

01/19/86

NEW MEXICO GUARANTY FUND ASSESSMENT FOR YEAR ENDING DECEMBER 31, 1984
WITHOUT REGARD TO PREVIOUS ASSESSMENTS

Page: 1

ASSESSMENT $500,000.00
CAP 5%

OTHER LIABILITY

Zero Companies Excluded.

NAIC CODE	COMPANY NAME	DOM	DIRECT WRITTEN PREMIUM	DIVIDENDS	NET WRITTEN PREMIUM	SHARE OF TOTAL PREM	CURRENT ASSESSMENT	ANNUAL ASSESSMENT WITH CAP	MAXIMUM EXCESS OF CAP
68241	COMPANY X	NJ	21,267,703	8,748,187	12,519,516	.0632	31,644.59	625,975.80	.00
66915	COMPANY Y	NY	17,129,002	6,146,177	10,982,825	.0555	27,760.42	549,141.25	.00
62944	COMPANY Z	NY	13,180,502	2,683,593	10,496,909	.0530	26,532.21	524,845.45	.00

The NAIC calculates and compares these ratios with a "usual range" of results for each ratio. The by company results are then reviewed by a team of examiners and financial analysts representing the four NAIC zones.

Insurance Regulatory Information System (IRIS)

NAIC Property and Liability Financial Ratios

Company No.	Company Name		Prem to Surp	Chng In Writ	Surp Aid/ Surp	2 Yr Ov Op Ratio	Inv Yld	Chng In Surp	Liab /Liq Asset	Agnt Bal/	1 Yr Res Devl	2 Yr Res Devl	Crnt Res Defic	Key Annual Statement Info ($Thousands) Capital and Surplus	Net Written Premium	Assets
	Deleted	DC	242	28	89*	133*	5.4					185*	111*	12589	30468	81650
		VA	178	-24	116*	109	4.7					195*	76*	13351	23733	87849
		CO	229	-26	95*	110*						117*	19	13660	33963	97629
		OH	186	-4	3	113*						97*	13	13172	24441	63109
		MN	421*	-7	18							41*	156*	6038	25439	57612

Overall Ratios
- Ratio 1 - Premium to Surplus
- Ratio 2 - Change in Writings
- Ratio 3 - Surplus Aid to Surplus

Profitability Ratios
- Ratio 4 - Two-Year Overall Operating Ratio
- Ratio 5 - Investment Yield
- Ratio 6 - Change in Surplus

Liquidity Ratio
- Ratio 7 - Liabilities to Liquid Assets
- Ratio 8 - Agent's Balances to Surplus

Reserve Ratio
- Ratio 9 - One-Year Reserve Development to Surplus
- Ratio 10 - Two-Year Reserve Development to Surplus
- Ratio 11 - Estimated Current Reserve Deficiency to Surplus

Exhibit 11

The NAIC publishes profitability reports by line of insurance and by state, along with a transmittal letter describing the contents, data sources, methods of allocation to states, adjustments to the source data, and certain caveats about the use of the reports.

08/24/86
12:05:30

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
1985 PROFITABILITY RESULTS

COUNTRY WIDE

LINE OF BUSINESS	(1) PREMIUMS EARNED (000'S)	PERCENT OF PREMIUM EARNED (2) LOSS INCR	(3) LOSS ADJ EXPNS	(4) GENRL EXPNS	(5) SELL EXPNS	(6) TAXES LIC. FEES	(7) DIV TO POL-HLDR	(8) UNDERWRITING PROFIT (1)-(2) THRU (7)	(9) INVEST GAIN	(10) FED TAXES	(11) OPER. PROFIT INV- REST
PRIV PASS AUTO LIABILITY	26,989,759	82.9	12.7	4.9	17.2	3.0	.8	-21.5	10.1	-7.0	-4.3
PRIV PASS AUTO PHYS DAMAG	20,036,402	67.2	8.1	4.6	17.6	2.9	.7	-1.1	3.0	.4	1.6
COMM AUTO LIABILILITY	7,505,852	90.7	13.6	7.2	21.0	3.7	.5	-36.7	13.3	-13.2	-10.3
COMM AUTO PHYS DAMG	3,859,713	61.5	6.9	6.5	21.8	3.2	.3	-.1	2.9	.8	2.0
HOMEOWNERS	13,659,946	70.8	9.3	5.7	23.8	3.1	.5	-13.2	5.3	-4.6	-3.4
FARMOWNERS	803,397	74.7	7.9	6.5	22.4	2.4	.3	-14.3	5.3	-5.1	-3.9
COMM MULTIPLE PERIL	12,360,034	71.2	15.7	10.1	25.5	3.8	.2	-26.6	9.1	-9.7	-7.9
OCEAN AND AIRCRAFT	2,038,032	73.7	7.4	6.6	18.2	1.7	.1	-7.6	9.3	-.9	2.6
FIRE AND ALLIED LINES	10,421,833	59.3	5.4	8.7	24.3	3.9	.3	-1.9	4.4	.3	2.1
MEDICAL MALPRACTICE	2,660,985	121.6	44.0	5.4	8.4	2.8	.7	-82.8	35.5	-28.1	-19.3
OTHER LIABILITY	12,380,205	105.0	36.8	7.3	20.8	3.8	.3	-73.9	19.9	-28.4	-25.6
WORKERS' COMPENSATION	19,145,960	83.3	9.7	6.0	8.8	4.7	8.2	-20.8	16.0	-5.0	.3
GROUP ACCIDENT & HEALTH	4,327,572	86.2	2.6	7.9	5.8	1.1	.1	-3.6	13.7	2.2	7.9
CREDIT ACCIDENT & HEALTH*	52,046	40.7	1.3	5.7	23.7	2.6	.0	26.0	9.4	14.6	20.8
OTHER ACCIDENT & HEALTH	1,401,023	62.6	4.5	5.6	24.3	1.9	.0	1.2	4.4	1.8	3.8
FIDELITY AND SURETY	2,209,580	70.4	20.3	12.7	35.7	4.0	.3	-43.5	11.6	-16.7	-15.2
CREDIT	629,161	84.7	4.8	10.1	23.5	4.2	.0	-27.2	19.1	-7.1	-1.0
TOTAL ALL LINES	140,481,499	78.8	12.2	6.4	18.6	3.3	1.5	-20.9	10.0	-6.8	-4.1

* FIGURES FOR COUNTRY WIDE BY STATE PAGE AND TOT WILL DIFFER TO THE EXTENT THAT ASSUMED BUSINESS FROM ALL SOURCES EXCEEDS CEDED.

The **A.M. Best Company** is the most widely known private sector organization providing compilations, reports, and analyses of insurer Annual Statement data. Best's reports are available to regulators and the general public for a broad range of purposes. Best's reports include the following publications:

- Best's Executive Data Service compiles data from Page 14 of the Annual Statement. It provides various loss ratios, market share, and market share trend information for the largest groups as well as on an aggregate basis. It is available by line of business and by state.

- Best's Aggregates and Averages contain special reports based on Annual Statement data, consolidated for all companies. One particular portion, "Time Series," displays industry trends over a number of years, like those for industry loss and expense ratios.

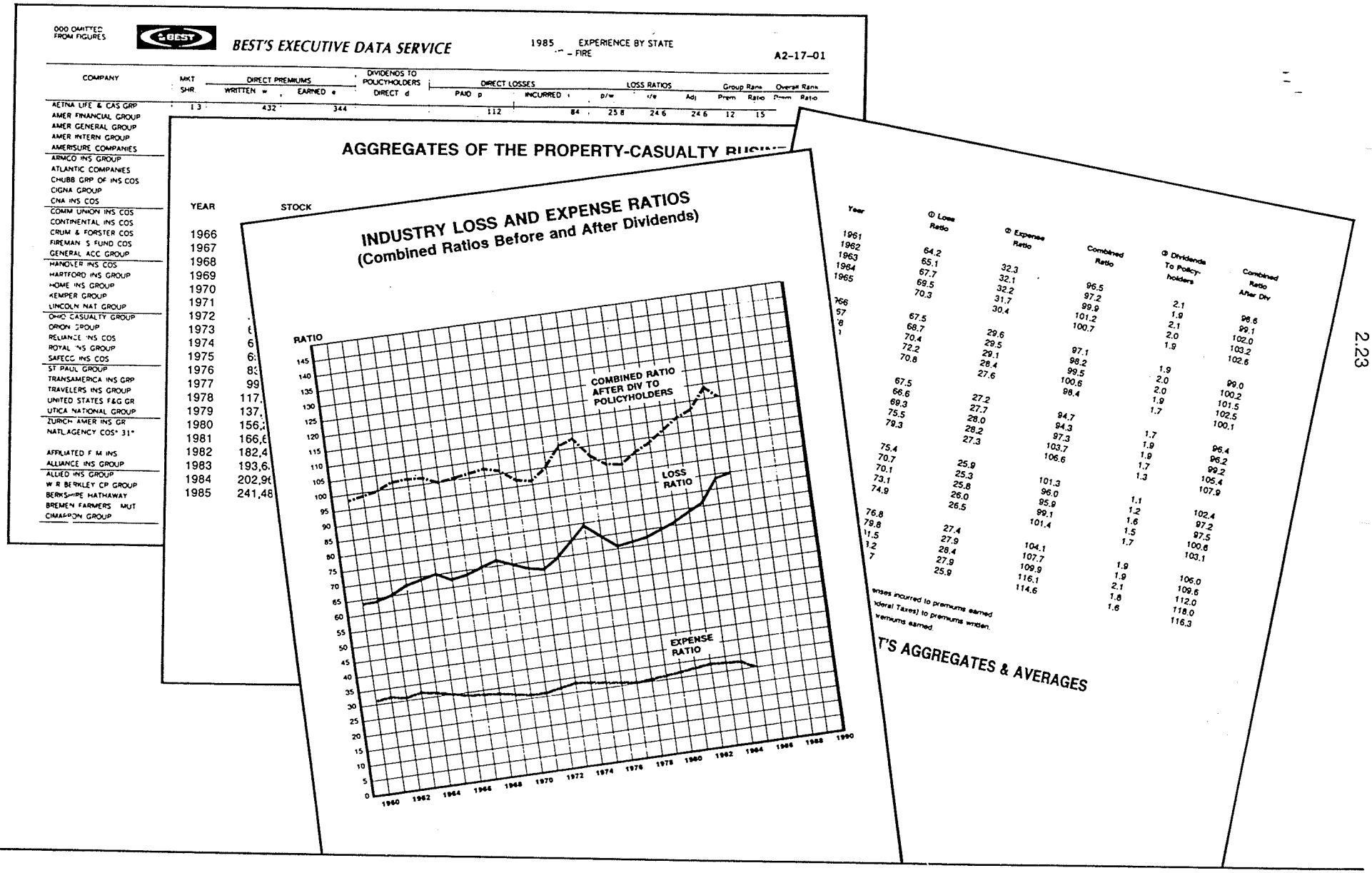
- Best's Insurance Reports contain financial data and information about the history, management and operation of each insurance company.

Samples of exhibits from Best's Executive Data Service and Best's Aggregates and Averages are contained in Exhibit 12.

Other private entities, like **Conning & Company**, also analyze insurer data to develop financial commentaries and provide investment services.

Exhibit 12

A.M. Best publishes both summary and company detail for each of the major Annual Statement exhibits.



000 OMITTED FROM FIGURES

BEST'S EXECUTIVE DATA SERVICE

1985 EXPERIENCE BY STATE – FIRE

A2-17-01

COMPANY	MKT SHR	DIRECT PREMIUMS WRITTEN w	DIRECT PREMIUMS EARNED e	DIVIDENDS TO POLICYHOLDERS DIRECT d	DIRECT LOSSES PAID p	DIRECT LOSSES INCURRED i	LOSS RATIOS p/w	LOSS RATIOS i/e	LOSS RATIOS Adj	Group Rank Prem	Group Rank Ratio	Overall Rank Prem	Overall Rank Ratio
AETNA LIFE & CAS GRP	1 3	432	344		112	84	25 8	24 6	24 6	12	15		
AMER FINANCIAL GROUP													
AMER GENERAL GROUP													
AMER INTERN GROUP													
AMERISURE COMPANIES													
ARMCO INS GROUP													
ATLANTIC COMPANIES													
CHUBB GRP OF INS COS													
CIGNA GROUP													
CNA INS COS													
COMM UNION INS COS													
CONTINENTAL INS COS													
CRUM & FORSTER COS													
FIREMAN S FUND COS													
GENERAL ACC GROUP													
HANOVER INS COS													
HARTFORD INS GROUP													
HOME INS GROUP													
KEMPER GROUP													
LINCOLN NAT GROUP													
OHIO CASUALTY GROUP													
ORION GROUP													
RELIANCE INS COS													
ROYAL INS GROUP													
SAFECO INS COS													
ST PAUL GROUP													
TRANSAMERICA INS GRP													
TRAVELERS INS GROUP													
UNITED STATES F&G GR													
UTICA NATIONAL GROUP													
ZURICH AMER INS GR													
NATL AGENCY COS* 31*													
AFFILIATED F M INS													
ALLIANCE INS GROUP													
ALLIED INS GROUP													
W R BERKLEY CP GROUP													
BERKSHIRE HATHAWAY													
BREMEN FARMERS MUT													
CIMARRON GROUP													

AGGREGATES OF THE PROPERTY-CASUALTY BUSIN

YEAR	STOCK
1966	
1967	
1968	
1969	
1970	
1971	
1972	
1973	
1974	6
1975	6
1976	8
1977	99
1978	117,
1979	137,
1980	156,
1981	166,6
1982	182,4
1983	193,6
1984	202,9
1985	241,48

INDUSTRY LOSS AND EXPENSE RATIOS
(Combined Ratios Before and After Dividends)

Year	① Loss Ratio	② Expense Ratio	Combined Ratio	③ Dividends To Policy-holders	Combined Ratio After Div
1961	64.2	32.3	96.5	2.1	98.6
1962	65.1	32.1	97.2	1.9	99.1
1963	67.7	32.2	99.9	2.1	102.0
1964	69.5	31.7	101.2	2.0	103.2
1965	70.3	30.4	100.7	1.9	102.6
	67.5	29.6	97.1	1.9	99.0
	68.7	29.5	98.2	2.0	100.2
	70.4	29.1	99.5	2.0	101.5
	72.2	28.4	100.6	1.9	102.5
	70.8	27.6	98.4	1.7	100.1
	67.5	27.2	94.7	1.7	96.4
	66.6	27.7	94.3	1.9	96.2
	69.3	28.0	97.3	1.9	99.2
	75.5	28.2	103.7	1.7	105.4
	79.3	27.3	106.6	1.3	107.9
	75.4	25.9	101.3	1.1	102.4
	70.7	25.3	96.0	1.2	97.2
	70.1	25.8	95.9	1.6	97.5
	73.1	26.0	99.1	1.5	100.6
	74.9	26.5	101.4	1.7	103.1
	76.8	27.4	104.1	1.9	106.0
	79.8	27.9	107.7	1.9	109.6
	11.5	28.4	109.9	2.1	112.0
	12	27.9	116.1	1.8	118.0
	7	25.9	114.6	1.6	116.3

enses incurred to premiums earned
idoral Taxes) to premiums written.
remiums earned.

T'S AGGREGATES & AVERAGES

The other basic type of insurance information is statistical data. The collection of statistical data is required by statute to substantiate that the rates charged by insurance companies are not excessive, inadequate or unfairly discriminatory.

Like financial data, statistical data are derived from the individual business transactions conducted by an insurance company. They contain fundamental information about insurance coverages, and the premium and loss experience related to those coverages. Statistical data are collected in all states, regardless of whether insurance rates for those states are introduced with the prior approval of the regulator, or are implemented by the company and subject to later regulatory review. "Countrywide Results for Selected Commercial Liability Classes" is an example of the type of analysis that can be performed using statistical data. It is included later in this section.

Statistical data assists regulators in analyzing whether insurers' rates meet the rate standards encompassed in the model rating law: that they not be "excessive, inadequate or unfairly discriminatory." Companies use statistical data in assessing their underwriting and pricing performance.

For statistical data to be valuable in supporting regulatory oversight of rate adequacy and pricing structures, they must be analyzed in an appropriate context. To test adequacy and fairness, the analysis must relate premiums to losses for a given set of policyholders. The analysis should include data in a level of detail that allows the evaluation of the rate structure and its component parts, e.g., class, territory and coverage. To assist in projecting future costs, the analysis must accurately recognize loss development, and loss frequency and severity trends.

Specific statutory and regulatory requirements govern the collection and production of statistical data.

State laws and regulations empower insurance regulators to collect the statistical data necessary to evaluate the adequacy and fairness of the rates and rating plans used in their states. These laws are patterned after the All-Industry Model Rating Law, adopted by the NAIC.

In most cases, the regulatory agencies appoint designated **statistical agents** to perform this function on their behalf. In addition, some states accept statistical data submissions directly from companies. The major statistical agents include:

- American Association of Insurance Services
- Insurance Services Office, Inc.
- National Association of Independent Insurers
- National Independent Statistical Service

Acting on behalf of state regulators, the statistical agents develop detailed instruction books, called statistical plans, which define the data elements (e.g., line of business, coverage, class, state, territory, premium, etc.) as well as the formats and timeframes for company reporting. The statistical plans specify the way each insurer is to code and submit its premium and loss data to the statistical agent. They are continuously reviewed by the statistical agents and are modified, when necessary, to correspond to approved rating structures and coverage programs.

Statistical plans are subject to review and approval by individual states. Moreover, the statistical agents are subject to regulatory examination to assure that they are performing in accordance with regulatory standards. The procedures of Insurance Services Office, Inc. (ISO) and the National Association of Independent Insurers (NAII) illustrate the role statistical agents play in the data collection process.

Data under the ISO statistical plans are collected on a unit transaction basis, i.e., a record is coded and reported to ISO every time a policy is issued, a loss is paid, or a case reserve is established or revised.

Companies reporting to ISO submit relevant information about individual commercial lines policies. Consistent with the purpose of statistical plans, the reported data vary for each commercial line of insurance. However, the data generally include elements necessary for a thorough evaluation of the rate structure for a given state, line, and class of business.

ISO collects data on a "unit transaction" basis—every premium and loss transaction is reported. That means one or more premium records are generated each time a policy is written. In addition to the premium dollars, the record captures substantial information about the risk's characteristics, such as the line of business (e.g., general liability, products and completed operations), the classification (e.g., dairy products manufacturing), the coverages (e.g., bodily injury, property damage), the exposure (e.g., units of area, receipts or sales), the location (e.g., state and territory), policy limits and deductible.

Exhibit 13 contains a list of the principal data elements captured by an ISO premium record.

Similar reporting is required on the loss side. A loss record is generated every time a loss is paid, or a case reserve is established or changed. Total loss dollars are reported separately for paid losses and outstanding losses. In addition to the risk characteristics reported on the premium record—line, class, coverage, state—information such as "type of loss" and "claim count" is also collected. Exhibit 13 also contains a list of the principal items captured by an ISO loss record.

To meet statutory demands, ISO provides data in the complete detail of approved coverage forms * and rating structures for each line of insurance. For general liability insurance alone, ISO collects premium and loss data for over 1,100 separate classes in each state. These classes range from day care centers to grocery stores to paper manufacturers. To the extent that these classifications generate enough data for a credible analysis, the data can be used to review historic rate level adequacy for each class, or as the basis for prospective rate levels.

A sample of the class data produced by ISO is displayed in Exhibit 14.

Processing this data at ISO may involve as many as 28 individual insurer data submissions per year: monthly premium reports, monthly paid loss submissions, and quarterly outstanding loss reports. Each of those reports is provided in the detail required by the statistical plan.

* But for only those programs that are consistant with their rating & statistical codes.

Exhibit 13

The ISO statistical plan requires the reporting of all major risk identifying characteristics, including coverage, class and premium for each policy written. Similarly, for each loss a record is reported with complete identifying detail.

PRINCIPAL ISO PREMIUM CODING FIELDS

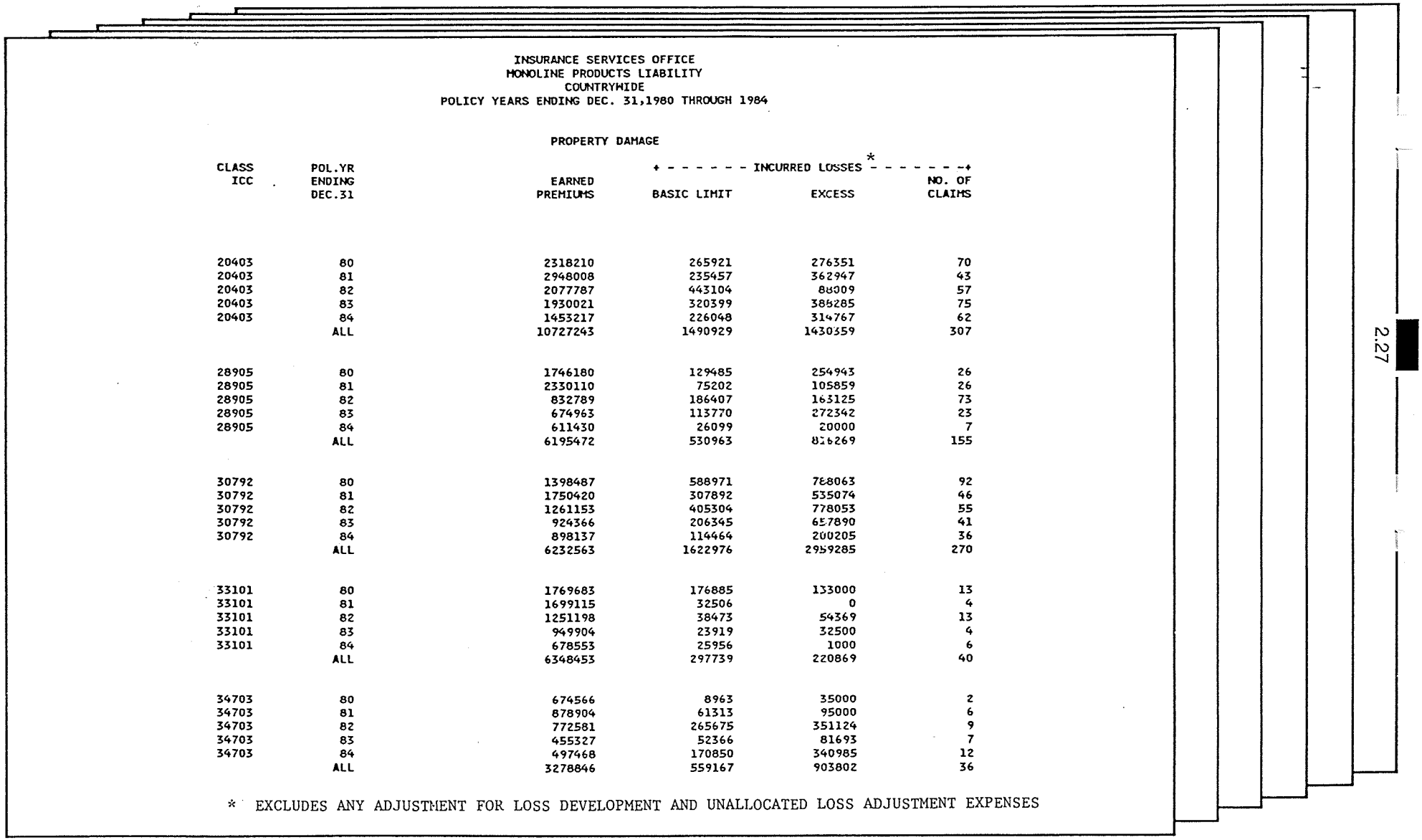
Company or Group Number
Transaction Type
Accounting Date
Inception Date
Transaction Effective Date
Transaction Expiration Date
State
Territory
Type of Policy
Annual Statement L.O.B.
Subline
Classification
Coverage
Rating ID
Construction
Protection
Deductible
Exposure/Amount of Insurance
Rating Modification Factor
Rate Departure Factor
Premium Amount
Premium Record ID
Form
Policy Limits
Entry into Claims Made Date
Limits ID
BI or CSL Limit
PD Limit
BI Deductible
PD Deductible
State Exception
Zone Rating
BI or Combined Premium
PD Premium
PIP Premium
PIP Limit
PIP Deductible
PIP Rating Basis
OTC Coverage
Collision Coverage
Anti-theft Device
Age
Value per Rating Unit
Building and Open Lots
Original Cost New
OTC Premium
Collision Premium
Number of Employees
Rate Group
Type Rating Deductible
Area/Number of Apartments

PRINCIPAL ISO LOSS CODING FIELDS

Company/Group Number
Transaction Type
Accounting Date
Inception Date
Loss Date
State
Territory
Type of Policy
Annual Statement L.O.B.
Subline
Class
Coverage
Rating ID
Construction
Protection
Deductible
Type of Loss
Claim Count
Exposure/Amount of Insurance
Loss amount
Loss Record ID
Premium Record ID
Form
Policy Limits
Entry into Claims Made Date
Receipt of Claims Notice Date
Status of Claim
Limits ID
Notice of Occurrence Date
State Exception
Accident State
Zone Rating
PIP Unit
PIP Deductible
PIP Rating
PIP Limit
Anti-theft Device
Age
Value per Rating Unit
Building and Open Lots
Original Cost New
Number of Employees
Rate Group
Type
Rating Deductible
Actual Deductible

Exhibit 14

The ISO statistical plan captures information in individual class detail for each line of insurance and each coverage. The classifications vary by line of insurance and/or coverage. For the General Liability lines, there are 1,100 different class codes captured.



INSURANCE SERVICES OFFICE
MONOLINE PRODUCTS LIABILITY
COUNTRYWIDE
POLICY YEARS ENDING DEC. 31,1980 THROUGH 1984

PROPERTY DAMAGE

CLASS ICC	POL.YR ENDING DEC.31	EARNED PREMIUMS	INCURRED LOSSES * BASIC LIMIT	INCURRED LOSSES * EXCESS	NO. OF CLAIMS
20403	80	2318210	265921	276351	70
20403	81	2948008	235457	362947	43
20403	82	2077787	443104	88009	57
20403	83	1930021	320399	386285	75
20403	84	1453217	226048	314767	62
	ALL	10727243	1490929	1430359	307
28905	80	1746180	129485	254943	26
28905	81	2330110	75202	105859	26
28905	82	832789	186407	163125	73
28905	83	674963	113770	272342	23
28905	84	611430	26099	20000	7
	ALL	6195472	530963	816269	155
30792	80	1398487	588971	768063	92
30792	81	1750420	307892	535074	46
30792	82	1261153	405304	778053	55
30792	83	924366	206345	657890	41
30792	84	898137	114464	200205	36
	ALL	6232563	1622976	2959285	270
33101	80	1769683	176885	133000	13
33101	81	1699115	32506	0	4
33101	82	1251198	38473	54369	13
33101	83	949904	23919	32500	4
33101	84	678553	25956	1000	6
	ALL	6348453	297739	220869	40
34703	80	674566	8963	35000	2
34703	81	878904	61313	95000	6
34703	82	772581	265675	351124	9
34703	83	455327	52366	81693	7
34703	84	497468	170850	340985	12
	ALL	3278846	559167	903802	36

* EXCLUDES ANY ADJUSTMENT FOR LOSS DEVELOPMENT AND UNALLOCATED LOSS ADJUSTMENT EXPENSES

A comprehensive data quality program is an integral part of the data processing function at ISO. Any data errors that are detected during processing are returned to the companies, who are then responsible for correcting the errors and resubmitting the data to ISO. This is not a selective process—it applies to every company and every submission without exception. In addition, the data quality effort is supported by a program of incentive assessments, which are designed to encourage prompt and accurate reporting.

Key steps in the data quality process include:

- **Submission Balancing**: Each company submission sent to ISO includes a transmittal letter containing the control totals (number of records and total dollar amounts) of all the data included in the submission. After the data are processed and summarized by ISO, the results are balanced against the transmittal letter totals. These totals then serve as the basis for control totals throughout the report production process at ISO.

- **Record Editing**: Each individual record is subjected to a series of edits (checks) and rejected if it is in error:

  - **Absolute Edits**
    Each field on the record is checked to be sure it contains codes conforming to the statistical plan.

  - **Field Relationship Edits**
    Codes determined to be valid by the absolute edits are thereafter considered invalid if inconsistent with codes in other fields. For example, the presence of the Iowa state code and an otherwise valid territory code that is not applicable in Iowa causes the record to be rejected.

- After the data have been aggregated, **Distributional Editing** is performed. By comparing the submitted data with historic profiles for the company and the industry, systematic errors can be discovered and corrected.

- Each year, the statistical data are also reconciled to Annual Statement Page 14 in order to ensure completeness.

The data included in ISO reports are not finally accepted until the consolidated experience of all companies is examined. Only after ISO has verified that the reported data are valid, reliable and accurate is a final data base created.

NAII Statistical Plans are designed for simplified reporting. They respect the different territorial classifications and rating plans of different companies, and contain sufficient information for the administration of rates as required in the NAIC model rating law.

Data reported under NAII statistical plans are collected on a summary basis. This means that company records containing the same coded information for all required data elements are summarized together, thus minimizing the number of records to be processed through NAII's systems. This allows the company and NAII to focus on validating those data elements, which are necessary to support the statistical agent function. This level of detail allows for the consolidation of premium and loss statistics of all reporting companies resulting in meaningful reports compatible with other statistical agents.

Upon receipt at NAII, company data enter NAII's validation system. This system provides controls over the processing of the data in addition to various types of editing and distributional checks. The first processing step is to verify that the data processed through NAII's system match the company's transmittal letter, which represents control totals. The transmittal letter is submitted with each data submission. Company data are then edited to ensure the validity of statistical coding. For lines of insurance reported in a manner compatible with company financial data, reconciliations are performed of statistical data to Page 14. In order to ensure the reasonability of statistical data, NAII performs distributional-type edits on each company's submission. This type of edit detects systematic errors through examination of company and industry profiles. The usual method of performing this edit is to compare a company's current data to the preceding year's data. Distributions of company experience include comparisons of coverage, class and territory as well as the other required data elements included in a company's submission.

All of these checks provide the means for errors and questionable situations to be corrected or verified before the data is included in NAII's data base. This results in an output of quality data, which can be used in NAII's report system.

Once the statistical data have been verified as valid, reliable and accurate, they can be reported to regulators to assist them in determining whether existing rate systems are in compliance with the insurance statutes of their states. The NAIC Statistical Handbook specifies the statistical reports that regulators receive to fulfill their statutory responsibilities.

The **Statistical Handbook**, adopted by the National Association of Insurance Commissioners (NAIC), defines the content and format of the reports that the statistical agents are required to produce on an annual basis. It suggests an efficient production schedule for the reports defined in the Handbook—and identifies other reports that can be produced within a specified time of their request. Moreover, it develops clear explanations of the data capabilities of each of the statistical agents so that differences can be easily identified and compatibility promoted when possible.

In accordance with the requirements of the Statistical Handbook, the statistical agents file reports on an annual basis for each line of insurance with each state regulator. As the Statistical Handbook (Section II, Page 1) explains:

> The statistical reports can be used to review what the experience has been both over broad categories and for individual coverages. The loss ratios, average claim costs, claim frequencies, and pure premiums appearing on the reports can be used to compare different coverages and to determine trends. For example, territory experience and that for the entire state can be contrasted and differences between coverages can be discerned. Long term trends in loss ratio, claim cost and claim frequency can be reviewed. Aggregate results may serve as indicators of areas which warrant additional investigation.

A sample of the information contained in statistical filings is displayed in Exhibit 15.

The NAIC Statistical Handbook specifies reports produced each year by state, line of insurance, coverage, class, and territory, as appropriate. Additional reports are specified for production upon request, with appropriate lead time.

AUTOMOBILE LIABILITY EXPERIENCE
ACCIDENT YEARS ENDED DECEMBER 31, 1980, 1981, 1982, 1983, 1984

BODILY INJURY LIABILITY

ALL COMPANIES THAT FILED
EXPERIENCE WITH ISO

COMMERCIAL - VOLUNTARY RISK

SAMPLE STATE

ACC YR	EARNED CAR YEARS	COLLECTED EARNED 2 PREMIUM	INCURRED LOSSES BASIC LIMITS	INCURRED LOSSES EXCESS LIMITS	NO. OF CLAIMS	AVG 4 CLAIM COST	3 CLAIM FREQ.	4 PURE PREM
LOCATION A								
80	2485	573917	119897	40586	20	5995	0.80	48.25
81	2771	669075	347812	103181	39	8918	1.41	125.52
82	2762	736683	244379	13288	53	4611	1.92	88.48
83	2793	707954	126805	102220	27	4696	0.97	45.40
84	2765	791337	210401	106044	33	6376	1.19	76.09
TOT	13576	3478966	1049294	365319	172	6101	1.27	77.29
LOCATION B								
80	1586	163424	93169	31075	10	9317	0.63	58.74
81	1889	190836	32683		14	2335	0.74	17.30
82	1855	232699	38633		9	4293	0.49	20.83
83	2126	269769	48808		15	3254	0.71	22.96
84	2379	342593	151408	10164	21	7210	0.88	63.64
TOT	9835	1199321	364701	41239	69	5286	0.70	37.08
STATEWIDE TOTALS								
80	66194	6477373	2093316	1832380	292	7169	0.44	31.62
81	77153	8190157	2411004	2526170	374	6447	0.48	31.25
82	77566	9512761	2480173	2283985	297	8351	0.38	31.98
83	80884	9941807	2489515	3064414	275	9053	0.34	30.78
84	77852	10476269	3219691	4307798	319	10093	0.41	41.36
TOT	379649	44598367	12693699	14014747	1557	8153	0.41	33.44

NOTES

2 PREMIUMS INCLUDE CHARGES FOR EXCESS LIMITS (FOR BODILY INJURY THEY ALSO INCLUDE PREMIUMS FOR MEDICAL PAYMENTS AND U.M. COVERAGES)

3 CLAIM FREQUENCY IS PER 100 CARS DEVELOPED

4 BASIC LIMITS

The requirements of the NAIC Statistical Handbook foster efficiency in the data collection process.

The Statistical Handbook was drafted on the premise that the annual reports submitted to regulators were, at that time, far in excess of their need for information. What the Handbook did was to streamline the regulatory requirements to provide for an overview of statistical developments, giving the regulator the option to request more detailed statistics if they are needed.

The Handbook drafters further recognized the need for efficiency by permitting companies with limited premium volume to report less detailed statistics. The drafters properly reasoned that whatever benefits could be derived from full detail reporting for all companies were outweighed by improvements in the timeliness of the reports and the elimination of other problems. Not only does this lessen the burden for smaller companies, but it allows for a concentration of effort on the processing of data for those groups which are more statistically significant.

Finally, to the extent that the Handbook also allows for flexibility in the submissions that insurers provide to the statistical agents, conversion and processing costs are minimized for companies with independent or unique coverage and rating programs.

The requirements of the NAIC Statistical Handbook are designed to recognize that data must be compiled in accordance with the purposes for which they will be studied.

To evaluate financial results for any given year, data are compiled on a **calendar year** basis. Calendar year statistics are defined as experience developed on premium and loss transactions occurring during the twelve calendar months beginning January 1, regardless of the effective dates of the policies on which those transactions took place.

For evaluating rates or for ratemaking purposes, running calendar year totals are generally not sufficient to provide the necessary match of premiums and losses for a given set of policyholders. Therefore, data must be compiled on an accident year or policy year basis. **Accident year** statistics include exposures and premiums earned during a twelve-month period, and the incurred losses and number of claims resulting from accidents that occurred during the same period. **Policy year** statistics represent an aggregate record of all transactions (premiums and losses incurred) on contracts becoming effective during a given twelve month period.

By their definitions, accident year data and policy year data cannot be produced as quickly as calendar year data. Nevertheless, they introduce a degree of data maturity that is fundamental to any rate or ratemaking analysis. A technical discussion of these compilations is contained in Section VII, Appendix A of the NAIC Statistical Handbook, which has been reproduced later in this section.

A sample of the information contained in the Statistical Handbook is displayed in Exhibit 16.

In addition to the detail of the annual reports, the NAIC Statistical Handbook specifies the production schedules for each line of insurance, consistent with each line's compilation basis, which is also specified, i.e., calendar year, accident year, policy year.

TIME GRAPH FOR PROCESSING STATISTICAL DATA

HOMEOWNERS AND
PERSONAL PROPERTY OTHER THAN HOMEOWNERS

COMPANY DATA PROCESSING
- Data Due at Statistical Agent on Final Date

STATISTICAL AGENT DATA PROCESSING
- Receipt and Acceptance Processing
- Company Error Corrections
- Report Production
- Overall Review
- Statistical Reports Supplied to Regulators on Final Date

B-18

2.33

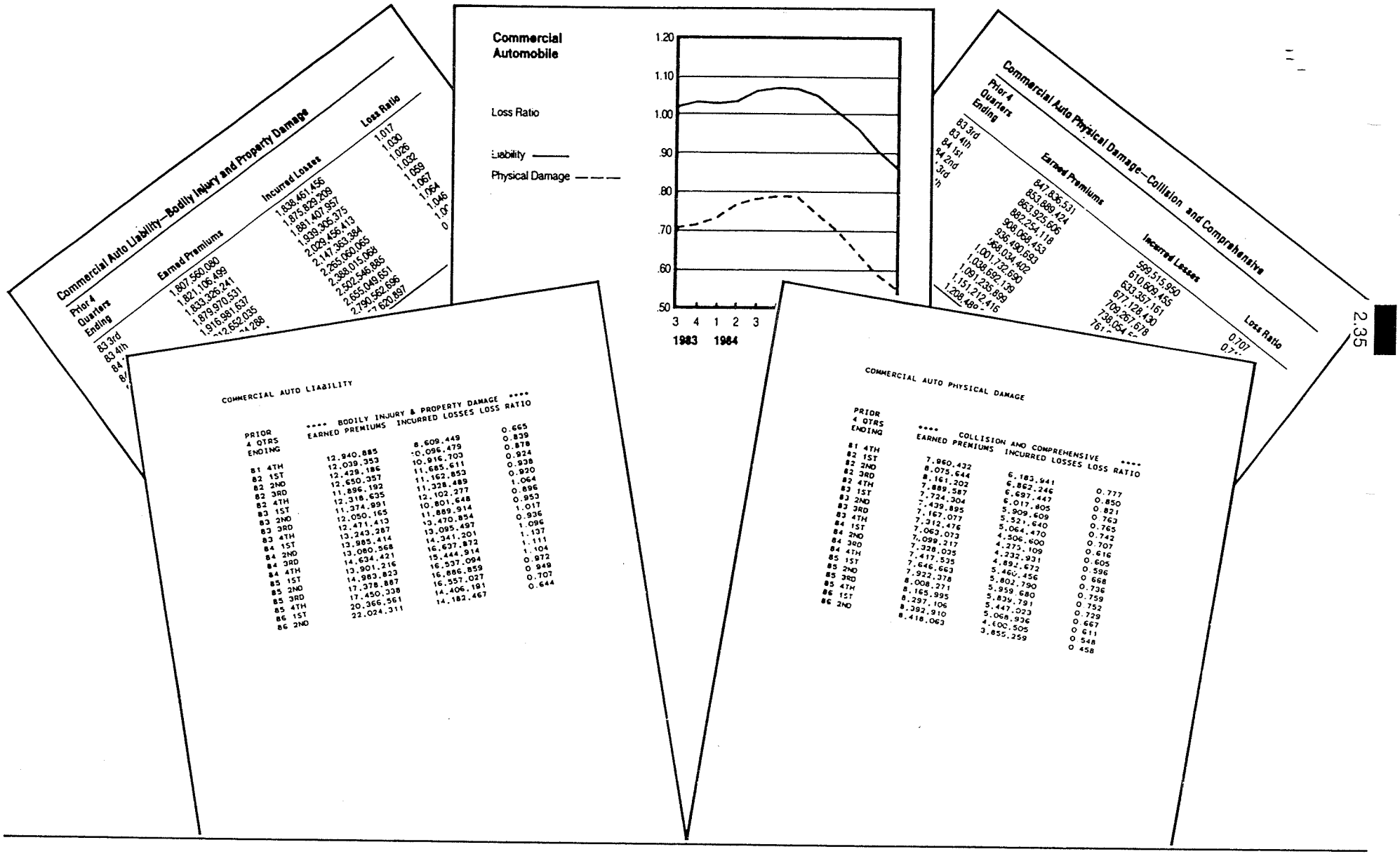
***In addition to the report requirements specified in the Statistical Handbook, the statistical agents are also required to compile data for the NAIC* Fast Track Monitoring System.**

Under the **Fast Track Monitoring System**, loss ratio data, compiled by state and in the aggregate for the major lines of insurance, are used to give an early indication of the by line underwriting experience of the industry.

To produce Fast Track data, companies that together write a large percentage of the industry's premium for Fast Track lines report highly summarized accounting data by quarter, on an accelerated schedule, to the two major statistical agents. The statistical agents, ISO and NAII, combine these data and make them available to regulators.

A sample of the Fast Track data is included in Exhibit 17.

Similar data is available for the following lines: Commercial Fire and Allied Lines, Dwelling Fire and Allied Lines, Medical Professional Liability, Commercial Multiple Peril, Private Passenger Automobile, General Liability, Homeowners, and Farm Business. Details include: countrywide net (with respect to reinsurance) loss ratio data; claim cost and frequency; and direct loss ratio data on a countrywide basis and by state.



KANSAS BAR ASSOCIATION

1200 Harrison
P.O. Box 1037
Topeka, Kansas 66601
(913) 234-5696

March 25, 1987
SB 247

Mr. Chairman. Members of the House Insurance Committee. I am Ron Smith, KBA Legislative Counsel.

KBA Supports SB 247.

This legislation is similar to 1986 SB 729. Last year KBA did not have positions on such insurance matters. Over the summer, our legislative committee studied these issues and the Kansas Bar Association now supports legislation which allows the Insurance Commissioner to adopt or require property-casualty insurance companies to file statistical information plans to support rate increases.

Current law restricts the authority of the commissioner to require PC companies to file statistical information to support such increases. This legislation should provide the commissioner with authority to develop statistical plans requiring most PC companies to record and report loss and expense experience on specific classes of insurance in a more timely and efficient manner.

PROPOSED AMENDMENT TO

SENATE BILL No. 247

AN ACT relating to insurance; concerning recording and reporting of loss and expense experience; amending K.S.A. 40-937 and 40-1118 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 40-937 is hereby amended to read as follows: 40-937. (a) Recording and reporting of loss and expense experience. The commissioner shall ~~promulgate~~ develop reasonable ~~rules and~~ statistical plans, ~~reasonably adopted to each of the rating systems on file with, which may be modified from time to time and~~ which shall be used ~~thereafter~~ by each insurer in the recording and reporting of its loss and ~~country-wide~~ expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid ~~him~~ the commissioner in determining whether rating systems comply with the standards set forth in K.S.A. 40-927, and amendments thereto. Information supplied by the statistical plan shall include but not be limited to the following:

(1) Premiums earned;
(2) premiums written;
(3) number of claims;
(4) number of new claims during the reporting period;
(5) number of claims closed during the reporting period and actual payouts;
(6) number of claims outstanding at the end of the reporting period;
(7) total losses incurred;
(8) total losses incurred as a percentage of premiums earned;
(9) total number of policies in force on the last day of the reporting period;
(10) total number of policies canceled;
(11) total number of policies nonrenewed;
(12) net underwriting gain or loss;
(13) separate allocating of expenses for commissions, other acquisition costs, general office expenses, taxes, licenses, fees and other expenses;
(14) whether or not the company sets reserves for claims for losses which have been incurred, but not reported;
(15) all reserves established in connection with the company's casualty line;
(16) how dollars reserved are treated in each of the catagories listed for federal income tax purposes;
(17) with respect to amount paid in claims for the year next preceding the filing of each annual report, each company shall provide the following information:

(A) Total amounts reserved with respect to those claims;
(B) the year in which the reserves were set; and
(C) the amounts set in each year;
(18) the value of the securities held in the company's investment portfolio as of December 31 of the year next preceding the filing of each annual report. Such information should be submitted in the same manner as provided by K.S.A. 40-225 and amendments thereto; and
(19) any published annual reports to shareholders or policyholders shall be submitted with the report.

Such ~~rules and~~ plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state ~~and are not susceptible of determination by a prorating of country wide expense experience. In promulgating such rules and~~ developing such plans, the commissioner shall give due consideration to the rating systems on file with ~~him~~ the commissioner and, in order that such ~~rules and~~ plans may be as uniform as is practicable among the several states, ~~to the rules and~~ to the form of the plans used for such rating systems in other states. ~~No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.~~ The commissioner may designate one or more rating organizations or other agencies to assist ~~him~~ the commissioner in gathering such experience and making compilations thereof, and such compilations shall be made available, ~~subject to reasonable rules promulgated~~ by the commissioner, to insurers and rating organizations: ~~Provided, That nothing in this act shall be construed to require, nor shall the commissioner adopt any rule to require, any insurer to record or report its loss or expense experience on any basis or statistical plan not consistent with the rating system filed by it.~~

(b) Interchange of rating plan data. Reasonable ~~rules and~~ plans may be ~~promulgated~~ developed by the commissioner for the interchange of data necessary for the application of rating plans.

(c) Consultation with other states. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

(d) Rules and regulations. The commissioner may make reasonable rules and regulations necessary to effect the purposes of this act.

Sec. 2. K.S.A. 40-1118 is hereby amended to read as follows: 40-1118. (a) Recording and reporting of loss and expense experience. The commissioner shall ~~promulgate rules and~~ develop statistical plans, ~~reasonbaly adopted to each of the rating systems on file with him, which may be modified from time to time and~~ which shall be used ~~thereafter~~ by each insurer in the recording and reporting of its loss and ~~country wide~~ expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid ~~him~~ the commissioner in determining whether rating systems comply with the standards set forth in K.S.A. 40-1112, and amendments thereto.

Information supplied by the statistical plan shall include but not be limited to the following:

(1) Premiums earned;
(2) premiums written;
(3) number of claims;
(4) number of new claims during the reporting period;
(5) number of claims closed during the reporting period and actual payouts;
(6) number of claims outstanding at the end of the reporting period;
(7) total losses incurred;
(8) total losses incurred as a percentage of premiums earned;
(9) total number of policies in force on the last day of the reporting period;
(10) total number of policies canceled;
(11) total number of policies nonrenewed;
(12) net underwriting gain or loss;
(13) separate allocating of expenses for commissions, other acquisition costs, general office expenses, taxes, licenses, fees and other expenses;
(14) whether or not the company sets reserves for claims for losses which have been incurred, but not reported;
(15) all reserves established in connection with the company's casualty line;
(16) how dollars reserved are treated in each of the catagories listed for federal income tax purposes;
(17) with respect to amount paid in claims for the year next preceding the filing of each annual report, each company shall provide the following information:

(A) Total amounts reserved with respect to those claims;
(B) the year in which the reserves were set; and
(C) the amounts set in each year;
(18) the value of the securities held in the company's investment portfolio as of December 31 of the year next preceding the filing of each annual report. Such information should be submitted in the same manner as provided by K.S.A. 40-225 and amendments thereto; and
(19) any published annual reports to shareholders or policyholders shall be submitted with the report.

Such ~~rules and~~ plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state ~~and are not susceptible of determination by a prorating of country wide expense experience~~. in promulgating such ~~rules and~~ plans, the commissioner shall give due consideration to the rating systems on file with ~~him~~ the commissioner and, in order that such ~~rules and~~ plans may be as uniform as is practicable among the several states, ~~to the rules and~~ to the form of the plans used for such rating systems in other states. ~~No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it~~. The commissioner may designate one or more rating organizations or other agencies to assist him the commissioner in gathering such experience and making compilations thereof, and such compilations shall be made available, ~~subject to reasonable rules promulgated~~ by the commissioner, to insurers and rating organizations: ~~Provided, That nothing in this act shall be construed to require, nor shall the commissioner adopt any rule to require, any insurer to record or report its loss or expense experience on any basis or statistical plan not consistent with the rating system filed by it~~.

(b) Interchange of rating plan data. Reasonable ~~rules and~~ plans may be ~~promulgated~~ developed by the commissioner for the interchange of data necessary for the application of rating plans.

(c) Consultation with other states. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

(d) Rules and regulations. The commissioner may make reasonable rules and regulations necessary to effect the purposes of this act.

Sec. 3. K.S.A. 40-937 and 40-1118 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.